

# APPENDIX 1

## Basic Elements of a SOAP (Progress) Note in Psychiatry

### **S : Subjective**

- Chief complaint
- Interval history per patient
- Nursing reports regarding behavior
- Information from collateral contacts (e.g., family, friends, legal, other healthcare professionals, etc.)

### **O : Objective**

- Vital signs
- Mental status examination
- Pertinent physical exam findings
- Nature of interactions with others (e.g., staff, patients)
- Current Medications
- Laboratory/imaging results and others (EKG, EEG etc)

### **A : Assessment**

- Diagnoses: psychiatric (Axes I-V) and medical
- Psychosocial assessment and implications

### **P : Plan**

- Treatment plan (e.g., psychotherapy, medications, social interventions, discharge plans)
- Recommendations, if a consult
- Plans for gathering further information
- Plans for further evaluation (e.g., tests, labs, assessments)

## APPENDIX 2

### General Outline for History & Physical (H&P) in Psychiatry

**Chief concerns:** As much as possible, use the patient's own words to describe the presenting symptoms and/or the primary reason the patient is seeking psychiatric care.

**History of present illness (HPI):** This is a detailed description of the psychiatric symptoms which brought the patient to seek care. Include the temporal relationship of the presenting complaints, recent stressors in the patient's life, and patient attempts to cope with the symptoms and stressors. The primary purposes of the HPI are to:

- Develop initial differential diagnoses and rank order of diagnostic priorities, both psychiatric and contributing medical diagnoses
- Identify events that may have led to an acute exacerbation of symptoms and/or treatment seeking
- Estimate the patient's current level of functioning and illness severity
- Estimate the patient's current level of danger to self (suicidal ideation) and danger to others (homicidal ideation)
- Anticipate the course of the disorder
- Anticipate the course of treatment

**Past Psychiatric History:** Relevant historical information is collected regarding:

- Past Episodes of Psychiatric Illnesses (including substance dependence/abuse)
- Prior Treatments and response to them
- Hospitalizations
- Suicidal ideation (danger to self) and suicide attempts
- Homicidal ideation (danger to others) and acts of aggression
- Current Mental Health providers (psychiatrist, psychotherapist)

**Past Medical History:** Places the patient and her/his symptoms within a larger medical context. Relevant historical information is collected, leading up to and including the patient's *current* medical conditions, regarding:

- Hospitalizations
- Illnesses
- Surgeries
- Reproductive history (where applicable)
- Current Medical providers

**Medications:**

**Allergies:**

**Family history:**

- Family history of medical illnesses
- Family history of psychiatric illness including suicide. It is also helpful to ask about unexplained deaths in the family and substance use patterns in close family members

**Past and current *personal and social* information:** Not all elements are relevant to every case, but detailed personal and social information is often essential to an adequate psychiatric H&P. This information places the patient and her/his symptoms within the patient's larger psychosocial context (e.g., community, life events, race/ethnicity, work, socioeconomic status, education, age, gender, attitudes, beliefs, personality, etc.). Relevant historical information may be collected, leading up to and including the patient's *current* state (where applicable), regarding:

- Childhood and adolescent family life
- Childhood and adolescent developmental delays and socialization
- Physical, sexual, and/or emotional abuse/neglect
- Education (highest level attained; special education/learning disabled; grades repeated; conduct or behavior problems; expulsions; academic achievement)
- Military service
- Sexual orientation
- Relationships (married, divorced, widowed, etc.)
- Children
- Sexual activity
- Domestic abuse
- Employment, job satisfaction, disability
- Legal issues (law suits, claims) and arrests
- Financial situation (income, money problems)
- Living conditions (community, place of residence)
- Major life stressors (patient and family: job loss, bereavement, divorce, illness, etc.)
- Spirituality
- Support networks and coping
- Lifestyle (exercise, diet, recreation)

This type of information is important for evaluating patient risks and assets—with regard to psychiatric disorders and response to treatment—as a function of psychosocial history and current milieu. It helps identify challenges to effective psychiatric intervention, which may include the demands, support/resource limitations, and stressors in the patient's life. Finally, personal and social information gives insight into the patient's personality, including information relevant to personality disorders (e.g., borderline or antisocial personality disorder).

### **Examination:**

**Physical Examination:** Some level of physical exam is often required in order to evaluate the patient's current level of physical/medical functioning, and to assess the contribution of medical factors to the presenting psychiatric symptoms. The physical exam may include:

- Vital signs
- HEENT (head, eye, ear, nose, throat)
- Neck/Thyroid
- Lungs
- Heart
- Breasts
- Abdomen
- Genital/Rectal
- Back/Spine
- Extremities/Joints
- Neurological

Mental Status Examination: This is a detailed assessment of the patient's mental state based on the interviewer's observation gathered throughout the interview. Thus it includes observations made from the beginning of the patient interaction (in the waiting room, or from the moment the patient enters the room) as well as information gathered during the more formal questioning on areas such as cognition and abstraction. The areas covered include:

- Attitude and eye contact
- General Appearance
- Psychomotor Activity
- Speech
- Mood
- Affect
- Thought process
- Thought content
- Perceptions
- Abstraction
- Cognition: may include alertness, orientation, recent and remote memory, attention and concentration, language skills and more complex functions such as executive functioning
- Insight
- Judgement

## APPENDIX 3

### Mental Status Examination in Psychiatry

#### A. General

1. Apparent age
2. Grooming and hygiene
3. Attire, for example:
  - a. meticulous
  - b. eccentric
  - c. stereotyped (e.g., VA patient dressed in battle fatigues)
  - d. inappropriate for season/weather
4. Physical abnormalities/disabilities
5. Jewelry/Cosmetic use
6. Tattoos/Identifying marks
7. Attitude during interview and toward examiner, for example:
  - a. irritable
  - b. cooperative
  - c. hostile
  - d. impulsive
  - e. silly
  - f. sensitive
  - g. apathetic
  - h. withdrawn
  - i. evasive
  - j. passive
  - k. dramatic
  - l. dependent
  - m. seductive
  - n. friendly
  - o. confrontative
  - p. *la belle indifférence*
  - q. eager/over-eager

#### B. Sensorium

1. Level of consciousness, for example:
  - a. alert/hyperalert
  - b. somnolent
  - c. lethargic
  - d. comatose
  - e. fluctuations in consciousness
2. Orientation:
  - a. person (know *who* they are)
  - b. place (know *where* they are)
  - c. time (know *when* they are: month/day/year, day of week, time of day)

**C. Cognition (or Mini-Mental Status Examination–MMSE)**

- 1. Memory:
  - a. short term recall (remember 3 words)
  - b. recent
  - c. remote
  - d. amnesia
  - e. confabulations
- 2. Attention:
  - a. Digit Span: Patient repeats number series back to examiner, forward and reverse. Average expected performance is 5-8 forward and 4-6 reverse. Forward vs. reverse discrepancy should not exceed 3.

Forward	2-5	3-8-6	7-2-9-6	3-4-1-9-6	8-4-2-3-9-6	1-6-5-2-9-8-7	8-5-9-2-5-1-4-7
Reverse	6-3	2-5-9	8-4-1-3	9-4-7-8-5	7-9-6-4-8-2	3-8-9-1-7-4-2	3-1-7-9-5-2-8-4

- 3. Concentration:
  - a. Patient subtracts by 7 from 100 ('serial 7s'); five subtractions; < 3 errors expected
  - b. Patient spells 'WORLD' *backwards*; score is number of letters in correct order
- 4. Intelligence & abstract thinking:
  - a. Estimate based on educational attainment, work status, socioeconomic status, general fund of knowledge, vocabulary (below average, average, above average)
  - b. Interpretation of similes and proverbs
- 5. Visual-Motor ability:
  - a. Patient copies a complex figure (e.g., two intersecting pentagons, cube)

**D. Mood: Patient's internal feeling over the recent past**

- 1. Quality: Stated in patient's own words
  - a. Sad/depressed
  - b. Happy
  - c. euphoric
  - d. anxious
  - e. irritable/angry
- 2. Stability/Duration

**E. Affect: Observed evidence (behavioral, verbal) of patient's emotional state**

1. Quality:
  - a. sad
  - b. anxious/fearful
  - c. content
  - d. indifferent
  - e. hostile
  - f. expressionless
  - g. laughing
2. Range/reactivity:
  - a. flat
  - b. blunted
  - c. constricted
  - d. restricted
  - e. responsive/reactive
  - f. normal
  - g. dramatic
  - h. passionate
  - i. labile
3. Appropriateness (appropriate vs. inappropriate)
4. Congruence to stated mood

**F. Thought Processes: How the patient thinks**

1. Organization of ideas:
  - a. logical
  - b. goal-directed
  - c. circumstantial
  - d. flight of ideas
  - e. loosening of associations
  - f. perseveration
  - g. blocking
  - h. echolalia
  - i. clang associations
  - j. word salad

## **G. Thought Content: What the patient says/believes**

1. Delusions:
  - a. persecution
  - b. somatic
  - c. jealous
  - d. grandiose
  - e. thought insertion
  - f. thought withdrawal
2. Obsessions, preoccupations, compulsions
3. Phobias, fears/concerns
4. Suicide:
  - a. plans vs. impulsivity
  - b. gradation of suicidality:
    - passive desire
    - thoughts of wanting to die
    - plans
    - safety inside hospital vs. outside
  - c. hope, planning for the future
5. Homicide or violence/aggression:
  - a. plans vs. impulsivity
  - b. specificity of the intended victim
6. Somatic Concerns: screen if anxiety, depression, or dementia present
7. Other topics:
  - a. guilt
  - b. ideas of reference
  - c. suspiciousness

## **H. Psychomotor Activity**

1. General observations:
  - a. agitation
  - b. psychomotor retardation
  - c. hyperactivity
2. Specific movements:
  - a. gait
  - b. tics
  - c. tremor
  - d. posture
  - e. akathisia
  - f. catatonia
  - g. dystonias
  - h. tardive dyskinesia
  - i. choreoathetoid movements

## **I. Speech**

1. Accent and dialect
2. Amount of speech:
  - a. responsive
  - b. spontaneous
  - c. fluent
  - d. pressured
  - e. verbose
  - f. mutism
3. Modulation: loudness or softness
4. Articulation:
  - a. garbled
  - b. slurred
  - c. choppy
  - d. clear
5. Pitch: highness or lowness of spoken words
6. Spontaneity or latency
7. Rhythm or cadence: stuttering, aprosody
8. Language: aphasia

## **J. Perceptions**

1. Illusions
2. Hallucinations:
  - a. auditory: regarding 'voices':
    - number, duration, clarity
    - effort needed to ignore
    - intent
  - b. tactile
  - c. olfactory
  - d. kinesthetic
3. Derealization
4. Depersonalization

## **K. Judgment**

1. Describe patient's understanding of the outcomes of behavior, ability to demonstrate proper judgment in hypothetical situations, and the link between good judgment and planned behavior. Consider whether patient's judgment is:
  - a. reliable
  - b. practical
  - c. realistic
  - d. sensible
  - e. normative
  - f. intellectual vs. emotional

**L. Insight**

1. Describe degree of patient's awareness and understanding regarding his/her symptoms and illness. Describe degree of patient's awareness regarding how his/her motives/feelings can lead to changes in behavior (emotional insight). Consider whether insight is:
  - a. realistic
  - b. reliable
  - c. practical
  - d. sensible
  - e. normative

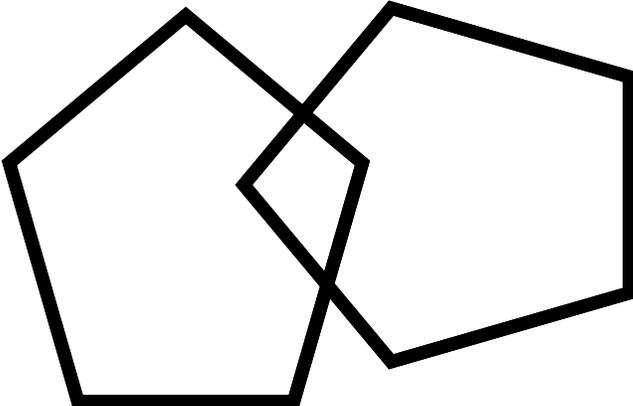
## APPENDIX 4

### MINI-MENTAL STATUS EXAMINATION (MMSE)

<b>Orientation</b>	<b>Scores</b>
1. <i>Year</i> (0-1:__); <i>Season</i> (0-1:__); <i>Date</i> (0-1:__); <i>Day of week</i> (0-1:__); <i>Month</i> (0-1:__); SCORE = 0-5	
2. <i>City</i> (“ <i>What city do you live in?</i> ”) (0-1:__); <i>State</i> (0-1:__); <i>Country</i> (0-1:__); <i>Name of this place</i> (“ <i>Where are you right now?</i> ”) (0-1:__); <i>Floor of building</i> (“ <i>What floor of the building are we on right now?</i> ”) (0-1:__); SCORE = 0-5	
<b>Registration</b>	
3. <i>Test your memory; lemon, key, ball; repeat back</i> (“ <i>Can you say those 3 words for me?</i> ”) Score 1 <sup>st</sup> repetition (but allow up to 5 trials to learn list); 1 pt/word; SCORE = 0-3	
<b>Attention/Concentration</b>	
4a. <i>Begin at 100, subtract by 7; stop after 5</i> (allow for correction after miss; eg., 93-85-78-71-64 = 4); 1 pt/correct #; SUBSCORE = 0-5	
4b. <i>Spell “WORLD” backwards</i> ; 1 pt for each letter in correct order (e.g., DLROW=5; DLRW=4; DLORW, DLW=3; OW=2; DRLWO=1); SUBSCORE = 0-5	
4. SCORE = higher of 4a and 4b = 0-5	
<b>Recall</b>	
5. <i>Recall of lemon, key, ball</i> (from item #11); ignore order; 1 pt/word; SCORE = 0-3	
<b>Naming</b>	
6. <i>Name watch, pencil</i> ; 1 pt each; SCORE = 0-2	
<b>Repetition</b>	
7. <i>Repeat “No ifs, ands, or buts.”</i> ; 1 trial; 1 pt if correct; SCORE = 0-1	
<b>Directions</b>	
8. <i>Take paper in your right hand, fold in half, put it on floor</i> ; 1 pt/correct step; SCORE = 0-3	
<b>Reading/Writing</b>	
9.* <i>Read sentence (“Close your eyes” printed on paper) and do what it says to do</i> ; SCORE = 0-1	
10. <i>Write a sentence</i> ; ignore punctuation/grammar; 1 pt = sensible sentence, subject/verb; SCORE = 0-1	
<b>Construction/copying</b>	
11.* <i>Copy figure</i> ; ignore tremor, rotation; 1 pt = 10 angles present + intersection; SCORE = 0-1	
<b>TOTAL SCORE = 0-30 [SUM OF 1-11; 4a/4b ARE SCORED IN BOX 4]</b>	

\*See next page for stimulus materials.

# CLOSE YOUR EYES



**MMSE interpretation of severity of cognitive impairment:**

Severe = 0-9

Moderate = 10-20

Mild-None = 21-30

Expected decline in MMSE score in untreated people with mild-moderate Alzheimer's disease is 2-4 points per year.

**Standard Citation for MMSE:**

Folstein MF, Folstein SE, McHugh PR. "Mini-mental state." A practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 1975; 12: 189-198.

## APPENDIX 5

### Five Axis Diagnostic System for Psychiatric Disorders

#### Diagnostic Assessment:

- Axis I = Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention
- Axis II = Personality Disorders; Mental Retardation
- Axis III = General Medical Conditions
- Axis IV = Psychosocial and Environmental Problems (see details below)
- Axis V = Global Assessment of Functioning (see details below)

#### Axis IV – Psychosocial and Environmental Problems:

- **Problems with primary support group:** death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling
- **Problems related to the social environment:** death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)
- **Educational problems:** illiteracy; academic problems; discord with teachers or classmates; inadequate school environment
- **Occupational problems:** unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers
- **Housing problems:** homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord
- **Economic problems:** extreme poverty; inadequate finances; insufficient welfare support
- **Problems with access to health care services:** inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance
- **Problems related to interaction with the legal system/crime:** arrest; incarceration; litigation; victim of crime
- **Other psychosocial and environmental issues:** exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies

## Axis V – Global Assessment of Functioning:

Consider psychological, social, and occupational functioning secondary to mental illness. Do not include impairment in functioning due to physical (or environmental) limitations. (Use intermediate codes when appropriate, e.g., 45, 68, 72.)

Codes	Descriptions
100 ↔ 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90 ↔ 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 ↔ 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
70 ↔ 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 ↔ 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers).
50 ↔ 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning ( e.g., no friends, unable to keep a job).
40 ↔ 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up on younger children, is defiant at home, and is failing at school).
30 ↔ 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
20 ↔ 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 ↔ 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

## APPENDIX 6

### CRISIS INTERVENTION in PSYCHIATRY

#### I. Suicide

##### A. Settings and flow of pts:

Out Pt/ED → Hospitalize → a. ICU  
b. Nonpsychiatric floor – 1:1 sitter  
c. Psychiatric floor – suicide precautions, 15 min checks  
↓  
Home: F/U, social, environment

##### B. Assess risk–evaluate balance between pt's coping ability, hopelessness, social support

**SAD PERSONS** scale, risk factors for suicide:

**Sex** - male  
**Age** - greater than 45  
**Depression**  
**Previous attempt**  
**Ethanol or Drug Abuse**  
**Rational thinking loss**  
**Social support lacking**  
**Organized plan for suicide**  
**No spouse**  
**Sickness**

Assess lethality as a measure of pt's intentions and accessibility of means:

- Reversibility (jump vs. superficial wrist cut)
- Timing-Probability of rescue
- Method chosen in light of methods available

Look for Motivation - escape from an unbearable situation:

- Longstanding conflicts
- Progressive escalation of problems
- Dissolution of meaningful social relationship
- Failure of non-suicidal efforts of resolution

Assess the family support system when sending pt home

Be aware of the top risk factors for completed suicide:

- |                               |  |
|-------------------------------|--|
| 1- Age greater than 45        | 6- Unwillingness to accept help                    |
| 2- EtOH dependence            | 7- Current depression longer than usual depression |
| 3- Irritation, Rage, Violence | 8- Prior Inpt psychiatric treatment                |
| 4- Prior suicidal behavior    | 9- Recent loss or separation                       |
| 5- Male gender                | 10- Depression                                     |

### C. Chronic risk of suicide

- Ask depressed patients about suicidal thoughts and plans frequently. You will not plant ideas that were not there merely by asking. Document carefully. Reassess risk of suicide at every visit with depressed patients.
- Hospitalize suicidal patients, even if it means hospitalizing them against their will. Patients who do *not* have suicidal plans and *do* have supportive families who can monitor them might be managed at home.
- In the outpatient setting, write frequent small prescriptions, and consider the lethality of all medications the person is taking. (Even what is available in the home.) Have the family remove all firearms from the home.
- Remember that even though the risk factors are known, it is not possible to predict who will commit suicide.
- One must use good clinical judgment, provide close follow-up, and prescribe effective treatments.

### D. Suicide myths and facts

Myth: People who talk about suicide don't commit suicide.

Fact: Of any 10 people who kill themselves, 8 have given definite warnings of their suicidal intentions.

Myth: Suicide happens without warning.

Fact: Studies reveal that the suicidal person gives many clues and warnings regarding his or her suicidal intentions.

Myth: Suicidal people are fully intent on dying.

Fact: Most suicidal people are undecided about living or dying and they gamble with death, leaving it to others to save them. Almost no one commits suicide without letting others know how he or she is feeling.

Myth: Once a person is suicidal, he/she is suicidal forever.

Fact: Individuals who wish to kill themselves are suicidal only for a limited period of time.

Myth: Improvement following a suicidal crisis means that the suicidal risk is over.

Fact: Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put morbid thoughts and feelings into effect.

Myth: Suicide strikes more often among the rich--or, conversely, among the poor.

Fact: Suicide is represented proportionately among all levels of society.

Myth: All suicidal individuals are mentally ill.

Fact: Although the suicidal person is extremely unhappy he/she is not necessarily mentally ill.

## II. Violent Patient

### A. Determine whether the pt is acutely out of control (balance of pt and environment):

- Out of control = Restrain, possible approach
- Angry = Approach

### B. Approaching the patient:

#### 1. Protect yourself:

- Know as much as possible about the patient before the meeting
- Be alert to the physical surroundings (i.e., door access and objects in room)
- Be alert to patient's signals (verbal and non-verbal)
- Have other persons in the vicinity
- Leave physical restraint to those trained
- Develop an alliance with the patient, avoid confrontation while pt is emotionally irrational
- Choose non-threatening posture, language, intonation

#### 2. Protect others:

- Inform the patient that violence is not acceptable and restraint or seclusion will be used if needed
- Approach patient in a non-threatening manner
- Reassure to calm patient or assist reality testing
- Have another capable and reliable person ready to restrain patient

### C. Determine the etiology of the violence and treat appropriately

### D. Risk factors for violence:

- History of acts of violence, especially if recent
- History of impulsive behavior or inability to control anger (e.g., antisocial or borderline personality disorders)
- Paranoid ideation or frank psychosis, such as command hallucinations
- Verbal or physical threats
- Brain diseases with global or frontal lobe impairment (i.e. dementia, delirium)
- Alcohol or substance intoxication

### E. Legal responsibilities:

- Tarisoff I = duty to warn
- Tarisoff II = duty to protect
- Commitment:
  1. Suffering from a potentially treatable mental illness
  2. In danger of harming self or others
  3. Types: 96-hour hold or 21-day hold

## APPENDIX 7

### GLOSSARY OF PSYCHIATRIC TERMS

AFFECT. An immediately expressed and observable emotion. Affect is distinguished from mood, which refers to a pervasive and sustained emotion. Examples of affect are euphoria, anger, and sadness.

A range of affect may be described as broad (normal), restricted (constricted), blunted, or flat. Restricted affect is characterized by a clear reduction in the expressive range and intensity of affects. Blunted affect is marked by a severe reduction in the intensity of affective expression. In flat affect there is a lack of signs of affective expression; the voice may be monotonous and the face, immobile.

Affect is inappropriate when it is clearly discordant with the content of the person's speech or ideation.

Affect is labile when it is characterized by repeated, rapid, and abrupt shifts.

AKATHISIA. Inner disquietness progressing to motor restlessness and/or inability to sit still due to antipsychotic medication.

ANXIETY. Apprehension, tension, or uneasiness, the source of which is largely unknown, as contrasted to fear which is the response to a consciously recognized and usually external threat or danger. The manifestations of anxiety and fear are the same and include motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance and scanning.

Anxiety may be focused on an object, situation, or activity which is avoided (phobia), or may be unfocused (free-floating anxiety). It may be experienced in discrete periods of sudden onset and be accompanied by physical symptoms (panic attacks).

ATTENTION. The ability to focus in a sustained manner on one task or activity.

BLOCKING. Interruption of a train of speech before a thought or idea has been completed. After a period of silence, which may last from a few seconds to minutes, the person indicates that he or she cannot recall what he or she has been saying or meant to say.

CIRCUMSTANTIALITY. A term used to describe speech that is indirect and delayed in reaching the point because of unnecessary, tedious details, and parenthetical remarks.

COMPULSION. Repetitive and seemingly purposeful behavior that is performed according to certain rules or in a stereotyped fashion.

CONFABULATION. Fabrication of facts or events in response to questions about situations or events that are not recalled because of memory impairment. It differs from lying in that the individual is not consciously attempting to deceive.

CONVERSION SYMPTOM. A loss or alteration of physical functioning that suggests a physical disorder but that is actually a direct expression of a psychological conflict or need. The disturbance is not under voluntary control, and is not explained by any physical disorder (this possibility having been excluded by appropriate investigation).

**DELUSION.** A false personal belief based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith).

Delusion of being controlled. A delusion in which feelings, impulses, thoughts, or actions are experienced as being not one's own, as being imposed by some external force.

Delusion, grandiose. A delusion whose content involves an exaggerated sense of one's importance, power, knowledge, or identity. It may have a religious, somatic, or other theme.

Delusional jealousy. The delusion that one's sexual partner is unfaithful.

Delusion, nihilistic. A delusion involving the theme of non-existence of the self or part of the self, others, or the world.

Delusion, persecutory. A delusion in which the central theme is that a person or group is being attacked, harassed, cheated, persecuted, or conspired against.

Delusion of poverty. A delusion that the person is, or will be, bereft of all, or virtually all, material possessions.

Delusion of reference. (Idea of Reference) A delusion whose theme is that events, objects, or other people in the person's immediate environment have a particular and unusual significance.

Delusion, somatic. A delusion whose main content pertains to the functioning of one's body.

**DISORIENTATION.** Confusion about the date/time of day, where one is (place), or who one is (identity).

**FLIGHT OF IDEAS.** A nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable associations, distracting stimuli, or plays on words.

**HALLUCINATION.** A sensory perception without external stimulation of the relevant sensory organ.

Hallucination, auditory (phoneme). A hallucination of sound, most commonly of voices, but sometimes of clicks, rushing noises, music, etc.

Hallucination, gustatory. A hallucination of taste, unpleasant tastes being the most common.

Hallucination, olfactory. A hallucination involving smell.

Hallucination, somatic. A hallucination involving the perception of a physical experience localized within the body.

Hallucination, tactile. A hallucination involving the sense of touch, often of something on/under the skin.

Hallucination, visual. A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light.

**ILLUSION.** A misperception of a real external stimulus.

INSOMNIA. Difficulty falling or staying asleep. Initial insomnia is difficulty in falling asleep. Middle insomnia involves awakening, followed by difficulty returning to sleep, but eventually doing so. Terminal insomnia is awakening at least 2 hours before one's usual wake time and being unable to return to sleep.

LOOSENING OF ASSOCIATIONS. Thinking characterized by speech in which ideas shift from one subject to another that is completely unrelated or only obliquely related without the speaker's showing any awareness that the topics are unconnected.

MOOD. A pervasive and sustained emotion that in the extreme, markedly colors the person's perception of the world.

Mood, euphoric. An exaggerated feeling of well-being.

Mood, euthymic. Mood in the "normal" range, which implies the absence of depressed or elevated mood.

Mood, depressed.

NEOLOGISMS. New words invented by the subject, distortions of words, or standard words to which the subject has given new, highly idiosyncratic meaning.

NEUROTIC DISORDER. A mental disorder in which the predominant disturbance is a symptom or group of symptoms that is distressing to the individual and is recognized by him or her as unacceptable and alien (ego-dystonic); reality testing is grossly intact. Behavior does not actively violate gross social norms (though it may be quite disabling). The disturbance is relatively enduring or recurrent without treatment, and is not limited to a transitory reaction to stressors. There is no demonstrable organic etiology or factor.

OBSSESSIONS. Recurrent, persistent ideas, thoughts, images, or impulses that are ego-dystonic, that is, they are not experienced as voluntarily produced, but rather as ideas that invade consciousness, and are recognizably irrational or unacceptable.

ORIENTATION. Awareness of where one is in relation to time, place, and person.

PANIC ATTACKS. Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During the attacks there are such symptoms as dyspnea, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of going crazy or losing control.

PERSEVERATION. Persistent repetition of words, ideas, or subjects so that, once as individual begins speaking about a particular subject or uses a particular word, it continually recurs.

PERSONALITY. Deep ingrained patterns of behavior, which include the way one relates to, perceives, and thinks about the environment and oneself. Personality traits are prominent aspects of personality, and do not imply pathology. Personality disorder implies inflexible and maladaptive patterns of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

PHOBIA. A persistent, irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (the phobic stimulus).

POVERTY OF SPEECH. Restriction in the amount of speech, so that spontaneous speech and replies to questions are brief and unelaborated.

PRESSURE OF SPEECH. Speech that is increased in amount, accelerated, and difficult or impossible to interrupt.

PSEUDODEMENTIA. Clinical features resembling a Dementia that are not due to organic brain dysfunction or disease; pseudodementia may occur in a major depressive episode.

PSYCHOMOTOR AGITATION. Visible generalized accelerating of physical reactions, movements, and speech.

PSYCHOMOTOR RETARDATION. Visible generalized slowing of physical reactions, movements, and speech.

PSYCHOTIC. A term indicating gross impairment in reality testing. Direct evidence of psychotic behavior is the presence of either delusions or hallucinations without insight into their pathological nature.

## APPENDIX 8

### Abnormal Involuntary Movement Scale (AIMS) *Examination Procedure*

Either before or after completing the Examination Procedure, observe the patient unobtrusively, at rest (e.g, in waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

1. Ask patient to remove shoes and socks.
2. Ask patient whether there is anything in his/her mouth (i.e, gum, candy, etc.) and if there is, to remove it.
3. Ask patient about the current condition of his/her teeth. Ask patient if he/she wears dentures. Do teeth or dentures bother patient now?
4. Ask patient whether he/she notices any movements in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother patient or interfere with his/her activities.
5. Have patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at entire body for movements while in this position.)
6. Ask patient to sit with hands hanging unsupported. If male, between legs, if female and wearing a dress, hanging over knees. (Observe hands and other body areas.)
7. Ask patient to open mouth. (Observe tongue at rest in mouth.) Do this twice.
8. Ask patient to protrude tongue. (Observe abnormalities of tongue movement.) Do this twice.
9. Ask patient to tap thumb, with each finger, as rapidly as possible for 10 to 15 seconds; separately with right hand, then with left hand. (Observe facial and leg movements.)
10. Flex and extend patient's left and right arms (one at a time.) (Note any rigidity.)
11. Ask patient to stand up. (Observe in profile. Observe all body areas again, hips included.)
12. Ask patient to extend both arms outstretched in front with palms down. (Observe trunk, legs, and mouth.)
13. Have patient walk a few paces, turn, and walk back to chair. (Observe hands and gait.) Do this twice.

**Abnormal Involuntary Movement Scale (AIMS)  
Scoring Procedure**

Instructions:

- Complete Examination Procedure before making ratings
- For movement ratings, rate highest severity observed
- Severity of abnormality scale for items 1-9 (*note that items 10-12 use a different scale*):
  - 1 = None
  - 2 = Minimal (may be extreme normal)
  - 3 = Mild
  - 4 = Moderate
  - 5 = Severe

FACIAL AND ORAL MOVEMENTS	1. Muscles of facial expression (e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing)	
	2. Lips and perioral area (e.g., puckering, pouting, smacking)	
	3. Jaw (e.g., biting, clenching, chewing, mouth opening, lateral movement)	
	4. Tongue; rate only increase in movements both in and out of mouth, NOT inability to sustain movement	
EXTREMITY MOVEMENTS	5. Upper: arms, wrists, hands, fingers; include <i>choreic</i> movements (e.g., rapid, objectively purposeless, irregular, spontaneous) and <i>athetoid</i> movements (e.g., slow, irregular, complex, serpentine); do NOT include tremor (e.g., repetitive, regular, rhythmic)	
	6. Lower: legs, knees, ankles, toes (e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion/eversion of foot)	
TRUNK MOVEMENTS	7. Neck, shoulders, hips (e.g., rocking, twisting, squirming, pelvic gyrations)	
GLOBAL JUDGMENTS	8. Severity of abnormal movements	
	9. Incapacitation due to abnormal movements	
	10. Patient's awareness of abnormal movements (rate only patient's self report): <b>No Awareness = 1; Aware/No Distress = 2; Aware/Mild Distress = 3; Aware/Moderate Distress = 4; Aware/Severe Distress = 5</b>	
DENTAL STATUS	11. Current problems with teeth and/or dentures: <b>No = 1, Yes = 2</b>	
	12. Does patient usually wear dentures?: <b>No = 1, Yes = 2</b>	

TOTAL SCORE	
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## **APPENDIX 9**

### **SEXUAL ABUSE AND ADULT SEQUELAE**

#### **1. The incidence of sexual abuse is unknown**

- A. Definitions vary
- B. Differences in terminology lead to confusion
- C. Perpetrators unlikely to voluntarily identify themselves
- D. Most reliable estimates are about 10-20% of the general population are victims
- E. Ratio of female to male is 9:1
  - 1) Under reporting in males secondary to:
    - a) fear of homosexuality
    - b) rite of passage misconceptions
    - c) bias of diagnosticians

#### **2. Allegations of reported abuse have increased at an alarming rate**

- A. More abuse
- B. Media coverage
- C. Better case-finding

#### **3. Diagnosis in children**

- A. No one single reaction observed in all sexually abused children
- B. Anxiety symptoms are nonspecific
- C. Behaviors more specific to sexual abuse include sexualized doll play, inserting objects into anus or vagina, excessive or public masturbation, seductive behavior, requesting sexual stimulation from other children or adults, and age-incongruent sexual knowledge
- D. Medical evidence of sexual abuse
  - 1) If occurred within 72 hours then a rape kit should be used
  - 2) Chronic abuse may present as vaginal scarring or sexually transmitted diseases

#### **4. Adult sequelae of sexual abuse**

##### **A. PTSD**

- 1) 8 to 15% of the general population have some symptoms of PTSD
- 2) 1% of the adult population and one-third of jailed women have full syndrome
- 3) Four core features of PTSD in children:
  - a) repeatedly visualized or perceived memories
  - b) repetitive behaviors
  - c) trauma-specific fears
  - d) changed interpersonal attitudes and pessimism about the future

##### **B. Borderline Personality Disorder**

- 1) Increased prevalence of childhood sexual abuse
- 2) An overlap in the prevalence of childhood sexual abuse between BPD and non-BPD patients
- 3) Higher frequency of multiple perpetrators of abuse in the BPD group
- 4) Only measures of severity of abuse which were significant were penetration and multiple perpetrators

##### **C. Revictimization**

- 1) Lack early warning system that signals danger
- 2) Reinforces a “blame the victim” mentality
- 3) High risk for therapist and spousal abuse

##### **D. Perpetrating violence**

- 1) May become an abusing parent although the majority do not
- 2) Acts out the internalized aggression and enters the criminal justice system only to risk revictimization
- 3) Chronic PTSD causes behavior which precipitates violence
- 4) DID patients can have a violent alter or the host personality can victimize the therapist

##### **E. Somatization syndromes**

- 1) Higher prevalence of a childhood history of abuse
- 2) Significant relationship between adult somatization and abuse
- 3) Variety of somatic symptoms:
  - a) chronic pain syndromes (including pelvic pain)
  - b) gastrointestinal complaints
  - c) fibromyalgia
  - d) asthma
  - e) neurological symptoms
- 4) 10% of pseudoseizure cases may be related to childhood incest
- 5) Often present initially to non-psychiatric physicians where sexual abuse history may not be routine
- 6) When no organic etiology found, sense of not being believed, perhaps a repetition of the response she got as a child

##### **F. Substance abuse**

- 1) High rates of sexual abuse in females in drug treatment programs
- 2) Addiction must be addressed before childhood abuse

### **G. Sexual dysfunction**

- 1) Abuse history easily missed in couples presenting for marital therapy
- 2) Presenting complaints of these couples diffuse and vague
- 3) Dyspareunia, inhibited desire, diminished arousal, and phobic avoidance of sexual intimacy

### **H. Eating disorders**

- 1) Commonly have history of child sexual abuse
- 2) An intense body hatred
- 3) Distorted body image
- 4) Need to be overcontrolled
- 5) Extreme childhood abuse may involve abnormal eating experiences
- 6) Lack of hedonistic pleasure in eating
- 7) Patients with DID may have unregulated eating habits due to different alters eating different foods at different times

### **I. Dissociative Identity Disorder (DID)**

- 1) Incest may be involved in the childhood histories of over 80% with DID
- 2) Etiology and severity may be related to the unpredictability of the abuse by an adult who is also providing some nurturing
- 3) Dissociation takes predisposition, precipitating trauma, and perpetuating traumas:
  - a) experiences amnesic periods, lost time, or blackouts

## **5. Variables affecting outcome**

- A. *Nature of the sexual abuse* - more invasive, the more traumatic
- B. *Whether force was used* - the use of force correlates with more negative and lasting responses
- C. *Duration of the abuse* - the longer, the more damaging
- D. *Age of the victim* - more severe when the abuse began at an early age
- E. *Age difference* - greater the difference, the greater the trauma
- F. *Sex of the perpetrator* - male perpetrators are more traumatic
- G. *Relationship to the perpetrator* - sexual relations between a father and daughter or a stepfather and a stepdaughter most damaging
- H. *Parental response* - a mother's response to the abuse is critical to the outcome
- I. *Access to treatment* - earlier access to treatment is better

## 6. Trauma and memory

- A. Traumatic events can create cognitive confusion and disorientation that paralyze the ability to respond adaptively
- B. Two choices:
  - 1) Ignore the incoming information (new information incorporated into old ideas)
  - 2) Assimilate and accommodate (adjust old ideas to accept new info):
    - a) basic assumptions about the world and self become malevolent
- C. Eventually memories may be denied conscious awareness making them unavailable for voluntary recall
- D. If trauma experience too threatening or affect too intense, motivated to forget:
  - 1) Repressed memory banished to unconscious becoming fragmented and disguised by fusion with other unconscious material
  - 2) Dissociated memory also banished to the realm of the unconscious but retains vividness and detail
- E. Recovered memories may be:
  - 1) Essentially accurate
  - 2) Partially accurate
  - 3) Largely distorted
  - 4) Intentionally false
  - 5) Iatrogenically produced
- F. Therapeutic effort is to rework and recategorize these memories into coherent patterns to be integrated into the life narrative
- G. Nondirective and nonsuggestive attitude by therapist

## 7. Reporting laws

- A. All 50 states
- B. Mandated to report are teachers, physicians, nurses, mental health professionals, social workers, and day care providers
- C. Report must be made in good faith and with reasonable professional judgment
- D. Penalty for the failure to report in most states is a misdemeanor
- E. Immunity from civil and criminal liability if in good faith

F. Procedure:

- 1) You should inform the person that you must do so
- 2) Call - Reveal only the information necessary to support your suspicions; you are not legally permitted to reveal confidential and unrelated patient information

**MISSOURI:           1-800-392-3738 for children under age 18**  
**1-800-392-0210 for adults over the age of 18**

**ILLINOIS:           217 524-2606 (outside Illinois)**

Follow up with a written letter reiterating the allegations. This helps prevent the case getting lost in the shuffle at DFS, documents for the chart (put a copy of the letter in the chart) thereby alerting other medical personnel to take a more careful history of "accidental injuries" in children. When they also report suspected abuse, the weight of the evidence increases, perhaps enabling DFS to take action to prevent further abuse. Documents you have fulfilled your legal and ethical duty.

**8. Protective custody**

- A. All states protect children in emergencies
- B. Police officers have authority to take children into temporary protective custody
- C. Strict time limits
- D. When more time is necessary Child Protective Services must start legal proceedings

## APPENDIX 10

### PSYCHIATRIC DISORDERS OF CHILDHOOD

#### CHILDHOOD PERVASIVE DEVELOPMENTAL DISORDERS

##### A. Autistic Disorder

Criteria:

1. Qualitative impairment in social interaction:
  - impairment in use of multiple nonverbal behaviors (gaze, body posture)
  - failure to develop peer relationships (compare to developmental level)
  - does not seek to share enjoyment with others
  - lack of social reciprocity
  
2. Qualitative impairment in communication:
  - delay in spoken language
  - does not initiate or sustain conversation with others
  - repetitive use of language
  - lacks spontaneous make-believe play or social imitative play
  
3. Restricted repetitive patterns of behavior, interest and activities:
  - preoccupation which is abnormal in intensity or focus
  - inflexible routines
  - repetitive motor mannerisms
  - preoccupation with parts of objects

##### B. Other Developmental Disorders

	<b>Retts</b>	<b>Aspergers</b>	<b>Childhood Disintegrative Disorders</b>
<b>Period of Normal Development</b>	<ul style="list-style-type: none"> <li>• Prenatal through 5 months</li> <li>• Normal head circumference at birth</li> </ul>		2 year
<b>Social interaction</b>	•Loss of social engagement early on	Impairment	Impaired in 2 or 3 (see above)
<b>Communication</b>	•Impaired with severe psychomotor retardation	Delay in development	Impaired in 2 or 3 (see above)
<b>Stereotyped Patterns of Behavior</b>		Impairment	Manifests 2 or 3 (see above)
<b>Other Distinguishing Characteristics</b>	<ul style="list-style-type: none"> <li>•Deceleration of head growth</li> <li>•Apraxia</li> <li>•Poorly coordinated trunk movements</li> </ul>		Loss of acquired skills in language, social skills, adaptive behavior, bowel or bladder control, play, or motor skills

## CHILDHOOD DISRUPTIVE BEHAVIOR DISORDERS

### A. Oppositional Defiant Disorder

- Kid with an attitude
- Prevalence: 3-10% children

#### Criteria:

##### Hostile, defiant behavior:

- loses temper
- argues with adults
- deliberately annoys people
- blames others
- angry

Duration: 6 months

Treatments: teach parents to give positive reinforcement, specific commands and token economics

### B. Conduct Disorder

- ODD + actions
- Prevalence: 2-3%
- Male : Female 4:1

#### Criteria:

##### 1. Aggression to people and animals:

- bully
- fights
- weapon
- cruel
- rape
- rob

##### 2. Destruction of property:

- fire setting
- destroyed others' property

##### 3. Lying and stealing

- burglary
- lies
- steals

##### 4. Serious violations of rules

- curfew
- truancy
- run away

## Risk Factors:

### 1. Psychiatric disorder:

- Antisocial Personality Disorder
- Substance Abuse
- Mood Disorders
- ADHD
- Schizophrenia
- LD

### 2. Low Verbal IQ

### 3. Neurological:

- low serotonin levels
- seizures
- perinatal problems

### 4. Temperament - difficult

### 5. Parenting and family

- large family
- young mother
- marital discord
- absent or alcoholic father
- abuse
- abandonment, neglect by parents
- depressed, irritable, substance-using or psychotic parent
- lack of parental supervision / monitoring
- harsh, unpredictable discipline
- similar behavior by parents
- lack of language use in problem-solving (not taught)

### 6. Sociological Factors

- behavioral norm in gang and drug infested neighborhoods
- status seeking
- delinquent peer group

## Treatments:

- Legal
- Family
- Social support
- Behavior Modification and problem solving therapy
- Pharmacology

## FEEDING AND EATING DISORDERS OF INFANCY OR EARLY CHILDHOOD

### A. Pica

- eating of non-nutritive substances for at least 1 month
- inappropriate for developmental level
- common in children with developmental disorders

Treatment:

1. Metabolic deficiency
2. Reorganize child's supervision

### B. Rumination Disorder

Repeated regurgitation and rechewing of food for a period of at least 1 month following a period of normal eating habits; not due to an associated gastrointestinal or other general medical condition.

In 1/3 of the pregnancies, obstetrical complications were reported and 1/4 of the children have developmental delays (often MR or PDD). Often the disorder begins in the absence of the caregivers or other sources of stimulation.

## CHILDHOOD ELIMINATION DISORDERS

### A. Encopresis:

- passage of feces into inappropriate places (clothing, floor) for 3 months
- age at least 4 years
- must rule out laxative use and GMC

Prevalence rates:

- 4 yr olds – 3%
- 6 yr olds – 2%
- 10-11 yr olds – 1.6%
- Adolescence - rare
- Male:Female = 4:1

### B. Enuresis:

- repeated voiding into bed or clothes for 3 months
- age at least 5 years
- must rule out diuretic and GMC
- daytime bladder control typically precedes nocturnal control by 1-2 yrs

Prevalence rates:

5 yr old – 20%

10 yr old boy – 3% (male predominance diminishes with age)

10 yr old girl – 2%

Treatments:

- Bell and pad / urine alarm
- DDAVP (Desmopresin)
- Low dose TCAs at bedtime

## OTHER DISORDERS OF INFANCY, CHILDHOOD AND/OR ADOLESCENCE

### A. Separation Anxiety Disorder:

- excessive fear of separation from primary attachment figure(s)
- onset before age 18 years
- duration at least 4 weeks
- Prevalence: 3-4%
- Male:Female = 1:2
- 1/3 of SAD children have MDD
- 1/3 of SAD children have Overanxious Disorder of Childhood

### B. Selective Mutism:

- consistent failure to speak in specific social situations although can speak in other situations
- duration at least 1 month

### Proposed etiologies:

- "shy" temperament
- witness to trauma
- early hospitalization and family instability
- 25% have delayed speech onset
- 50% have speech disorders
- Prevalence: <1% school age children

### C. Reactive Attachment Disorder of Infancy or Early Childhood:

- disturbed social relatedness
- diffuse attachments
- excessively inhibited
- hypervigilant
- highly ambivalent
- pathologic care where disregard for child's physical or psychological needs is evident or frequent changes in primary care giver

### D. Overanxious Disorder of Childhood:

- similar to Generalized Anxiety Disorder
- Prevalence: 7%
- Female sex predominance after puberty

## "ADULT" DISORDERS SEEN IN CHILDHOOD

### **Drug Abuse**

Children and adolescents may abuse or develop dependency on tobacco, alcohol, marijuana, inhalants, and other illicit drugs. No factors have been able to predict who experiments and who goes on to chemical dependency; however, family history, early onset, and rapid progression substance use leads to an increased risk. Adolescent risk of death, both intentional and through risk-taking behaviors, is increased in substance abusers.

Treatment: Substance abuse programs utilize an AA-like approach. Children are evaluated for comorbid disorders and the family is evaluated. A structure for support and accountability is prepared.

### **Schizophrenia**

Onset of schizophrenia before age 13, when the dopaminergic tracks complete their myelination, is rare. After age 13, the prevalence approaches 1%, similar to the adult population.

In children, the criteria for schizophrenia differ in that the child may fail to reach developmental milestones rather than deteriorate. Visual hallucinations are more common than in adults and are almost always accompanied by auditory hallucinations.

Treatment: These children require assessment and support in the areas of family, education, development and pharmacology.

### **Mood Disorders**

Key factors of depression in young people are declining school performance, withdrawal from social activities, somatic symptoms, sleep problems and conduct problems. Children often manifest as irritable rather than depressed mood. The length of times required for a child to suffer from depression when diagnosing MDD and dysthymia are half that of their adult counterparts.

Rarely does a child under the age of 10 commit suicide. Younger children do not have the capacity to anticipate the future, and thus cannot assume it will be hopeless.

Mania is rare before middle adolescence.

The etiological factors for the mood disorders in children and adolescents are similar to adults.

Treatment: Psychotherapy and family therapy are the first steps. Other factors are evaluated and coordinated such as social pressures, academic issues. Then medications are considered.

## Anxiety Disorders

Some fears are developmentally appropriate. The younger the child, the more likely the fear will manifest somatically (headaches, tummy aches). Many children who suffer from anxiety disorder will suffer as adults also.

Treatment: Evaluation of the etiology sets the treatment. A child suffering from sexual abuse and PTSD is treated differently than one suffering from a social phobia, which would be treated with behavioral therapy. Other therapies include: systemic desensitization, modeling, cognitive therapy and family therapy. Pharmacological treatment is similar to that of adults.

## Gender Identity Disorder

A child establishes a core gender identity by 3 years of age. Gender role behavior is established by 6 years. Culturally, tomboys are encouraged more than effeminate boys. The outcome of children engaging in cross gender behaviors varies from homosexual orientation to transsexual adults to heterosexual orientation.

Treatment: Childhood treatment is more effective than adolescent. Reinforcement is given for gender-concordant behaviors.

## Sleep Disorders

Children, especially when afraid of the dark, have difficulty settling in to sleep and later wake up calling out to parents. Chronic insomnia is more common in children with psychiatric diagnoses and may be medication related. Children may suffer from narcolepsy and sleep apnea. The treatment varies with the etiology of the sleep disorder. Nightmares typically occur in preschool children and reassurance is the first course of action. Sleep terror disorder is managed initially by evaluating the child's sleep hygiene. When children sleepwalk, the parents are asked to remove hazards. A low dose of Imipramine is possible treatment for the latter two disorders.

## Mental Retardation

The definition requires both low IQ and deficits in adaptive functioning.

Prevalence: 1%

IQ	MILD 55-70	MODERATE 40-55	SEVERE 25-40	PROFOUND <25
Education	Educable	Trainable (self care)	simple skills	--
Residence	Community	Sheltered	High structure	High structure
Economic	Makes change Holds job Assisted budget	Makes small change Able to manage pocket money	Can use coin machines Can take notes to stores	

## ATTENTION DEFICIT HYPERACTIVITY DISORDER

- A. Either (1) or (2):
- (1) Inattention:
    - short attention span and distractibility
    - poor organizational skills
    - random thought pattern
    - forgetful and loses things
      - (performance inconsistency)
      - (poor short-term memory)
  - (2) Hyperactivity-impulsivity:
    - "on the go," fidgeting, busy
    - difficulty waiting turn
    - intrusive
    - talks excessively
      - (social immaturity)
- B. Signs by seven years of age.
- C. Symptoms must be present in two or more situations (e.g., at school, work, and at home), be maladaptive and inconsistent with developmental level.
- D. Does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia or other Psychotic Disorder, and is not better accounted for by a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder.

### Types

**Attention-Deficit/Hyperactivity Disorder**, Predominantly Inattentive Type: if criterion A1) is met but not criterion A2) for the past six months

**Attention-Deficit/Hyperactivity Disorder**, Predominantly Hyperactive-Impulsive Type: if criterion A2) is met but not criterion A1) for the past six months

**Attention-Deficit/Hyperactivity Disorder**, Combined Type: if both criteria A1) and A2) are met for the past six months

Non Pharmacological Interventions:

1. Structure household and school
2. Teach parents additional parenting skills
3. Avoid overstimulation of child

Medications:

**Stimulants** treat reward subtype:

1. Methylphenidate (Ritalin, Methylin, Concerta)  
Ritalin when given to children with ADD - 80% are calmed  
Ritalin when given to children without ADD - 60% are calmed
2. Dextroamphetamine (Dexedrine, Adderall)

*Benefits:*

Improve performance at lower doses  
Improve behavior at higher doses

Side Effects:

Rebound irritability (short-acting Ritalin), appetite suppression, insomnia, increased blood pressure, pulse, depression, short stature, nausea, potentially unmasks tics

**Nonstimulant NE Reuptake Inhibitor:**

1. Atomoxetine (Strattera): 50% response rate in children with ADD

Side Effects:

Sedation, itching, anorexia, and possibly depression  
Metabolized by CYP2D6

**Antidepressants** treat excessive emotionality subtype:

1. Imipramine
2. Desipramine  
TCA guidelines: obtain an EKG at the onset of tx, annually and when doses are increased. Stop usage if resting HR > 130, PR interval > 200 msec, QRS is widened > 30% baseline, or QTC > 460 msec.
3. SSRI – (Fluoxetine, Sertraline, Paroxetine, Nafazodone)

*Benefits:* Relieve Anxiety and Depression

**Alpha 2 Adrenergic Agonists:**

1. Clonidine (Catapres)
2. Guanfacine hydrochloride (Tenex)

Side Effects:

Sedation, lowers blood pressure, dry mouth, enlarged pupils

Comorbidities of ADD:

- ODD or Conduct Disorders = 50%
- Anxiety Disorders= 25%
- Mood Disorders= 20%
- Tics – lifetime prevalence= 12%

## **LEARNING DISORDERS**

Criteria:

- (1) Specific skill, as measured by individually administered academic tests, is substantially below patient's chronological age, measured intelligence, and age-appropriate education.
- (2) Interference with academic achievement

- A. Reading Disorders
- B. Mathematics Disorders
- C. Disorders of Written Expression
- D. Learning Disorders NOS

## **MOTOR SKILLS DISORDERS**

Developmental Coordination Disorder:

- Motor difficulties substantially below expected for patient's age or IQ, interfering with ADLs
- R/O Etiology of GMC

## **COMMUNICATION DISORDERS**

Criteria:

- (1) Specific skill, measured by individualized standard testing is substantially below what is expected based on standard tests of IQ
- (2) The difficulty must interfere with achievement or ADL
- (3) Take into account patient's IQ, other deficits and environmental deprivation

- A. Expressive Language Disorder
- B. Mixed Receptive-Expressive Language Disorder
- C. Phonological Disorder
- D. Stuttering
- E. Communication Disorder NOS

# APPENDIX 11

## STIMULANT MEDICATIONS

The stimulant drugs that have found use in psychiatry are sympathomimetic amines, of which the prototype is amphetamine.

Clinical utility of stimulants has been limited by their abuse potential. Until recently, large quantities of these drugs were being diverted to nonprescription use, often through the intermediary so-called "script doctors" who prescribed them without proper indication. In 1970, the drugs were reclassified as schedule II by the FDA (the most restrictive classification for drugs that are medically useful). They are currently approved only for the treatment of attention deficit disorder with hyperactivity and for narcolepsy. However, they have several other possible uses in psychiatric practice. Those psychostimulants that are still used in clinical practice are dextroamphetamine, methylphenidate (Ritalin) and pemoline (Cylert).

### Indications for Psychostimulants

Effective:

- Narcolepsy
- Attention deficit-hyperactivity disorder (in children)

Probably effective:

- Treatment of apathy and withdrawal (in the medically ill and elderly)
- Potential of narcotic analgesics

Possibly effective:

- Residual attention deficit disorder (in adults)

### Available Preparations

<b>Drug</b>	<b>Trade Name</b>	<b>Dosage Forms</b>
d-Amphetamine	Dexedrine and generics	5-mg tablets 5 mg/5 ml elixir 5-,10-,15-mg SR* tablets
Methylphenidate	Ritalin and generics	5-,10-,20-mg tablets 20-mg SR tablets
Pemoline	Cylert	18.75-,37.5-,75-mg tablets

\*SR = sustained release

## I. Pharmacology

### *Absorption and Metabolism*

**Amphetamine** is well absorbed after oral administration. It has a short half-life (8-12 hrs); thus, it is usually administered 2-3 times per day. It crosses the blood brain barrier easily and develops high concentrations in brain. Amphetamine is partly metabolized in the liver and partly excreted unchanged in the urine. Its excretion is hastened by acidification of the urine.

**Methylphenidate** is well absorbed after oral administration. It has a very short biologic life; it reaches peak plasma concentrations in 1-2 hours and has an elimination half-life of 1-2 hours. Clinically, its effects last 3-4 hours, or even less in some patients. This requires multiple doses during the day. Its concentrations in the brain appear to be higher than those in the blood. Methylphenidate is metabolized by hepatic microsomal enzymes.

**Pemoline** has a long half half-life, permitting once a day dosing. Its therapeutic actions in attention deficit hyperactivity disorder (ADHD) are usually delayed by 3-4 weeks. It is 60% metabolized by the liver and 40% excreted unchanged in the urine.

All psychostimulant drugs can compete for hepatic enzymes and thus increase the levels of other drugs. Tolerance to the sympatho-mimetic effects and to the drug-induced euphoria of amphetamine and methylphenidate develops rapidly. Thus, chronic abusers often take very large doses that would be extremely toxic or lethal if taken by a nontolerant individual.

## II. Mechanism of Action

Amphetamine and the similarly acting methylphenidate are often termed "indirectly acting" amines. This is because they act by causing release of norepinephrine (NE), dopamine (DA), and serotonin (5-HT) from presynaptic nerve terminals as opposed to having direct agonist effects on the postsynaptic receptors themselves. In addition, amphetamine inhibits both NE and DA reuptake and has very mild monoamine oxidase inhibitory effects, thus prolonging and enhancing the effects of the amines it releases from presynaptic terminals.

Amphetamine and its derivatives probably increase alertness by stimulating the ascending reticular activating system. Hypothalamic effects are probably responsible for its appetite suppressant properties. Its stimulatory effects on locomotion and its tendency to produce euphoria are largely a result of facilitation of dopaminergic neurotransmission in the forebrain. Amphetamine and its derivatives are also potent stimulants of the sympathetic nervous system, probably because they enhance noradrenergic neurotransmission. The peripheral effects of the amphetamine-like drugs at therapeutic doses include mild increases in both systolic and diastolic blood pressure and often a reflex slowing of the heart rate. With higher doses, the heart rate increases and there may be arrhythmias. Pemoline, which is structurally different, has fewer peripheral sympathetic effects than amphetamine.

The mechanism of action of psychostimulants in ADHD is unknown. Unlike the sympathomimetic effects and euphoria, there appears to be no tolerance to the therapeutic effects in ADHD. A prior hypothesis held that somehow the stimulants "paradoxically" sedated children ADHD, but this appears not to be the case because the effects of amphetamine in children with ADHD differ only in degree, not in kind, from its effects in normal children.

High dose chronic use of amphetamines often produces a psychotic syndrome with prominent paranoid ideation. This syndrome closely resembles dysphoric mania.

### III. Therapeutic Indications

#### A. Attention Deficit-Hyperactivity Disorder

The symptoms of this childhood disorder include inattention, impulsiveness, and hyperactivity. Stimulant drugs are an effective treatment in 70-80% of children with this disorder but are best used as part of a comprehensive treatment program. (Stimulant drugs also "calm" 60% of children who do not have ADHD). Stimulant drugs improve attention and decrease impulsiveness and hyperactivity. However, they do not help with the specific learning disabilities that are often associated with ADHD (e.g., dyslexia). Stimulants are not indicated for "problem children" who do not meet the diagnostic criteria for ADHD.

Methylphenidate is the most commonly used agent, although d-amphetamine is equally effective. Pemoline also appears to be effective, although its use is less well established. The doses of d-amphetamine and methylphenidate are 0.3-1.5 mg/kg/day in divided doses. Pemoline is given at 0.5-3.0 mg/kg/day in a single daily dose.

#### B. Residual Attention Deficit Disorder in Adults

#### C. Narcolepsy

#### D. Depressed and Apathetic States

#### E. Major Depression

Despite multiple anecdotal reports and uncontrolled studies suggesting that dextroamphetamine, methylphenidate, or pemoline might be effective in the treatment of major depression, controlled studies have been largely negative or uninterpretable. Although the available literature does not permit a definitive statement, it is likely that cyclic antidepressants, fluoxetine, and MAOIs are all more effective than psychostimulants for major depression.

Psychostimulants have been used as adjuncts to cyclic antidepressants in the treatment of major depression in situations in which an adequate therapeutic trial of a cyclic antidepressant alone has not produced an adequate therapeutic response.

*Apathetic and Withdrawn States in Medically Ill Patients.* Medically ill patients (especially the elderly) may develop states of apathy, withdrawal, and a loss of appetite without the full manifestation of a major depressive episode. These states can compromise medical care by decreasing the patient's compliance with treatment and interest in life and diminishing adequate caloric intake. While such patients might respond to tricyclic antidepressant drugs, the time course of improvement with tricyclics (several weeks) is a definite disadvantage when medical treatment might be compromised. The judicious use of psychostimulants may improve the patient's mood, interest, compliance, and, in some cases, appetite. When effective, the stimulants work rapidly.

When prescribing stimulants to medically ill patients, generally only a short treatment course proves necessary (several days to several weeks) until the precipitating problem has passed. Patients are begun on low doses (5 mg bid in the elderly, 10 mg bid or tid in younger patients) with gradual increases until a therapeutic effect is achieved.

*Challenge Test For Prediction Of Antidepressant Response.* Several studies have suggested that a positive response to a challenge dose of d-amphetamine predicts good response to tricyclic antidepressants in depressed patients. Test doses have ranged from a single 30-mg dose to 7.5 mg bid for 3 days. A modification of this idea was that depressed patients who responded to d-amphetamine would respond preferentially to a tricyclic that would then preferentially block norepinephrine (NE) uptake, while those who did not respond to d-amphetamine would respond better to an agent that preferentially blocked serotonin uptake.

### **Therapeutic Use**

Prior to starting psychostimulants, patients should have a physical examination with attention to heart rate, rhythm, and blood pressure. Psychostimulants should be administered very carefully in patients with hypertension, and attention should be paid to follow-up monitoring. Psychostimulants should probably be withheld from patients with tachyarrhythmias. In children, a neurologic examination should be performed with attention to the presence of tics and dyskinetic movements (stimulants may precipitate or worsen Tourette's syndrome and dyskinesias). In the case of pemoline, it is prudent to obtain baseline liver function tests since liver function abnormalities occasionally develop. Pemoline should be avoided in patients with pre-existing liver disease; amphetamine and methylphenidate can be used, but in lower than usual doses. For patients with renal disease, methylphenidate, which is metabolized by the liver, is the best choice.

Methylphenidate is usually begun at 10 mg bid or tid in adults; children and the elderly might be given a test dose of 10 mg and then begun, initially, on 5-10 mg bid. Doses are slowly increased (10 mg every 2-4 days) until therapeutic results are achieved. The average daily adult dose is 30-40 mg, although doses as high as 80 mg may be used. Doses for children are in the range of 0.3-1.5 mg/kg/day. Methylphenidate is usually given in daily doses unless the sustained release form is used, in which case 1 dose might be given.

Pemoline has little established use in adults. For children with ADHD, it is usually begun at 37.5 mg/day and increased weekly by 18.75 mg until a therapeutic effect is achieved. The usual dosage range is 0.5-3.0 mg/kg/day in a single daily dose. Patients given pemoline should have their liver function tests monitored periodically.

## **Side Effects and Toxicity**

### *Central Nervous System Side Effects*

The major adverse effects of psychostimulants are central. These include anorexia, insomnia (which can often be minimized by administration early in the day), changes in arousal (either over-stimulated and anxious or alternatively listless and lethargic), and changes in mood (either overly euphoric or occasionally tearful and oversensitive). Dysphoric reactions are more commonly reported in children. Rarely, patients develop acute toxic psychoses. High doses used long-term, as may occur in some narcoleptics and drug abusers, may produce paranoid psychosis.

### *Other Side Effects*

Patients with underlying fixed or labile hypertension may have mild elevations in blood pressure; rarely, this is severe enough to require discontinuation of the drug. Sinus tachycardia and other tachyarrhythmias rarely occur at clinical doses. In general, these drugs have greater cardiovascular safety than tricyclic antidepressants. Other side effects include headaches and abdominal pain. Intravenous amphetamine abusers have developed necrotizing angitis affecting the brain.

In children, there has been concern about possible long-term growth and weight suppression, although this problem appears to be at most mild. Children given time off the drug (e.g., during summer vacation) appear to make up any weight loss. Pemoline produces liver function test abnormalities in some patients.

## **Abuse and Withdrawal**

### *Stimulant Abuse*

A major drawback to the use of psychostimulants is their potential for abuse. Amphetamines are abused orally or intravenously, and methylphenidate is abused orally. Pemoline does not appear to be commonly abused. These drugs produce feelings of euphoria and enhanced self-confidence. In the high doses of abuse, there are often signs of adrenergic overactivity (i.e., increased pulse and blood pressure, dry mouth, and pupillary dilatation). High doses of amphetamine may result in stereotyped behaviors, bruxism, formication, irritability, restlessness, emotional lability, and paranoia. With chronic abuse, a paranoid psychosis may develop, characterized by paranoid delusions, ideas of reference, and auditory, visual, or tactile hallucinations.

### *Withdrawal*

Although there is no apparent peripheral withdrawal syndrome, there may be central symptoms. Patients may complain of fatigue, hypersomnia, hyperphagia, and severe depression. Patients should be reassured that the symptoms are time-limited; currently, there is no pharmacologic treatment. Patients should be observed for the emergency of a major depressive syndrome. Recent studies of withdrawing cocaine abusers have documented that a significant minority develop symptoms of major depression that may be responsive to treatment with desipramine or other tricyclic antidepressants. This has not been well studied among amphetamine abusers, but a similar incidence of tricyclic-responsive depression would not be surprising.

## *Overdose*

Overdose with psychostimulants results in a syndrome of marked sympathetic overactivity (i.e., hypertension, tachycardia, hyperthermia) often accompanied by toxic psychosis or delirium. Patients may be irritable, paranoid, or violent. Grand mal seizures may occur. Death may result from sequelae of hypertension, hyperthermia, arrhythmias, or uncontrollable seizures.

Treatment consists of supportive care and blockage of adrenergic receptors. If the patient is unconscious or seizing, the airway must be protected. High fevers should be treated with cooling blankets. Seizures can be controlled with an intravenous benzodiazepine, such as lorazepam (1-2 mg) or diazepam (5-10 mg), repeated as necessary.

Delirium or psychosis usually responds to an antipsychotic agent. If the patient is also hypertensive, chlorpromazine has the advantage of blocking both alpha-adrenergic and dopamine receptors. Doses of 50 mg IM qid are usually adequate, although doses up to 100 mg qid may be necessary. Otherwise, haloperidol might be a better choice; 5 mg bid will usually suffice. Additional sedation can be provided by benzodiazepines, such as lorazepam 1-2 mg PO or 1 mg IM or diazepam 5-10 mg PO every 1-2 hours as needed. Delirium usually clears in 2-3 days, but paranoid psychoses due to long-term high dose abuse may take longer to clear. Severe hypertension or tachyarrhythmias can usually be treated with propranolol 1 mg IV every 5-10 minutes as needed up to a total of 8 mg.

## APPENDIX 12

### CASE CONFERENCES

#### Psychiatry Case Conference: Anxiety Disorders

##### Case #1

###### Identifying Information:

SP is a 50 year old married Hispanic male who presents on referral from his transplant nephrologists with complaints of anxiety.

###### History of Present Illness:

SP describes episodes of intense anxiety that have been occurring intermittently for ~5 years. They started infrequently. Episodes most often occur in social settings, but can happen when driving, or when crossing a bridge. Start with rapid heart rate, chest pain, intense nausea, tremulousness, sweating and continue for 10-30 minutes. During the first few episodes he tried throwing up and found that this led to some relief in his sense of nausea and a subsiding of the anxiety. At their most frequent the attacks were happening several times a week. He then began to have a more persistent sense of unease or anxiety that is prominent in the situations above, but also in places like stores and especially in lines at the checkout counter. This is in part linked to a feeling that if he got an attack he could not easily excuse himself in order to throw up. He now rarely goes to social gatherings. If he does then he and his wife find a place to sit at the edge of the gathering, so that he can get away if need be.

He feels the safest at home, although he has had occasional attacks there.

He is also reassured by the presence of family with him if he goes out or drives. In their absence he remains at home mostly.

He has rare nightmares now related to a past trauma (see below). Does describe some irritability, but denies frank anger or aggression. Sleep is interrupted with middle insomnia.

He was prescribed a medicine by his nephrologist that made him feel dizzy and a little drunk and he stopped taking it.

###### ROS:

No persistent sadness, although he does feel discouraged by being unable to go to social events. He feels guilty about not being able to do the things his wife wants to do and forces himself to go to some social functions for her.

He denies anhedonia and enjoys the company of his kids. He enjoys working on cars and chores at home that he has to do. He denies problems with energy or motivation. He denies suicidal ideation or wishing he was dead.

No history of delusions or hallucinations.

Denies obsessions or compulsions.

Denies manic symptoms.

#### Past Medical History:

1. Renal failure secondary to hypertension: diagnosed at 40 and on dialysis for 4 years.
2. Cadaveric Renal transplant at age 44. Uneventful post transplant course
3. Hypertension
4. Heartburn
5. Back pain

#### Past Psychiatric History:

Patient denies past episodes of depression.

Had problems after witnessing accident of a cousin in Mexico in his 20s. For several days had inability to sleep and recurrent nightmares.

At age 35 witnessed the accident of another cousin in LA. Car stalled on freeway off-ramp. Cousin stopped to help him. Saw cousin get pinned between cars when they were hit by another car. He developed period of intense depression, guilt, sleeplessness and recurrent intrusive thoughts of this. Also had more prolonged period of nightmares. Developed marked anxiety while driving, especially when pulled up at stop lights. Began to have occasional panic attacks as described above. Lasted ~ 2 years before gradually resolving. Did not seek treatment then.

#### Substance Use History:

Alcohol: In his late teens and 20s would drink heavily at social events. He denies any social, occupational or legal problems. Cut down after anxiety problems started. Quit altogether prior to his transplant. Prior to that had been a weekly social drinker.

Tobacco: None since transplant.

Illicit drugs/prescription drugs- never

#### Family History:

Not aware of significant family history of psychiatric illness. Has cousins and uncles with heavy alcohol use, but none with drugs that he is aware of. No suicides in the family. No psychotic disorders. Mother deceased. Father was killed in 1981.

#### Social History:

Lives with his wife and children. Has 6 children aged 8 to 25 yrs. All but the oldest live with him. 5 daughters and one son.

He grew up in Mexico. His father was a laborer and worked hard on a farm. He describes him as having a temper but not abusive. He looked up to him a lot. Patient was the oldest of 10 sibs. 2 siblings died young.

He had to go to work in mid teens due to financial trouble at home. Eventually he had to drop out of high school. His family moved to USA in 1976 when he was 18. He worked in the US for some time then moved back to Mexico where he met and married his wife. Has been married ~26 years. He describes their relationship as affectionate, but he does not really talk to her about his symptoms or his fears.

He worked a variety of jobs mostly involving physical labor until he was forced to quit work due to his health ~10 years previously. No military history.

Currently on Disability for kidney disease. Wife works part time to help support family. Daughter also contributes to finances. Some financial stress but says that they get by.

Medications:

Tacrolimus 1mg BID  
Mycophenolate Mofetil 180mg BID  
Prednisone 5mg qd  
Famotidine 20mg qd  
Omeprazole 20mg BID  
Magnesium Oxide 400mg BID  
Valsartan 320mg qd  
Lisinopril 40mg qd  
Amlodipine 10mg qd  
Baclofen 5mg TID

Allergies: NKDA

Vital Signs: HR 90/minute, BP 130/76, RR 16, T 37.4, Pulse Ox 96%

Mental Status Examination:

Appearance: Dressed neatly and appropriately in shirt and trousers. Good grooming.  
Attitude: Cooperative, apparently honest and open. Good eye contact.  
Activity: No overt psychomotor agitation/retardation. Posture somewhat rigid when discussing past trauma.  
Speech: regular in rate, rhythm, volume and prosody. Somewhat halting at times when searching for word in English.  
Mood: Fine. "Not moody".  
Affect: Anxious, hard to relax. Mildly restricted. Calm later in evaluation.  
Thought process: logical and goal directed  
Thought content: Denies suicidal or homicidal ideation. No delusions or hallucinations.  
Cognition: Awake, alert, oriented to time place and person. 3-item recall intact. Clock-drawing intact.  
Insight: Good  
Judgement: Good.

Questions to consider:

1. What is the differential diagnosis of his current presentation?
2. How would you characterize his earlier symptoms after the cousin's accident?
3. What factors would you consider in choosing among the available treatment options for his condition?

## **Case #2**

A 26 year old white female presents to her primary care physician for a routine annual physical. You apologize for running behind schedule and notice that she appears slightly tense and doesn't smile or shake hands. She has no significant medical problems, denies any active complaints, does not smoke or drink alcohol and her only medication is birth control pills. She is married and has a 1 year old daughter. In the course of the exam you notice that the skin on her hands is chapped and red and ask her about it. She blames it on washing her hands to keep things clean for her child. On further exploring this she admits to washing her hands 5-6 times after changing diapers and needing to clean the entire kitchen counter with antiseptic every time she makes a snack for the child. She changes her daughter's clothes whenever they return home. She avoids cooking meat because the cleaning up afterwards is so time consuming and tiring. She comments that in your line of work, you probably understand her concerns about "all those germs" and wonders how you manage to deal with this. She admits to being very meticulous about cleaning since she was in high school, a trait she gets from her mother, and in college her friends commented on how immaculate her dorm room was. She admits that while she was able to keep up with her needs for cleanliness earlier, things have been very stressful since she had her baby. She worries all the time about this and can't relax until she gets things clean enough. She says that her sister-in-law had mentioned that Xanax might help her with that and asks what you think.

### **Questions to consider:**

4. What would you consider in the differential diagnosis of this patient?
5. What additional information would help you clarify the diagnosis?
6. Is the patient's suggestion for treatment reasonable? What other options might she have for treatment?

## **Psychiatry Case Conference: Childhood Disorders**

### **Case #1**

Identifying information: AC is an 11yr old boy brought by his mother to you in the family practice clinic on the advice of his teacher, who is concerned about his recent behavior in school.

#### HPI:

AC's teacher has been concerned that he has increasingly disruptive in school, with several fights in the last 2 months. He has been more sullen and angry and increasingly disruptive in class, talking out of turn and at times refusing redirection. He has missed several days of school in the last few months due to stomach aches.

His mother notes that for the last 2 months he has been not been eating well and thinks that he may have lost a little weight. He is no longer excited about his usual activities like Tae Kwon Do and doesn't want to go out and play with his friends. He has been quite irritable with her and at times refuses to follow rules.

She notes that he has always been a high energy child and was "quite a handful" when he was a toddler. He needed much redirection and his father often had to scold him or use time outs. His father also used to spank him on occasion.

He had difficulty in school in 2<sup>nd</sup> and 3<sup>rd</sup> grades due to his forgetfulness and would often forget to hand in homework. In addition he was frequently getting in trouble for being out of his chair in class. However between his mother's putting him on a gluten free diet and having teachers that "understood" him over the last 2 years, he had done better and had been an average student. She had also had him in several after school activities to help control his extra energy, like Tae Kwon Do and soccer.

#### PMHx:

Review of the clinic chart shows several visits to the acute care clinic of your practice with complaints of abdominal pain, without evidence of significant pathology.

#### Past Psychiatric History:

Never seen a psychiatrist before. He did see a counselor briefly last year after his parents' divorce.

#### Family History:

He is an only child. She notes that his father has no known psychiatric illness but is a heavy drinker. She herself used to drink heavily prior to his birth, but cut down dramatically once she had a child and doesn't really drink at all now. She notes that she was started on an antidepressant 6 months ago to help her cope with the divorce.

#### Substance Use History:

No known substance use history.

#### Medications:

None

#### Allergies: Penicillin

Social/Developmental History:

His mother reports that she had an uneventful pregnancy, although she did not realize she was pregnant initially and was drinking alcohol and smoking through the first part of the first trimester. She wonders if this could have led to his problems. To the best of her knowledge his milestones were appropriate. He started walking around age 1, but didn't really talk much till almost two and a half.

His father was a plumber and she worked as a secretary prior to his birth. She was off work for a year after his birth, but resumed work part time since then. He went to daycare and did OK there, although there were complaints at times that they had difficulty putting him to sleep for naps because he wanted to keep playing.

He has always been a fairly social child, but has difficulty keeping friends because at times his play would be too rough. He has done well in his more structured activities like soccer and martial arts.

His mother denies him having ever had any abusive experiences and denies that his father's spanking was excessive or inappropriate. In fact she felt that it helped keep him from getting out of hand and noted that he had been harder to handle since their separation.

His parents separated about a year ago due to the father's drinking and infidelity. The divorce was contentious, but was finalized about 6 months ago. His father has visitation every other weekend, but in the last 2 months has not been consistent about showing up to take him on those occasions.

ROS:

Sleep has always been difficult. Bedtime has always been a time of drama with difficulty getting him to wind down and go to bed. In the past they have used Benadryl at times to help him sleep, though not recently.

The mother denies any concerns regarding self harm or suicide for the patient.

No hallucinatory experiences noted.

O/E:

HR: 76, BP: 104/66, RR: 16, T: 37.2, Wt unchanged over the last 4 months, and height appropriate for developmental age.

Thin Caucasian male in no acute distress. Cooperative with exam. No abnormalities noted on abdominal, chest or heart exam.

MSE: Dressed appropriately, though slightly disheveled. Initially is quite cranky with his mother and restless while history is being taken. Wandering about exam room and fiddling with items on counter. Accepts redirection from interviewer and engages better when directly addressed. Says his mood is fine, but as noted appears irritable initially and later somewhat subdued with a restricted affect. Thoughts are logical, although speech is somewhat rapid. Not excessively talkative, though intermittently interrupts mother when she is talking to interviewer with requests for water, something to eat and need to use the bathroom as well as asking to leave. Does not appear to be reacting to internal stimuli and does not endorse any thoughts about death or suicide. On talking about the divorce, he refuses to discuss and gets upset and irritable again saying that he hates his life. Insight and judgement are limited but overall age appropriate.

Questions to consider:

1. What factors could contribute to his current presentation?
2. What would be in the differential for his current problems?
3. What steps could be taken to manage his current symptoms?
4. What would the prognosis be for his current symptoms as well as his longer term problems?

## **Psychiatry Case Conference: Cognitive Disorders, Cognitive Enhancers**

A retired 68 yr old man is brought in to the ER by his wife after falling at home. She reported that for the last 2 weeks he hasn't been eating or drinking much, he has been unusually quiet, although he is uncharacteristically irritable when he does speak and she sometimes notes him to be crying. She notes that yesterday he was incontinent of urine and then last night he tried to get up in the middle of the night and fell down by the bed.

Past Medical History: Hypertension, diabetes mellitus type 2, benign prostatic hypertrophy.

Medications: Hydrochlorothiazide-recently increased to 25mg daily, tamsulosin 0.4mg daily, Glyburide 5mg daily, Aspirin 81mg daily.

Allergies: penicillin

On exam his vitals are HR 104, BP 112/60, RR 18, T 36.2 deg C. Mucosae are slightly dry, no pallor or cyanosis is noted. His chest is clear and heart tones regular without murmur. He is found to have no focal neurological deficits, but is oriented to person and place only.

His labs include Na 148, K 3.2, BUN 34, Cr 1.5, Albumin 3.0, WBC 11,000 with mild neutrophilia. Chest X-ray is without infiltrates and CT Scan Brain without contrast reveals no acute abnormalities, but mildly prominent ventricles.

He is admitted to the medicine service and given IV fluids and potassium replacement overnight.

The next morning the medicine service finds him to be calm & cooperative although he remains quiet and looks sad. Psychiatry is consulted to evaluate him for depression.

When you arrive to his room he is sitting on the side of the bed, tangled in his sheet, trying to get up. He is hard to redirect to get back in the bed. He is restless and asks you to help him get to the kitchen. He says it is 1968 and cannot identify the season. He repeatedly asks for his wife even though you tell him that she is not here now.

### Questions to consider:

1. What syndrome might this represent?
2. What factors could be contributing to CK's current problem?
3. What additional tests might you order to help assess the cause?
4. How might you approach treatment for CK?

Further diagnostic testing reveals a reversible condition that he completes a course of treatment for. In addition his electrolytes normalize and over the next 3 days his oral intake improves. He is able to say that he is in the hospital, although he still gets confused as to which hospital. In the evenings he continues to be restless, but is redirectable.

You are able to talk to his wife who says that she has never seen him like this before and doesn't understand what happened. She denies that he has ever had confusion before and notes that his memory is very good and he can talk at length about events from his days in the military, 50 years ago.

He retired from a career as a plumber at age 58 and they have survived on first his union pension and later their social security benefits. They have 2 grown children that live several hours away. She notes that he used to be quite an avid poker player, but has withdrawn from this over the last 2 years. He gave over the finances to her a year ago and in the last 6 months

has quit reading the newspaper because the print is too small. She does note that he has begun to repeat himself a lot and sometimes she has to answer the same questions several times. When you ask about family history she remembers that his mother had begun to behave “oddly” at the old folks home before her death at age 72. She apparently became convinced that the children were plotting to take all her money.

Questions to consider:

5. What might explain the patient’s gradual functional decline?
6. Would any further testing be helpful?
7. What non-pharmacological interventions could help with this situation?
8. Is there a role for medications in helping this patient?

## **Psychiatry Case Conference: Mood Disorders**

### **Case #1**

Identifying Information: CK is a 30 yr old white female, currently unemployed and living with her boyfriend in St. Louis who comes to see you in the outpatient psychiatry clinic.

Chief Complaint: Worsening Depression x 8 months

#### History of Present Illness:

CK describes problems with feeling depressed for about the last 8 months. She graduated from a Masters program in Washington DC about 10 months ago and had a lot of trouble deciding what to do next. She was torn between coming to St. Louis to live with her boyfriend and the alternative of accepting a job offer in Washington DC. She began to worry excessively and felt stressed. She began crying from time to time, and noticed her motivation declining.

She initially decided to stay in DC and did well at her job despite having increasing trouble with crying spells, worries about the future and worsening motivation and energy.

Her boyfriend continued to pressure her to join him and she finally decided to give up the job and move to St. Louis approximately 3 months ago.

Since the move she has noticed continued crying spells and very poor motivation. She spends a lot of her time in bed or on the couch. She has a hard time getting excited or happy about things that would normally interest her. She has felt paralyzed by indecision over even minor things (eg: difficulty sending emails for jobs, unable to choose a planner). She describes poor concentration and difficulty focusing (unable to read a magazine article). She describes going over and over in her mind about her current situation and the future. She also describes feelings of guilt and worthlessness for her perceived lack of achievement, and feelings of hopelessness (I can never handle basic things in life). She has been sleeping more than usual, ~10-12 hours. Her appetite has been poor, but when she does eat, she craves carbohydrates. She denies any thoughts of death or suicide.

Her problems have caused a lot of conflict with her boyfriend. She takes some of the blame, saying that she has been hard to live with. However she admits to some resentment of his having pressured her to come. He has a hard time understanding her depression and has been telling her that she needs to get up and get a job. They argue a lot and a few days ago it got to the point that he asked her to leave.

#### ROS:

No recent panic attacks. Denies obsessions or compulsions. Denies hallucinations. Denies periods of feeling excessively elevated mood, decreased need for sleep or excessive spending.

#### Past Medical History:

Multiple sclerosis diagnosed 5 years ago. She had period of intense fatigue and excessive sleepiness preceding this which resolved with treatment. Approximately 7 months ago she had a brief exacerbation of Multiple Sclerosis, marked by tingling on the left side of her body. She started a new medicine for this, and the symptoms resolved. She stopped the medication after

about a month due to all that was going on. She does realize that she should be on it, but has not had the energy or motivation to resume it or to seek neurologic care in St. Louis.

Medications: None

Allergies: NKDA

Past Psychiatric History:

First saw a counselor after her Mother died 12 years ago. She felt numb and couldn't grieve, and sought help to understand this.

Approximately 9 years ago she developed panic attacks and persistent anxiety in college on a semester abroad. She saw a therapist and psychiatrist in Michigan for several years to treat this. Her panic attacks resolved with medication but she developed depressive symptoms with low mood, apathy, poor energy and excessive sleep. These responded to medication but recurred when she was diagnosed with MS. She sought treatment again and once again was able to return to normal functioning for the last 2 years off medications. No prior suicidal ideation or attempts.

Substance Use History:

She drinks socially, every couple of weeks, 1-2 drinks per occasion. Never heavy use. Never smoked. Never used illicit drugs/prescription drugs.

Family History:

Her mother and sister have both suffered depression. No family history of suicide.

Social History:

She was raised in Michigan by her biological parents and has one older sister. Her parents both taught in college. Her memories of early childhood are happy, with a warm and supportive family. When she was around 10 years old her parents went through a period of marital conflict. She did poorly in school for a couple of years, although she was otherwise always an excellent student. Her mother was diagnosed with cancer when she was in high school. She went on to college near her home in Michigan to be near her mother. Her mother died during her sophomore year. After her BA, she started a Masters program, which was delayed by her problems with depression and MS. She was able to complete it successfully. She has had a few serious relationships, starting in high school. She has been seeing her current boyfriend for about 5 years and much of their relationship has been long distance. Her major supports at this time are her sister and a close friend (the cousin of her boyfriend).

Mental Status Examination:

Appearance: Dressed neatly in blouse and trousers. Good grooming.

Attitude: Cooperative. Good eye contact.

Activity: No overt psychomotor agitation/retardation.

Speech: Increased in rate and amount, feels that she has a lot to say. Regular in rhythm, volume and prosody. Fluent.

Mood: Depressed.

Affect: Tearful and dysphoric for most of interview, although is able to laugh appropriately at times. Is responsive to reassurance. Fair range and reactivity.

Thought process: Mostly logical and goal directed. At times mildly circumstantial.

Thought content: Denies suicidal or homicidal ideation. No delusions or hallucinations.

Cognition: Awake, alert, oriented to time place and person. Attention span fair. Knowledge of recent events is good. Able to recall 3 words at 5 minutes and complete serial 7s without difficulty.

Insight: Good

Judgement: Good.

Questions to consider:

1. What is the most likely diagnosis?
2. What factors could be contributing to CK's current problem?
3. What would be in the differential diagnosis for her current problem?
4. How might you approach treatment for CK?

## **Psychiatry Case Conference: Personality Disorders**

### **Case #1**

#### Identifying Information:

BK is a 26 year old white female who presents to the emergency room for urgent evaluation of feelings of depression.

#### History of Present Illness:

BK presents as a walk in to the ER requesting to be seen urgently for depression. She notes severe depression that has been worse due to her boyfriend having an affair with another woman. She notes that she can't stop crying and that she would rather be dead than have to live without him. She admits to thoughts of cutting her wrists and isn't sure that she could be safe at home.

She reports that she worries a lot about their relationship and has a hard time relaxing. She endorses poor sleep, with mostly initial insomnia. She states that her appetite has been stable until the last 3 days, when it has been poor. Over the last week her symptoms have worsened because her husband has had to stay late at work on 3 occasions and she is sure he is really having an affair. She has confronted him about it several times and she feels that he has been acting distant and cold over the last few days. This has reinforced her fears that he is going to leave her.

She says that in the last week, when she is alone at home she sees shadows out of the corner of her eyes, but there is no one there when she turns her head. This has made her feel even more jumpy.

Before you go to see her the ER nurse mentions that they saw some cuts on her thighs when they had her change into a hospital gown, and when you ask her about this she initially appears not to know what you are talking about, but later admits that she has been cutting herself on the thighs (because this is covered by clothes and no-one can see). When you ask why she says that she does not know, but wonders if she is punishing herself for being a bad partner in her relationship. She intensely fears being alone and reveals that when alone she feels a deep sense of emptiness and at times fears that she does not exist.

#### ROS:

She reports anhedonia in the last week. She does not go out with her friends the way she used to.

Denies hearing voices talking to her or about her.

Does note that she has "mood swings" and wonders if she might be bipolar.

Has a history of panic attacks since late teens, but have been worsening in last 2 years. Xanax has helped with these symptoms, but lately has had to double up on dose.

Problems with anger outbursts dating back to high school.

#### Past Medical History:

1. Chronic headaches
2. Gastro esophageal reflux disease

Past Psychiatric History:

Reports mood problems dating back to her early teens. Was hospitalized for depression at age 13 and had a suicide attempt by overdose at age 16. Has been treated with antidepressants including Sertraline, Paroxetine, venlafaxine, fluoxetine without much benefit. Did take Depakote for a year with slight improvements in her mood swings.

Cutting started in high school and decreased around age 18. Resumed in last year.

When describing eating problems a year ago, she further admits to purging by inducing vomiting, to try to lose weight. Says she did this because she thought that she was too fat and that her boyfriend was going to leave her.

Has seen several counselors since age 16. Says she was molested by one of those counselors at age 18. Recently fired her psychiatrist because they were mean to her.

Substance Use History:

Alcohol: Heavy drinking as a senior in high school, mostly on weekends. Became daily for a couple of years then had 2 DUIs in quick succession, which led to court mandated rehab and reduction in use x 3 years.

Tobacco: None

Illicit drugs/prescription drugs- Denies

Family History:

Mother had marked anxiety and depression. She had multiple psych admissions when patient was an infant. Older sister is treated for depression.

Social History:

Lives with boyfriend of 2 years- difficult relationship due to patient's fears of his infidelity.

Separated several times, but usually get back together. She had a succession of relationships since high school, but none has lasted more than a year. At least one was physically and emotionally abusive to her. Frequently has fears her partner is going to leave her. She however feels unable to leave partners, even when abusive.

Worked as a waitress in the past. Not in over a year. Has had difficulty with work relationships, often getting angry with supervisors perceived as overcontrolling.

Has had 3 children all in foster care.

Was sexually abused by her biological father from ages 6 to 12. He ended up in jail for an unrelated matter and died when she was 14. She then lived with her grandmother till age 18.

Dropped out of high school in Junior year but completed her GED.

Medications:

Pepcid 40mg daily

Fiorcet 2 tabs TID prn headaches

Xanax 1mg PO TID

Allergies: Clonazepam, imitrex, Codeine, morphine.

Vital Signs: HR 90/minute, BP 130/76, RR 16, T 37.4, Pulse Ox 96%

Mental Status Examination:

Appearance: Dressed in hospital gown when seen. Carefully applied make up, though make-up is running a little from crying.

Attitude: Distraught, but cooperative.

Activity: No overt psychomotor agitation/retardation.

Speech: Increased in rate, volume. Normal rhythm and prosody.

Mood: Depressed.

Affect: Anxious, Dysphoric, very tearful, hard to redirect.

Thought process: logical and goal directed

Thought content: Describes suicidal ideations. No homicidal ideation. No delusions or hallucinations.

Cognition: Awake, alert, oriented to time place and person. 3-item recall intact. Clock-drawing intact.

Insight: Limited

Judgement: Poor

Questions to consider:

1. What is the differential diagnosis of his current presentation?
2. Is this primarily a problem on Axis I or on Axis II ? Why/Why not?
3. What kinds of treatments would be beneficial for this patient?

Case #1 continued:

You see the patient on the ward the morning after admitting her. She indicates to you that what you gave her for sleep helped immensely. She is profusely thankful. She feels that you are the only doctor who seems to understand her problems and is hopeful that she can work with you in future. She indicates that she is still depressed and suicidal but that she has decided that her boyfriend is really a jerk and has heard from the man she was seeing prior to him, and is hopeful of getting back together with him.

**Case #2**

A 38 year old man is admitted to the hospital for an emergent appendectomy. You are consulted on day 2 post op due to his acting oddly and being non compliant with medications. On arrival you find a thin white male sitting in bed, who makes poor eye contact and appears nervous. Nursing notes that he has been refusing his medications at times. He mentions that he has to meditate over the medications for a few minutes to ensure that they will not hurt him. He notes that he had a dream last night that he might have a medication reaction. He denies visual or auditory hallucinations. He lives alone and has few friends. He was an only child and both parents are deceased. He works from home for a website maintenance service. He denies feeling that he will be poisoned, but does believe that his dreams predict the future on occasion, and have done so since his late teens. He has always been a loner despite getting above average grades in school. He has always worked from home and has never been married. He has been having greater problems recently due to some of his beliefs getting in the way of his working on websites for clients.

Questions to consider:

1. What cluster do this patient's symptoms fall in?
2. What axis I diagnoses may be related to this problem?
3. If this patient had active auditory hallucinations or delusions what could be the possible etiologies in this setting?

## **Psychiatry Case Conference: Psychosis**

### **Case #1**

Identifying information: MM is a single 43 yr old woman brought to the ER by ambulance

Chief Complaint: Not eating x 2 weeks; weak and unable to take care of herself

#### HPI:

MM's family called and ambulance to take her to the hospital as they found her very weak and unable to take care of herself. When you see her in the ER the family is not present, but the history related by the EMTs is that when they found her she seemed a little confused as to why they were there. She was weak and had a hard time getting up of the couch. The family told the EMTs that she was very concerned for her safety due to her ex-boyfriend harassing her. She can't understand why the police won't do something. He gets into her house and moves things around when she is not there.

The patient herself does not give very much history other than to say that she has not been eating for about 2 weeks. When you ask about why she isn't eating, with some hesitation she reveals that he is poisoning her food.

Past Medical History: Hypertension, Hepatitis C

Current medications: Hydrochlorothiazide (not currently taking)

Allergies: NKDA

#### Family History:

Mother has Hypertension and DM2. Father deceased of MI. No psych history in family

#### Social History:

Based on what is available in the ER: She lives alone, owns her own house, which her parents helped her buy. Her sister lives nearby and has been very involved with her in last year.

#### Substance Use History:

Patient denies current drug or alcohol use. She smokes a ½ pack/day

#### Physical Examination:

General: She appears tired/sedated. She is very thin/slightly emaciated

Oral mucosae are dry; Chest exam shows crackles in R base.

The rest of the physical exam, including neurological exam is within normal limits.

#### Mental Status Examination:

43 y/o white female who appears slightly older than her stated age.

She is only partially oriented to time and place, and appears mildly confused about recent events. She is lying quietly in bed

Speech soft but regular and prosodic.

Thoughts logical and mostly goal directed

Not clearly responding to internal stimuli

Mood: "OK"; Affect: Mostly tired, but at times appears fearful/nervous, restricted range.

Insight: poor; Judgment: Poor

Diagnostic studies:

Chest X-ray shows a small infiltrate in the R lower lung field

Labs are remarkable for hypokalemia, an elevated BUN & Cr, and an elevated WBC count with Neutrophilia

Questions to consider at this point:

5. What factors could contribute to her current presentation?
6. What would her differential diagnosis be?

Further hospital course:

Medical work up for renal and post-renal causes of renal insufficiency are negative

The patient's physical condition and lab tests improve with IV hydration and antibiotics.

By day 3 the patient is more awake and her confusion resolves. She is well oriented and is able to recall 3 words at 5 minutes without difficulty.

She begins to downplay her concerns regarding boyfriend and gets upset when people try to ask her about this situation. She now denies that she had quit eating.

You are able to gather the following history from her sister:

Past history of extensive drug use (cocaine, LSD and marijuana) and several abusive relationships. The last relationship ended 5 years ago and she quit using drugs around that time. Since then had been working part time and living on her own

In the last 2 years she has had a decline in her mood and ability to function.

Initially she was more anxious and depressed, not eating, with poor sleep. She stopped going to church and associating with the few friends that she had. She complained of feeling very tired. She took to staying at home all the time and was fired from her job.

Over the last year she has demonstrated increasing fearfulness and complaints over persecution by this ex-boyfriend. She blames him for minor problems in her house, eg: a screw falling out of light fixture, things being out of order in kitchen. She has made multiple calls to police complaining about it, but is frustrated as he always has an alibi and the police have stopped taking her seriously. In recent months she has talked about seeing him in her yard with his new girlfriend, mostly at night (in January in Iowa).

She was admitted to the local hospital 3 months ago due to dehydration, after which her primary care provider pressured her to improve her diet. With a lot of help from her sister, she was able to do better for a time. The primary care also started her on Sertraline and Olanzapine but patient was not compliant with this.

Further Questions to consider:

1. What signs of psychosis is she demonstrating
2. What is the differential diagnosis now?
3. What could be done to treat her at this point?

## **Psychiatry Case Conference: Somatoform Disorders**

**ID:** Mrs. S is a 35-year-old married white female from a nearby town. She resides with her husband and 4 children and is now hospitalized on the general medicine service due to nausea, vomiting and abdominal pain.

**CC:** "I feel horrible. I can't eat. I feel sick to my stomach all the time. No one knows what's wrong with me and I just know that I'm going to get worse."

**HPI:** Mrs. S reports she was in her usual state of health until about 1 week ago, when she developed nausea, vomiting and cramping abdominal pain. She reports often feeling bloated after eating, even the smallest amounts. In addition, she reports blood and mucus in her stools and pain so severe that she is now unable to care for her 4 children or perform activities of daily living. She has been taking narcotic analgesics so her intermittent diarrhea has now begun alternating with constipation. She has a long history of food intolerance/allergies and has been avoiding those foods without difficulty. She thinks she may have lost about 5 pounds in the last week. Nothing seems to make her symptoms better or worse.

While she has been hospitalized and extensive medical work-up has been performed. Abdominal X-rays and RUQ ultrasound were negative. EGD and colonoscopy were unremarkable. CBC, electrolytes, amylase, lipase, liver function tests, stool exam for ova and parasites were negative. Abdominal CT was unremarkable.

The internist states he doesn't know what else to do, there has been no medical explanation for her symptoms and has called a psychiatric consult in an attempt to see if there may be a psychiatric origin of her symptoms.

**Past Psychiatric History:** Marital counseling only about 5 years ago. She has been on no psychiatric medications in the past. There have been no suicide attempts, no previous psychiatric hospitalizations.

**Past Medical History:** Dysmenorrhea with menorrhagia with two dilation and curettage procedures and vaginal hysterectomy.

Rheumatoid Arthritis with negative rheumatoid factor, normal ESR

Thyroid problems

Exploratory Laparotomy about 10 months ago for similar complaints, pain, nausea, vomiting all improved after the surgery.

Vomiting throughout all 3 trimesters of all 4 pregnancies

**Allergies:** Erythromycin, penicillin, milk, peppers, latex, peanuts.

**Family History:** Mother was "sickly" with multiple medical problems. Father has alcoholism and hypertension. No family history of other psychiatric or medical disorders.

**Social History:** Mrs. S was born and raised in the same town where she continues to live. Mother was a stay at home mom and father worked at the local garage. She is a high school graduate and denies the use of tobacco, alcohol or illicit substances. She has been staying at home, taking care of her 4 children ages 10, 8, 7 and 6 but because of multiple medical problems has not been able to work outside the home. She worked as a clerk at the local bank

right after high school but developed double vision that interfered with her ability to work. She then worked for about a year in a factory but her heavy and painful periods caused her to lose her job as she was frequently absent. Her husband is often gone, as he has to work 2 jobs as "our medical bills are out of this world." In addition, now she is unable to care for the children or the house due to the abdominal pain.

Review of systems is almost entirely positive. She reports back, hip and knee pain, heart palpitations, weakness, dry skin, shortness of breath, fatigue, anxiousness, vaginal dryness and vaginal burning, numbness and tingling of all 4 extremities, difficulty swallowing and a period of 1 week last year for which she has no recollection. She no longer has double vision but did lose her vision entirely for about 3 days 5 years ago. No cause was ever found. She often has pain with defecation, occasional pain with urination and headaches that occur at least once per week. She reports decreased sensation in the right arm and the left arm often feels colder to touch.

Physical examination: VS 36.5, 85, 16, 124/72, 100% on room air

HEENT: NC, AT, PERRLA, EOM full

Neck: supple, no LAD, no thyroid enlargement

Lungs: CTA bilaterally

Heart: RRR, no M,R,G

Abdomen: diffusely tender, no rebound, no guarding, normoactive bowel sounds, previous appendectomy and exploratory laparotomy scars.

Ext: No calf tenderness, No C/C/E

Neurological examination is unremarkable other than decreased sensation to pinprick, light touch, cold in the right arm.

MSE: WDWN woman in NAD. She is pleasant and cooperative, alert and fully oriented with good eye contact. She is dressed in her pajamas and robe from home with a large pillow from home. Mood is described as "ok" affect is full. Thought process is logical and goal directed. Thought content is remarkable for multiple somatic complaints and worries about her physical problems. She denies suicidal or homicidal ideation, no evidence of delusions or hallucinations. Fund of knowledge was average. Psychomotor activity was within normal limits. Gait was steady. Estimate of intelligence was average. Insight into illness was minimal. Judgment was fair.

## **Psychiatry Case Conference: Substance abuse**

### **Case #1**

Identifying information: BK is a 45 yr old married Caucasian male who is admitted for management of a right ankle fracture.

#### HPI:

BK fractured his right ankle by falling down the stairs at his apartment. He was brought to the ER by ambulance where he was noted to be intoxicated and was found to have a blood alcohol level of 200mg/dL. He was admitted to the Orthopedic service and underwent an open reduction and internal fixation. He was treated postoperatively with oral morphine for pain and Cephalexin for perioperative prophylaxis.

On the first postoperative day he was noted to be somewhat sedated from the pain medication but was hemodynamically stable and afebrile.

On the second postoperative day he was noted to have an increase in his pulse and blood pressure and to get restless. This resulted in 2 IV lines being dislodged, and he was given an extra dose of morphine as the restlessness was attributed to pain.

You are called to see him at 1am due to his appearing agitated and trying to get out of bed. When you approach him he shouts at you to help him get out of here because he is being held prisoner. He points to an empty corner of the room and tells someone to “get the hell out of here”. He is unable to give you a more coherent history.

You call his wife and are able to clarify the following history.

#### PMHx:

Hypertension

Gastroesophageal reflux disease

#### Past Psychiatric History:

No prior formal psychiatric history.

He and his wife did see a marital counselor 2 years previously due to frequent arguments. He also attended AA for a few visits after this, at her insistence, but quit saying that he didn't want to hang around with a bunch of drunks.

#### Substance Use History:

He smokes a pack a day. His wife reports that he experimented with marijuana and LSD in college and during his early 20s. They both “partied hard” at that time in their lives and he would drink to the point of drunkenness every weekend. She quit drinking after their children were born, but he continued and in recent years was drinking daily- usually 4-6 beers and a couple of mixed drinks. They have been separated for a year so she does not know his current consumption. He showed up to pick up their kids smelling of alcohol a month ago, and has not been regular with visitation since.

#### Medications:

Lisinopril 5mg daily

Prilosec 20mg daily

Currently also taking Morphine 15mg PO q4hrs prn and Cephalexin

Allergies: NKDA

Social History:

The patient is currently living alone in an apartment, although he lived with his wife and 2 children up until a year ago. He works as an accountant. 3 months ago he lost his job of 12 years working for a local company. He now works part time for a small accounting firm. He grew up in St. Louis. His wife does not know his father who apparently drank heavily and was violent towards his mother. His parents separated when he was a teenager and he has no contact with his father. He was an average student and completed college. He has been married to his wife for 23 years and has 2 children a 15yr old son and a 12 year old daughter. They have been separated for a year. He has had 3 DUIs in the last year and recently lost his license.

O/E:

HR: 118, BP: 164/96, RR: 18, T: 38.4, Pulse Ox: 93%

Thin white male, lying in hospital bed. Appears restless and diaphoretic. Pupils are slightly dilated but reactive. No jaundice or pallor. Liver edge just palpable and mildly tender. His right leg is in a below knee cast. Coarse action tremor noted in his hands.

MSE: Awake, somewhat restless and at times appears agitated. Speech mildly slurred but increased in rate. Thoughts are illogical at times and hard to follow. Has some delusions regarding the motives of the nurses and medical team. Also appears to be talking to someone in corner of room (although no-one is there). He does not respond when asked about his mood, but his affect appears anxious and somewhat restricted. Cognition: he is unable to tell you the date and believes that he is in someone's house. He is able to register 3/3 words with difficulty but does not remember any at 3 minutes. Insight and judgement are both very poor.

Questions to consider:

7. What factors could contribute to his current presentation?
8. What would his diagnosis be?
9. What could have been done to prevent his current state of confusion?
10. What should be the next step in management?

**Case #2**

A 32 year old African American male is brought to the emergency room by the police after being found walking in the road acting oddly. He reports that someone he is being followed and he was trying to get away from the people that are after him. He is angry at having been brought to the hospital and says that being here is going to get him killed. On direct questioning he admits to hearing voices talking about him when there is no one around, but denies drug use. He has visited the ER once before with complaints of intense depression and suicidal thoughts, but denies this currently. He takes no medications and has no regular medical follow up. He has a history of a gun shot wound to his left leg under unclear circumstances. He rents a room at a boarding house and is currently working on and off for a temp agency. The ER staff notes that he has been very restless since he arrived and got into a loud argument with staff and threatened a nurses aid who was trying to get him into a hospital gown. Vitals include HR 110, BP 146/98, RR 24, T 37.8, Pulse Ox 97%. Exam shows a restless young man with dilated pupils, fine nystagmus, dry skin and a normal cardiopulmonary exam. His gait is mildly unsteady but he has no other focal neurological deficit. His speech is loud and angry. He perseverates on needing to be allowed to go so that he can "get them before they get me!" He stops speaking at times as if he hears something that the interviewer can't.

Questions to consider:

- What could be possible causes of this presentation?
- What should be done in management of this patient
  1. General measures?
  2. Pharmacologically?

**Case #3**

A 25 year old Caucasian male is brought to the ER at 3am by ambulance after friends found him unconscious in his apartment. He is unable to give any history although his friends report that he was at a party earlier that evening and had a few drinks. They also report that he has a steady job delivering auto parts, but lives alone and is estranged from his family. They do not think that he has any medical problems. Vitals are HR 62, BP 110/64, RR 10, T 36.8deg C. Examination shows a somewhat thin appearing white male with a couple of tattoos. He is obtunded and unable to answer any questions. His pupils are 1mm and sluggishly reactive. His mucosae are dry. His skin shows no signs of scars or needle tracks. Lungs are clear and heart sounds are slowed but regular with normal S1 and S2. Abdomen is soft with no organomegaly and sluggish bowel sounds. He is well groomed with fair hygiene. Lab examination shows normal chemistries and CBC. His blood alcohol level is 80mg/dL. Urine drug screen is pending. He is given 0.4mg of Naloxone IV and arouses partially. He is able to say his name and address but is somewhat confused and asks to leave the hospital. He denies taking any drugs initially and says he must have drunk too much at the party. An hour later he is again found to be obtunded and is admitted to the ICU on an IV infusion of Naloxone. In the meantime one of his friends returns to the hospital with a plastic bag with several white pills in it that he found at the patient's apartment.

Questions to consider:

1. What substance of abuse could cause this presentation?
2. Once his sensorium improves what kind of a withdrawal syndrome might be expected?
3. What steps might be appropriate in the management of this patient once he recovers from his overdose and any subsequent withdrawal?