Chart Review: Isabella A.

Menu

Calendar

Tests

BACKGROUND

Personal: 22-year-old Caucasian female

CURRENT PRESENTATION

Chief Complaint: "I am here because my depression and anxiety have not gotten better"

History of Present Illness: Isabella is a 22y/o female who most recently has struggled with anxiety and depression over the past 2 years. She has a history of panic attacks dating back to the age of 17 that started in relation to "stress" with her boyfriend. She is here for evaluation and treatment brought here by her parents. She recently moved back to Wisconsin after things were not going well at college. She had been seen by a psychiatrist in another city for medications and by a psychotherapist for regular psychotherapy. She was feeling well up until approx. 2 months ago when she resumed school on the west coast and then relapsed. She links her relapse to an encounter with a new "boy"that she met triggering intense thoughts of her relationship with her longstanding ex-boyfriend. She started college as a freshman two years ago but had to drop out after 2 semesters due to depression and anxiety. After 2 hospitalizations and intensive outpatient treatment she returned to her current new school on the west coast. She reports that despite the medications that she is taking she is quite depressed and anxious while living at home with her parents.

She states that she has at least 1-3 panic attacks every 2-3 days that last up to 1 hr and result in her retreating to her room, throwing up, and getting into her bed. During these attacks, she is scared and worried she could lose control. She admits to feeling sad and angry a lot of the time; she is generally anhedonic only feeling good when she is running. Overall her energy and motivation levels are low. She denies any current suicidal ideation. She also c/o significant anxiety/agitated feeling and also has difficulty concentrating and decreased appetite with recent weight loss of 10lbs. Her current body weight is 105 lbs and she is 5' 6" tall. With her medications, she sleeps throughout the night. She has a h/o attention problems for which she was prescribed a stimulant that she had taken since high school and states has been helpful. Over the past 2 years she has had 2 hospitalizations with one serious overdose resulting in seizures and requiring intubation. Her father is being treated for depression and anxiety. There is a strong h/o anxiety and depression in the family and her father has been reported to go on buying sprees but according to her has not been manic.

She has tried citalopram and venlafaxine in the past which have not been helpful. She also tried gabapentin which made her sleepy and did not help her anxiety. Her current medications include: stimulant (adderal) 10mg bid; quetiapine 200mg qd; lurasidone 20mg/d; seroquel 200 mg qd; latuda 20mg/d; clonazepam 1mg bid; and propanolol 20mg bid. She denies significant side effects. She can't tell if her lethargy is due to depression or her medications. She states that the only thing that seems to help her anxiety which at times is "unbearable" is clonazepam.

Prior to 2 years ago, her panic attacks were under control and she was relatively symptom free. Her panic attacks were managed with clonazepam. She was a star high school soccer player and got a scholarship to a D1 school. She also had a very athletic boyfriend for 4 years who was the high school quarterback. They were the king and queen for homecoming and she descried them as the "ideal couple". She also stated that she was "overly dependent" on

Menu

Calendar

Tests

him. Her anxiety and depression began after a constellation of events that included going off to a different college than her boyfriend, getting injured while playing and suffering loss of consciousness, a concussion and injury to her knee that required surgery. She was then unable to play D1 soccer and she caught her boyfriend cheating on her.

After considerable, intensive outpatient therapy she stabilized and this summer managed a solo trip by herself to Africa and Europe which she loved and during which she was symptom free. On starting school at University of San Diego, she relapsed with the trigger of her ex -boyfriend's team coming to play there. Also, she was triggered by the possibility of another relationship with a boy. Due to this, she decided to join her parents who recently moved to Wisconsin.

She reports a history of emotional and sexual abuse by her ex-boyfriend. She states that she was unaware that his behavior was abusive until she was in psychotherapy. which she has only recently recognized. There is no evidence of hypomania/mania, psychosis, self-injurious behavior, PH of eating disorder, OCD or substance abuse. Father is a physician and wants genetic testing and also suggested that ketamine should be tried for his daughter.

Psychiatric Review of Systems: The patient endorses the following: depression, anhedonia, loss of interest, poor attention, anxiety and panic. The patient denies the following: impulsivity, hallucinations and delusions.

Other Review of Systems: The patient endorses the following: weight loss, low energy and anxiety related vomiting.

Questionnaire Results: 17-item Hamilton Depression Ratting Scale score of 10, indicating mild depressive symptoms

Lab Test Results: Normal SMAC and CBC

PSYCHIATRIC HISTORY, MEDICAL HISTORY, AND OTHER HISTORY

Psychiatric History:
- Hospitalizations: 2 hospitalizations over past 2 years
- Emergency Department Visits: numerous ER visits for abdmonial symptoms which were diagnosed to be ovarian cysts
- Medication Trials: tried citalopram and venlafaxine—got nauseated–doses unknown
- Past Suicide Attempts: 2 suicide attempts
- Psychotherapy: Intensive outpatient therapy daily for 2 months after hospitalization and then weekly.

Family Psychiatric History: Mother: history for depression and anxiety; hypothyroid–citalopram and lorazepam were effective for her. Father: had to take disability due to severe depression also a h/o buying sprees –taking lamotrigine, duloxetine and clonazepam. Paternal Grandfather: alcoholic and "over-achiever". Was abusive to father until he was 40 years old. First cousin: committed suicide 3 years ago –substance abuse and anxiety

Medical History: No current medical problem. Uses IUD

Past Medical History: Four knee surgeries, two ruptured ovarian cysts, four concussions with loss of consciousness x2 over the past 5 years from soccer and mountain biking

Past Physical, Verbal, Emotional, or Sexual Abuse:
- Physical Abuse: denies
- Verbal Abuse: unclear
- Emotional Abuse: Likely with ex-boyfriend
- Sexual Abuse: Yes as discussed re: ex-boyfriend–relationship of 7 years with nonconsensual sex

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Menu

Calendar

Tests

MENTAL STATUS EXAM:

- **Appearance/Behavior:** Dress appropriate.
- **Behavior:** Interactive.
- **Facial Expressions/Eye Contact:** appropriate.
- **Unusual Mannerisms:** No
- **Musculoskeletal:** Abnormal Movements: none. Gait and Station: normal
- **Language/Speech:** Speech: normal rate, rhythm, volume, and prosody.
- **Mood/Affect:** Mood: "depressed and very anxious" Affect: dysphoric.
- **Thought Process and Associations:** linear, logical and goal directed.
- **Abnormal or Psychotic Thoughts:** Denies current suicidal ideation, auditory hallucinations, visual hallucinations, or delusions. Feels hopeless about getting better and worried she will end up like her father. Endorses doubting and indecision and free-floating anxiety.
- **Judgment and Insight:** Fair to good
- **Cognitive:** Orientation: alert and oriented to time, person and place
- **Memory:** Recent Memory: appears to be grossly intact
- **Remote Memory:** Appears to be grossly intact
- **Attention Span and Concentration:** Able to track conversation appropriately; history of attentional problems
- **Fund of Knowledge:** Average

RISK FACTORS

AODA: No concerns.

Suicide Risk Assessment:

- **Non-Modifiable Risk Factors:** Two Prior suicide attempts
- **Modifiable Risk Factors:** Means available. Recent losses or disruption of care. Psychic distress/anxiety/pain. Decreased self-esteem. Loss of pleasure/interest
- **Protective Factors:** Sense of responsibility to family and social supports/connections, Capacity to establish therapeutic alliance. Willingness to comply with treatment plan, Outpatient care in place
- **Suicide Review/Warning Signs:** Denies current SI or intent. made serious attempt last January
- **Behaviors:** Withdrawing from relationships
- **Overall Risk Ratings:** Acute risk: low. Chronic risk: moderate
- **Assessment of Risk:** She is not currently suicidal and wants to get better; she admits to feeling hopeless at times; clearly has the potential given past behavior and attempt

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