CUNY York College Physician Assistant Program
Summer 2020
Mariyanthie Linaris
Psychiatry Rotation – Queens Hospital Center

Case Write-Up 1

Identifying Data:

- *Name:* AK
- *Sex: Female*
- *Age:* 60 years
- *Date and Time:* August 8, 2020; 3:30 PM
- *Location:* NYC H+H/Queens Hospital Center - Comprehensive Psychiatric Emergency Program (CPEP)
- *Source of Information:* Self, reliable
- *Source of Referral:* Self/Cousin
- *Mode of Transport:* Taxi

Chief Complaint:

"I have not been sleeping and I am feeling very restless" x 3 weeks

History of Present Illness:

Patient is a 60-year-old black Jamaican female, employed, domiciled with daughter (36 years old) and brother with a significant past medical history of Glaucoma and significant past psychiatric history of Bipolar I Disorder (diagnosed April 2020, first episode) who presented to CPEP via taxi with her brother complaining of insomnia and anxiety. She reports that she did not want to come to the hospital, but her brother was concerned for her and brought her. Patient reports she had a "mental breakdown" in April while working as a laboratory technician at Elmhurst Hospital during the height of the COVID-19 pandemic in New York City and was admitted to Elmhurst Hospital's inpatient psychiatry service for 5 weeks. Patient's electronic medical record confirms that she was brought to the Elmhurst Hospital Emergency Department on 4/29/2020 due to bizarre behavior and was discharged on 6/4/2020. As per the patient's chart, the patient began screaming and singing and attempted to interrupt a press conference taking place at Elmhurst Hospital. She reports that she "was hearing Jesus speak" directly to her and felt like she needed to save everyone at the time. During her inpatient admission, she was evaluated for a manic episode with psychotic symptoms and treated with Haldol 5mg PO and diagnosed with Bipolar I Disorder. She has since been following up with psychiatrist Dr. Nazneen Khan and psychologist Dr. *** and was switched to once daily Risperidone 0.5 mg with dinner, but she has not been adherent with her medications as per outpatient follow-up notes. She says, "I don't feel like myself when I take the medication." Patient reports that she feels "restless" and has not been sleeping well. She denies any alcohol or illicit drug use. She recently followed up with a neurologist and was prescribed Ambien 5 mg by mouth as needed for sleep but reports no improvement in sleep despite taking the medication. She is the primary caretaker for her daughter who has Williams Syndrome and has not returned to work since her psychiatric episode in April. She has never been prescribed a mood stabilizer. The patient produced the discharge paperwork from her inpatient stay at Elmhurst Hospital for further information.

Collateral information was obtained from the patient's cousin (### [phone number]). ### is very involved in the patient's care and has accompanied the patient to outpatient follow-up appointments since her discharge from Elmhurst Hospital. Patient's cousin confirmed the patient's medical and psychiatric history and informed the writer that she is the patient's power of attorney. ### reports that the patient had a "mental breakdown" during the height of COVID-19 secondary to being overworked and not getting enough sleep. She reports that the patient "has not been herself" since her hospitalization at Elmhurst Hospital and has had difficulty sleeping despite separate trials with Trazodone and Ambien. Patient's cousin reports that the patient was improving "and just getting back to being herself" as of Thursday when she saw the patient, but she has

since gotten worse again. Patient's cousin and the patient are reluctant to start any new medications due to previous adverse reactions with Haldol (akathisia), Seroquel (anxiety), and Risperidone (anxiety), remarking that "the way she is now is way better than the way she was with medications because she was so doped up." The patient produced the discharge paperwork from her inpatient stay at Elmhurst Hospital for further information.

Past Medical History:

- Glaucoma x 12 years

Past Psychiatric History:

- Bipolar 1 disorder – diagnosed April 2020
    - 1 hospitalization – Elmhurst Hospital inpatient psychiatry service
    - Follows up with Elmhurst Hospital outpatient services

Allergies:

No known allergies to medications, foods, or environmental factors

Medications:

- Timolol (Timoptic) ophthalmic 0.5% solution
    - 1 drop in each eye once daily in the morning
    - Last dose this morning
- Prescribed Risperidone (Risperdal) 0.5 mg twice daily by psychiatrist Dr. Nazneen Khan, but is noncompliant

Family History:

Patient and patient's cousin deny any known family history of psychiatric illnesses

Social History:

AK is a black Jamaican female, single, heterosexual, employed, domiciled with her daughter (36 years old, Williams Syndrome) and brother. She has been employed as a lab technician at Elmhurst Hospital for the last 25 years but has not returned to work since April due to her psychiatric episode and subsequent hospitalization. She has no tentative return date but still holds her position. She currently reports little interest in going back to work. The patient was born in Jamaica and immigrated to the United States shortly before her daughter's birth. She reports that she graduated high school and has been working various jobs since then. When asked what she enjoys doing she says, "I do things in the house. I cook, I clean. I go to the bank. I do my errands." She has a close relationship with her cousin, ###, and admits that she does not have many friends. She reports poor sleep (less than three hours on average) and slightly decreased appetite. She remains active by walking to the store and doing work around the house. AK is her adult daughter's primary caretaker and has no other children. She denies alcohol or illicit drug use. She denies history of arrest, incarceration, or any other criminal activity.

Review of Systems:

- *General* – Patient admits to mildly decreased appetite ("I don't eat as much anymore") and denies weight loss or gain, fever, and fatigue
- *Skin* – No evidence of self-inflicted wounds, intravenous drug use, or skin picking

- *Neurology* – Patient denies headache, loss of consciousness, history of head trauma, unsteady gait, and unintentional body movements
- *Psychiatric* – Patient admits to feeling down sometimes and loss of interest in non-essential activities (activities that are not housework that she must do) for the past month. She denies suicidal/homicidal ideations and visual/auditory hallucinations

Vital Signs:

- BP: 138/78 (left arm, sitting)
- Pulse: 74 beats/minute (regular)
- Respiratory rate: 18 breaths/minute (unlabored)
- Temperature: 98.7 F (oral)
- SpO2: 99% (room air)
- Height: 69 inches
- Weight: 147 pounds
- BMI: 21.7

Mental Status Exam:

- *General*
  - Appearance - AK is a tall, slim, black female with a narrow frame and tightly coiled dark brown hair secured back in a low bun. She is dressed appropriately and is well groomed with good hygiene. She appears younger than her stated age. She does not appear to have any acute wounds or injuries.
  - Behavior - Upon initial evaluation in Comprehensive Psychiatric Emergency Program triage, the patient is seated looking at the ground and appears restless as noted by her intentionally rubbing her hands together and shifting in her seat. She does not appear to have any tics, tremors, or psychomotor agitation or retardation.
  - Attitude Towards Examiner – AK is calm and cooperative and responds to all questions appropriately. She appears guarded during the interview and maintained poor eye contact. She does not display any hostility or aggression towards the examiner or other unit staff. She was able to establish quick rapport with the examiner in a few minutes.
- *Sensorium and Cognition*
  - Alertness and Consciousness – AK was conscious and alert consistently throughout the interview
  - Orientation – Patient was oriented to person, place, time, and situation
  - Concentration and Attention – AK maintained attention and concentration throughout the interview and did not appear distractible or internally preoccupied. She was able to answer all questions appropriately
  - Visuospatial Ability – The patient displays normal visual perception as suggested by appropriate balance on her feet, normal gait, and purposeful body movements. She did not maintain consistent eye contact but displayed normal gaze when she did make eye contact.
  - Capacity to Read and Write – AK displayed average reading and writing ability as shown by her review and signing of admission documents and scanning of previous discharge paperwork from Elmhurst Hospital.
  - Abstract Thinking – The patient displays intact abstract thinking by interpretation of commonly used English metaphors
    - The grass is always greener on the other side – "You want what isn't yours because it looks better."

        - What makes apples and oranges similar? – "They are fruits."
    - Memory – The patient's remote and recent memory appear normal as suggested by her ability to provide her cousin's phone number from memory and recollection of recent events leading up to her presentation to the facility.
    - Fund of Information and Knowledge – AK's intellectual performance was average and consistent with her education level and training.
- *Mood and Affect*
    - Mood – The patient's mood appears depressed. She sat with her head down for most of the interview and did not smile at all. She states that she feels "fine" and wants to go home.
    - Affect – AK appeared guarded and her affect was flat.
    - Appropriateness – AK's mood and affect were congruent throughout the interview.
- *Motor*
    - Speech – AK's speech rate was slow, rhythm was monotone, and volume was low. Her speech was coherent and organized. The patient's answer latency was increased. She did not require redirection to answer questions.
    - Eye Contact – AK maintained poor eye contact and only made contact when she required a question to be repeated when she could not hear or understand due to the masks all parties involved were wearing.
    - Body Movements – Patient appeared fidgety during the exam as shown by rubbing her hands together and shifting in her seat. She reports that she feels restless and like she wants to move but is able to sit still when asked to. She does not display any tics or unintentional body movements. All movements were fluid.
- *Reasoning and Control*
    - Impulse Control – AK displays appropriate impulse control. She denies suicidal or homicidal urges. She is compliant with all requests (urine sample, blood samples, accepting food and drinks etc.)
    - Judgment – AK denies current paranoia, delusions, and auditory/visual hallucinations. Her judgment is appropriate.
        - If you were walking on the street and notices a letter with a stamp and address on the ground next to a mailbox you drop mail in, what would you do? – "I would put the letter in the mailbox."
    - Insight – AK's insight is appropriate; she is aware of her current condition and why she was brought to the hospital ("I have not been sleeping and I feel restless."). She prefers not to take medications due to her and her family's research on side effects and her own history of side effects with various medications (see HPI).

Patient Health Questionnaire – 9:

1. In the past 2 weeks have you felt little interest or pleasure in doing things you used to enjoy?
    a. Yes, Nearly every day - +3
2. In the past 2 weeks, have you been feeling down, depressed, or hopeless?
    a. Yes (I feel down sometimes), Nearly every day - +3
3. In the past 2 weeks, have you had trouble falling or staying asleep, or sleeping too much?
    a. Yes (insomnia), nearly every day - *+3*
4. In the past 2 weeks, have you been feeling tired or having little energy?
    a. Nearly every day - +3 (feeling too much energy) – 0
5. In the past 2 weeks, have you had poor appetite or been overeating?

   a. Yes, Nearly every day - +3
6. In the past 2 weeks, have you been feeling bad about yourself or that you are a failure or have let yourself or your family down?
   a. Nearly every day - +3 – 0
7. In the past 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?
   a. Nearly every day - +3 – 0
8. In the past 2 weeks, have you been moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?
   a. Yes (fidgety), nearly every day - *+3*
9. In the past 2 weeks, have you thought that you would be better off dead, or thoughts of hurting yourself in some way?
   a. Nearly every day - +3 – 0

Total Score – 26 – Suggests mild depression which may require only watchful waiting and repeat at follow-up.

Assessment:

Patient is a 60-year-old black Jamaican female, employed, domiciled with daughter (36 years old) and brother with a significant past medical history of Glaucoma and significant past psychiatric history of Bipolar I Disorder (diagnosed April 2020, first episode) who presented to CPEP via taxi with her brother complaining of insomnia and anxiety. She reports that she did not want to come to the hospital, but her brother was concerned for her and brought her. Patient reports she had a "mental breakdown" in April while working as a laboratory technician at Elmhurst Hospital during the height of the COVID-19 pandemic in New York City and was admitted to Elmhurst Hospital's inpatient psychiatry service for 5 weeks. Patient's electronic medical record confirms that she was brought to the Elmhurst Hospital Emergency Department on 4/29/2020 due to bizarre behavior and was discharged on 6/4/2020. She reports that she "was hearing Jesus speak" directly to her and felt like she needed to save everyone at the time. During her inpatient admission, she was evaluated for a manic episode with psychotic symptoms and treated with Haldol 5mg PO and diagnosed with Bipolar I Disorder. She has since been following up with psychiatrist Dr. Nazneen Khan and psychologist Dr. Hakyung Kim and was switched to once daily Risperidone 0.5 mg with dinner, but she has not been adherent with her medications as per outpatient follow-up notes. She says, "I don't feel like myself when I take the medication." Patient reports that she feels "restless" and has not been sleeping well.

Collateral information was obtained from the patient's cousin and medical power of attorney, Charmaine, who confirmed the patient's history and provided further information.

Patient was seen by the writer in CPEP triage. Patient was calm and cooperative but appeared restless. She is alert and oriented to person, place, time, and situation. Patient was appropriate in appearance and hygiene. Patient stated that her mood is "good" but appears guarded and depressed and has a flat affect. Patient made poor eye contact. Rate of patient's speech was slow, rhythm was monotone, and volume was low. Patient's answer latency was prolonged. Patient's insight and judgment are within normal limits. Patient denies suicidal/homicidal ideations, auditory/visual hallucinations, and alcohol/illicit drug use. She is reluctant to stay in the hospital and says, "just give me something to help me relax" so she can return home and care for her daughter, who is currently in the patient's brother's care. Patient's labs were reviewed, and she was medically cleared. The patient is not currently a danger to herself or others, but given severity of symptoms, depressed mood, and flat affect, the patient will be admitted for observation and re-evaluation with possible discharge in the morning.

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Differential Diagnosis:

1. *Schizoaffective Disorder, Bipolar Type (Depressive Episode)* – Based on the patient's history of grandiose delusion and auditory hallucinations/religious fixation, documented manic episode, and current depressive symptoms in conjunction with noncompliance with medications, it might make sense that the patient was actually suffering from Schizoaffective Disorder rather than Bipolar I Disorder
2. *Bipolar I Disorder, Depressive Episode* – Given the patient's prior diagnosis of Bipolar I Disorder during her manic episode with psychotic features and positive depression screen combined with her feelings of restlessness and difficulty sleeping, as well as her noncompliance with any medications at all (despite the fact that none would have been a mood stabilizer medication), it would be plausible that the patient is experiencing a depressive episode of her previously diagnosed condition. Given the patient's age at diagnosis and her and her family's denial of any previous episodes or diagnosis, it is quite uncommon for such late onset Bipolar Disorder (as per UpToDate). Additionally, as per the previous documentation and the patient's cousin's account that the manic episode was described to be more sudden rather than at least 5 days, this diagnosis seems questionable. It is also questionable that the inpatient service that initially diagnosed the patient with Bipolar I Disorder did not initiate a mood stabilizer drug like Depakote and instead initiated an antipsychotic.
3. *Adjustment Disorder with Depressed Mood* – Given the context of the patient's first episode in April (beginning/height of COVID-19 pandemic in NYC), increased work hours, lack of sleep, and onset within 3 months of this new change combined with the current depressive symptoms the patient is exhibiting. I ultimately find this to be less likely because of the initial presentation in April with psychosis that does not really fit the profile for this disorder.
4. *Generalized Anxiety Disorder* – The patient displays sleep disturbance and restlessness, but given her later onset, absence of excessive worry and at least one other symptom of easy fatiguability/difficulty concentrating/irritability/muscle tension, and less than 6 months of symptoms, the patient both does not meet criteria and is less likely to have this diagnosis.

Diagnosis:

- Schizoaffective Disorder, Bipolar Type

Plan:

- Admit patient to Comprehensive Psychiatric Emergency Program under Mental Hygeine Law 9.40 legal status for observation and re-evaluation in the morning due to depressed mood and flat affect
- CBC, CMP, urine toxicology completed and reviewed
    - Within normal limits
- Repeat vital signs in the morning
- Pending patient's consent, initiate Haldol 5mg by mouth before bed for sedative effect and evaluate in the morning for possible discharge
- Social work team to set up possible discharge in the morning and confirm follow up with the patient's regular outpatient Elmhurst Hospital psychiatry team
- Contact patient's cousin (###) when discharge is confirmed

Morning Re-Evaluation:

Patient re-evaluated the following morning in the unit during breakfast. Patient appears well groomed and was ambulating freely through the unit after having finished her breakfast. Patient consented to Haldol 5mg by mouth last night and reports that she slept between 7 and 8 hours overnight and feels well rested. Patient's mood appears much improved and she notes, "I am feeling good today." While patient's affect still appears

somewhat constricted, it is vastly improved from the previous day's evaluation. The rate, rhythm, and volume of the patient's speech are also improved. Her insight and judgment continue to be appropriate. She continues to deny suicidal/homicidal ideations and auditory/visual hallucinations. She is not a danger to herself or others and can be safely discharged home with transportation provided by her cousin (Charmaine). Patient refuses outpatient medication and is instructed and agrees to follow-up with her outpatient mental health provider.

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Case Write-Up 2

Identifying Data:

- *Name:* AK
- *Sex: Female*
- *Age:* 21 years
- *Date and Time:* August 14, 2020; 2:30 PM
- *Location:* NYC H+H/Queens Hospital Center - Comprehensive Psychiatric Emergency Program (CPEP)
- *Source of Information:* Self, reliable
- *Source of Referral:* Queens Hospital Center OB/GYN Clinic
- *Mode of Transport:* Personal Vehicle

Chief Complaint:

"I will drink bleach if I cannot have an abortion" x 1 week

History of Present Illness:

Patient is a 21-year-old G3P0020 (currently 27 weeks pregnant) bilingual (Punjabi and English) Indian female, unmarried, domiciled with parents and 2 brothers, student at LaGuardia Community College with no significant past medical or psychiatric history who was brought from the outpatient Queens Hospital Center OB/GYN clinic with her boyfriend due to suicidal ideations and Patient Health Questionnaire – 9 score of 23. She reports that she does not want her baby and has thought about drinking bleach to kill herself if she cannot have an abortion. She has not told her parents about her pregnancy and is scared to tell them because her parents do not like her boyfriend and instead want her to "marry someone rich." She expressed that she and her boyfriend want to get married, but she does not want to upset her family, especially since her mother was sick with COVID-19 recently and does not want to stress her further. She has had 2 medical abortions in the past year due to pregnancy by the same boyfriend due to similar concerns. She denies use of any contraceptive methods. She did not terminate this current pregnancy due to services being unavailable as a result of the pandemic. She denies intention to harm herself currently because she says, "I want to die, but I know people care about me," but she reports that she last had suicidal thoughts 1 week ago and said, "I just wanted to die." She did not have any prenatal care until the appointment she presented for today, but she has been taking prenatal vitamins. She is aware of options for adoption but reports that she has no plan for when she due to deliver her baby and no current intention to inform her family of her pregnancy. Patient denies verbal/physical/emotional abuse and intimate partner violence. She denies any past psychiatric diagnosis, psychiatric medications, or having seen a mental health professional. She denies auditory/visual hallucinations, paranoia, and alcohol/illicit drug use.

Collateral information was obtained from the patient's boyfriend, *** (phone number). He reports that he has never heard her express thoughts of harming herself or anyone else and denies that she wants to kill herself. He confirms that he wants to marry the patient, but she is fearful of her parents. Patient's boyfriend became aggressive and insisted on seeing/speaking with the patient when he found out she was staying in CPEP overnight.

Past Medical History:

- 2 previous pregnancies – 2019 and 2020
    - Terminated with medical abortion

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Past Psychiatric History:

- Patient denies any previous psychiatric history
- Patient denies alcohol/illicit drug use

Allergies:

No known allergies to medications, foods, or environmental factors

Medications:

- Prenatal vitamins

Family History:

Patient denies any known family history of psychiatric illnesses

Social History:

AK is a currently pregnant (27 weeks) English-speaking Indian female, in a relationship with her boyfriend x 4 years, heterosexual, unemployed, residing with her parents and 2 older brothers (ages 23 and 25). She is currently a student pursuing an Associate Degree in Business Administration at LaGuardia Community College. The patient was born in the United States to immigrant parents from the Punjab region of India. When asked what she enjoys doing she says, "I like to watch Netflix and do schoolwork." She does not have many close friends and spends most of her time with her boyfriend. She reports that she usually sleeps well (7-8 hours per night) but has been nervous about her pregnancy so she has been sleeping restlessly in the last week. She reports that she eats well and has had no changes in appetite. She does not exercise. She denies history of arrest, incarceration, or any other criminal activity.

Review of Systems:

- *General* – Patient admits that she has gained some weight due to her pregnancy and denies changes in appetite, weight loss, fever, and fatigue
- *Skin* – No evidence of self-inflicted wounds, intravenous drug use, or skin picking
- *Neurology* – Patient denies headache, loss of consciousness, history of head trauma, unsteady gait, and unintentional body movements
- *Psychiatric* – Patient admits to feeling depressed, hopeless, and anxious as a result of her pregnancy and family situation. She denies current suicidal ideations because she does not want to hurt her family, but she admits that she "just wanted to die" 1 week ago. She denies paranoia, delusions, and auditory/visual hallucinations

Vital Signs:

- BP: 116/72 (right arm, sitting)
- Pulse: 88 beats/minute (regular)
- Respiratory rate: 18 breaths/minute (unlabored)
- Temperature: 98.9 F (oral)
- SpO2: 99% (room air)
- Height: 63 inches
- Weight: 145 pounds
- BMI: 25.7

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Mental Status Exam:

- *General*
  - Appearance - AK is a short, slim but visibly pregnant, Indian female with a long, dark brown hair braided neatly down her back. She is dressed appropriately and is well groomed with good hygiene. She appears her stated age. She does not appear to have any acute wounds or injuries.
  - Behavior - Upon initial evaluation in Comprehensive Psychiatric Emergency Program triage, the patient is seated in a chair and appears worried. She does not appear to have any tics, tremors, or psychomotor agitation or retardation.
  - Attitude Towards Examiner – AK is nervous but cooperative and responds to all questions appropriately. She appears guarded during the interview and maintained appropriate eye contact. She does not display any hostility or aggression towards the examiner or other unit staff. She was able to establish quick rapport with the examiner in a few minutes.
- *Sensorium and Cognition*
  - Alertness and Consciousness – AK was conscious and alert consistently throughout the interview
  - Orientation – Patient was oriented to person, place, time, and situation
  - Concentration and Attention – AK maintained attention and concentration throughout the interview and did not appear distractible or internally preoccupied. She was able to answer all questions appropriately
  - Visuospatial Ability – The patient displays normal visual perception as suggested by appropriate balance on her feet, normal gait, and purposeful body movements. She maintained good eye contact with appropriate gaze.
  - Capacity to Read and Write – AK displayed average reading and writing ability as shown by her review and signing of admission documents
  - Abstract Thinking – The patient displays intact abstract thinking by interpretation of commonly used English metaphors
    - Don't cry over spilled milk – "Not to get upset over small things."
    - What makes apples and oranges similar? – "They are fruits."
  - Memory – The patient's remote and recent memory appear normal as suggested by her ability to provide her boyfriend's phone number from memory and recollection of recent events leading up to her presentation to the facility.
  - Fund of Information and Knowledge – AK's intellectual performance was average and consistent with her education level and training.
- *Mood and Affect*
  - Mood – The patient's mood appears anxious and depressed. She was tearful during the interview and did not smile. She states that she feels "fine" and wants to go home.
  - Affect – AK appeared guarded and her affect was congruent.
  - Appropriateness – AK's mood and affect were congruent throughout the interview.
- *Motor*
  - Speech – Rate, rhythm, and volume of AK's speech were within normal limits. Her speech was coherent and organized. The patient's answer latency was within normal limits. She did not require redirection to answer questions.
  - Eye Contact – AK maintained good eye contact.
  - Body Movements – No psychomotor abnormalities observed. She does not display any tics or unintentional body movements. All movements were fluid.
- *Reasoning and Control*

- Impulse Control – AK displays appropriate impulse control. She denies current suicidal or homicidal urges and says, "If I was going to kill myself I would have done it already." She is compliant with all requests (urine sample, blood samples, accepting food and drinks etc.)
- Judgment – AK denies current paranoia, delusions, and auditory/visual hallucinations. Her judgment is appropriate.
  - If you were walking on the street and notices a letter with a stamp and address on the ground next to a mailbox you drop mail in, what would you do? – "I would put the letter in the mailbox."
- Insight – AK's insight is appropriate; she is aware of her current condition and why she was brought to the hospital.

Patient Health Questionnaire – 9 (From OB/GYN Clinic)**:**

1. In the past 2 weeks have you felt little interest or pleasure in doing things you used to enjoy?
   a. Yes, Nearly every day - +3
2. In the past 2 weeks, have you been feeling down, depressed, or hopeless?
   a. Yes (I feel down sometimes), Nearly every day - +3
3. In the past 2 weeks, have you had trouble falling or staying asleep, or sleeping too much?
   a. Yes (insomnia), nearly every day - *+3*
4. In the past 2 weeks, have you been feeling tired or having little energy?
   a. Nearly every day (feeling tired) - +3
5. In the past 2 weeks, have you had poor appetite or been overeating?
   a. No - *0*
6. In the past 2 weeks, have you been feeling bad about yourself or that you are a failure or have let yourself or your family down?
   a. Yes, Nearly every day - +3
7. In the past 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?
   a. Yes, Nearly every day - +3
8. In the past 2 weeks, have you been moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?
   a. Yes (fidgety), most days - *+2*
9. In the past 2 weeks, have you thought that you would be better off dead, or thoughts of hurting yourself in some way?
   a. Yes, Nearly every day - +3

Total Score – 23 – Suggests severe depression

Assessment:

Patient is a 21-year-old G3P0020 (currently 27 weeks pregnant) bilingual (Punjabi and English) Indian female, unmarried, residing with parents and 2 brothers, student at LaGuardia Community College with no significant past medical or psychiatric history who was brought from the outpatient Queens Hospital Center OB/GYN clinic with her boyfriend due to suicidal ideations and Patient Health Questionnaire – 9 score of 23. She reports that she does not want her baby and has thought about drinking bleach to kill herself if she cannot have an abortion. She has not told her parents about her pregnancy and is scared to tell them because her parents do not like her boyfriend and instead want her to "marry someone rich." She expressed that she and her boyfriend want to get married, but she does not want to upset her family, especially since her mother was sick with COVID-19 recently and does not want to stress her further. She has had 2 medical abortions in the past year due to pregnancy by the same boyfriend due to similar concerns. She denies use of any contraceptive

methods. She did not terminate this current pregnancy due to services being unavailable as a result of the pandemic. She denies intention to harm herself currently because she says, "I want to die, but I know people care about me," but she reports that she last had suicidal thoughts 1 week ago and said, "I just wanted to die." She did not have any prenatal care until the appointment she presented for today, but she has been taking prenatal vitamins. She is aware of options for adoption but reports that she has no plan for when she due to deliver her baby and no current intention to inform her family of her pregnancy. Patient denies verbal/physical/emotional abuse and intimate partner violence. She denies any past psychiatric diagnosis, psychiatric medications, or having seen a mental health professional. She denies auditory/visual hallucinations, paranoia, and alcohol/illicit drug use.

Patient was seen in CPEP triage area by the writer. Patient was calm and cooperative, but tearful. Patient was alert and oriented x 4. Patient's mood appears depressed and she displays appropriate affect. She makes appropriate eye contact and has no observable psychomotor abnormalities. The rate, rhythm, and volume of her speech are within normal limits. Patient's insight and judgment are questionable at this time. She reports suicidal/homicidal ideations 1 week ago, but not currently. She denies homicidal ideations, visual/auditory hallucinations, or alcohol/illicit drug use. She is preoccupied with discharge because she does not want her family to find out about her pregnancy at this time. Patient admitted to CPEP for overnight observation and re-evaluation in the morning.

Differential Diagnosis:

1. *Major Depressive Disorder, Peripartum Onset* – Based on the patient's presentation and the indication given by the Patient Health Questionnaire – 9 score of 26, the patient likely suffers from major depressive disorder with peripartum onset. She feels hopeless, has sleep disturbance, has thought about suicide, and feels like she has let down her family. Her symptoms have persisted for longer than 2 weeks. Given that she is 6 months pregnant, this would coincide with peripartum onset.
2. *Adjustment Disorder with Depressed Mood* – In this case the stressor or combination of stressors the patient may be responding to are her unplanned pregnancy, the COVID-19 pandemic, and her mother's illness. While her daily functioning does not appear to be significantly impaired, this is still a potential differential. Typically, Adjustment Disorder resolves within 6 months of the stressor so the patient is slightly outside of that window depending on when she learned of her pregnancy.
3. *Generalized Anxiety Disorder* – Given the way the patient presented upon initial evaluation, this differential is less likely. However, given her restlessness and sleep disturbance, it may be possible. Since she has not had 6 months of symptoms, it would be too early to make this diagnosis for her.

Diagnosis:

- Major Depressive Disorder

Plan:

- Admit patient to Comprehensive Psychiatric Emergency Program under Mental Hygiene Law 9.40 legal status for observation and re-evaluation in the morning due to depressed mood and suicidal ideations
- CBC, CMP, urine toxicology completed and reviewed
    - Within normal limits
- Repeat vital signs in the morning
- 1-to-1 supervision with monitoring every 15 minutes
- Social work team to set up possible discharge in the morning and arrange outpatient follow up with Queens Hospital Center Adult Outpatient Clinic

- Counseled on making a plan for the rest of her pregnancy and provided with resources about adoption with Social Work team
- Counseled on benefits of telling her family about her pregnancy and wishes to marry her boyfriend
- Contact patient's mother (###, [phone number]) when discharge is confirmed for pick-up

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Morning Re-Evaluation:

Patient re-evaluated the following morning in the unit following breakfast. Patient slept well. Patient appears well groomed and was ambulating freely through the unit after having finished her breakfast. Patient's mood appears improved and she states that she is "ready to go home." Her affect is appropriate. Patient denies suicidal/homicidal ideations, plan/intent, delusions, and auditory/visual hallucinations. Patient says she thought about her situation and options and now understands that she has other options. Patient expressed intent to speak with her mother about her pregnancy and plans to marry her current boyfriend.

Patient psychiatrically stable and cleared for discharge from CPEP. Patient agreed to and provided with appointment for outpatient adult psychiatric clinic follow-up. Patient's mother informed of discharge and agreed to pick the patient up.

CUNY York College Physician Assistant Program
Summer 2020
Mariyanthie Linaris
Psychiatry Rotation – Queens Hospital Center

Case Write-Up 3

Identifying Data:

- *Name:* TR
- *Sex: Female*
- *Age:* 31 years
- *Date and Time:* August 16, 2020; 4:30 PM
- *Location:* NYC H+H/Queens Hospital Center - Comprehensive Psychiatric Emergency Program (CPEP)
- *Source of Information:* Self, questionably reliable
- *Source of Referral:* Patient's boyfriend
- *Mode of Transport:* Personal Vehicle

Chief Complaint:

Suicidal ideations x 2 days

History of Present Illness:

Patient is a 31-year-old English-speaking Ukrainian female, unemployed, residing with boyfriend and 2 children (ages 2 and 3 years), with no significant past medical history and a significant past psychiatric history of ?Depression/Anxiety (reported by patient's boyfriend) who was brought by Emergency Medical Services activated by her boyfriend due to suicidal ideations and self-harm. Patient's boyfriend reports that the patient cut herself and has been hitting her own head for 2 days. The patient denies this and insists that her boyfriend is abusive. She says, "He grabs me and leaves bruises and says mean things to me," and reports that this has been going on for about 4 years. She reports that he has been arrested 7 times for incidents of abuse and is currently on probation, so she does not wish to file a police report. She reports that she has felt "depressed" because of how her boyfriend treats her and because she believes he is cheating on her. She admits that she feels better when she is not around her boyfriend and is starting the process of leaving him. Patient admits that she confronted the woman she believes her boyfriend is cheating on her with and both her boyfriend and the woman deny the allegations, but she says, "they are lying because they were caught." She reports that she got into a fight with her boyfriend yesterday because she believes he is being unfaithful, so she cut her left arm superficially with a scissor (Tdap status unknown) and sent him a picture of it "to prove a point." This prompted him to call EMS. She reports that she does not want to kill herself and has never hurt herself before. She denies alcohol and illicit drug use. She denies suicidal/homicidal ideations, delusions, paranoia, or auditory/visual hallucinations. She denies having ever seen a psychiatrist and has never been admitted to a psychiatric hospital in the past.

Collateral information was obtained from the patient's boyfriend (phone number) and his mother (***, [phone number]). Patient's boyfriend reports that the patient has been very upset and angry because she believes that he is cheating on her with one of his coworkers, which he denies. He reports that she has a history of depression/anxiety and follows up with a psychiatrist but does not know who. He also says she takes Klonopin but does not know the dose. He reports that last night she started banging her head against a wall and on their children's bunkbed and that earlier today she Facetimed him and threatened to jump off their balcony and kill herself, both of which he claims to have on video. He also reports that she took 30 of her Klonopin last night to kill herself, but induced vomiting soon after and apologized. They did not report to the hospital at that time. He denies her allegations of abuse and insists that she is the one who physically attacks him. He alleges that he called the police 3 times yesterday due to her behavior, but no officers responded to the calls. Their children are

both currently in his care and he plans to take them with him to his parents' home, which *** confirms. Patient's boyfriend reports that she behaves this way frequently and alternates between extreme anger towards him and being very apologetic and affectionate towards him.

Past Medical History:

- Patient denies any past medical history

Past Psychiatric History:

- Patient denies any previous psychiatric history
- Patient denies alcohol/illicit drug use

Allergies:

No known allergies to medications, foods, or environmental factors

Medications:

- Patient denies taking any medications
    - Patient's boyfriend reports that she takes Klonopin (dose and frequency unknown)

Family History:

Patient denies any known family history of psychiatric illnesses

Social History:

TR is a 31-year-old English-speaking Ukrainian female, in a relationship with her boyfriend x 5 years, unemployed, residing with her boyfriend and 2 sons (ages 2 and 3 years). She was previously employed as a real estate agent but has been furloughed as a result of the COVID-19 pandemic. TR was born in Ukraine and became a legal resident of the United States 6 years ago. She was in the process of becoming a United States Citizen when the COVID-19 pandemic broke out, delaying her process. When asked what she enjoys doing she reports that she spends most of her time taking care of her children and likes cooking. She reports that her mother lives in Long Island, New York and that she has a good relationship with her boyfriend's mother. She reports that her relationship with her current boyfriend is poor and endorses intimate partner violence. She reports that she sleeps well and has no changes in appetite. She does yoga at home and enjoys going for a run most mornings when her boyfriend is home in the morning to watch their children. She denies history of arrest, incarceration, or any other criminal activity.

Review of Systems:

- *General* – Patient denies changes in appetite, unintentional weight loss or gain, fever, and fatigue
- *Skin* – Patient admits to multiple superficial, self-inflicted lacerations on her left forearm and wrist made with a scissor. No evidence of intravenous drug use, or skin picking
- *Neurology* – Patient denies headache, loss of consciousness, history of head trauma, unsteady gait, and unintentional body movements
- *Psychiatric* – Patient admits to feeling depressed because of how her boyfriend treats her and his alleged infidelity. She denies suicidal/homicidal ideations, paranoia, delusions, and auditory/visual hallucinations

Vital Signs:

- BP: 108/69 (right arm, sitting)

- Pulse: 74 beats/minute (regular)
- Respiratory rate: 18 breaths/minute (unlabored)
- Temperature: 97.8 F (oral)
- SpO2: 99% (room air)
- Height: 67 inches
- Weight: 125 pounds
- BMI: 19.6

Mental Status Exam:

- *General*
  - Appearance – TR is a thin, medium height female with blond hair tied back in a ponytail. She is dressed appropriately in a hospital gown and is well groomed with good hygiene. She appears her stated age. She has one 4-inch diagonal and three 2-inch horizontal superficial lacerations on her left forearm and wrist.
  - Behavior - Upon initial evaluation in the Medical Emergency Room, the patient is sitting up in her assigned bed. She does not appear to have any tics, tremors, or psychomotor agitation or retardation.
  - Attitude Towards Examiner – TR is pleasant, superficially cooperative, and responds to all questions appropriately. She does not display any hostility or aggression towards the examiner or other staff. She was able to establish quick rapport with the examiner in a few minutes.
- *Sensorium and Cognition*
  - Alertness and Consciousness – TR was conscious and alert consistently throughout the interview
  - Orientation – Patient was oriented to person, place, time, and situation
  - Concentration and Attention – TR maintained attention and concentration throughout the interview and did not appear distractible or internally preoccupied. She was able to answer all questions appropriately
  - Visuospatial Ability – The patient displays normal visual perception as suggested by appropriate, purposeful, and coordinated body movements. She maintained good eye contact with appropriate gaze.
  - Capacity to Read and Write – TR displayed average reading and writing ability as shown by her review and signing of documents and writing her boyfriend's phone number on a piece of paper.
  - Abstract Thinking – The patient displays intact abstract thinking by interpretation of commonly used English metaphors
    - What makes circles and squares similar? – "They are shapes."
  - Memory – The patient's remote and recent memory appear normal as suggested by her ability to provide her boyfriend's and boyfriend's mother's phone numbers from memory and recollection of recent events leading up to her presentation to the facility.
  - Fund of Information and Knowledge – TR's intellectual performance was average and consistent with her education level and training.
- *Mood and Affect*
  - Mood – The patient's mood is "good."
  - Affect – TR's affect was appropriate
  - Appropriateness – TR's mood and affect were congruent throughout the interview.
- *Motor*

  - Speech – Rate, rhythm, and volume of TR's speech were within normal limits. Her speech was coherent and organized. The patient's answer latency was within normal limits. She did not require redirection to answer questions.
  - Eye Contact – TR maintained good eye contact.
  - Body Movements – No psychomotor abnormalities observed. She does not display any tics or unintentional body movements. All movements were fluid.
- *Reasoning and Control*
  - Impulse Control – TR displays questionable impulse control based on her actions that caused her boyfriend to call EMS. She denies current suicidal or homicidal urges and says she only cut herself "to prove a point." She is compliant with all requests (urine sample, blood samples, accepting food and drinks etc.)
  - Judgment – TR denies current paranoia, delusions, and auditory/visual hallucinations. Her judgment is questionable based on her actions.
    - If you were walking on the street and notices a letter with a stamp and address on the ground next to a mailbox you drop mail in, what would you do? – "Drop it in the mailbox."
  - Insight – TR's insight is questionable; she is aware of her current condition and why she was brought to the hospital but does not believe it was warranted because she "just wanted to prove a point."

Assessment:

Patient is a 31-year-old English-speaking Ukrainian female, unemployed, residing with boyfriend and 2 children (ages 2 and 3 years), with no significant past medical history and a significant past psychiatric history of ?Depression/Anxiety (reported by patient's boyfriend) who was brought by Emergency Medical Services activated by her boyfriend due to suicidal ideations and self-harm. Patient's boyfriend reports that the patient cut herself and has been hitting her own head for 2 days. The patient denies this and insists that her boyfriend is abusive. She says, "He grabs me and leaves bruises and says mean things to me," and reports that this has been going on for about 4 years. She reports that he has been arrested 7 times for incidents of abuse and is currently on probation, so she does not wish to file a police report. She reports that she has felt "depressed" because of how her boyfriend treats her and because she believes he is cheating on her. She admits that she feels better when she is not around her boyfriend and is starting the process of leaving him. She reports that she got into a fight with her boyfriend yesterday because she believes he is being unfaithful, so she cut her left arm superficially with a scissor (Tdap status unknown) and sent him a picture of it "to prove a point." This prompted him to call EMS. She reports that she does not want to kill herself and has never hurt herself before. She denies alcohol and illicit drug use. She denies suicidal/homicidal ideations, delusions, paranoia, or auditory/visual hallucinations. She denies having ever seen a psychiatrist and has never been admitted to a psychiatric hospital in the past.

Patient was seen in the MER by the writer. She was sitting up in bed and dressed appropriately in a hospital gown. She was calm and superficially cooperative made appropriate eye contact. She was alert and oriented x 4. She has one diagonal and three horizontal superficial self-inflicted wounds and no other visible wounds. She has no observed psychomotor abnormalities. The rate, rhythm, and volume of her speech are within normal limits. She displays questionable judgment and insight. Her mood is "good" and her affect is appropriate. She denies suicidal/homicidal ideations, auditory/visual hallucinations, and alcohol/illicit drug use. Due to self-inflicted wounds and collateral information, patient will be admitted to CPEP for suicidal ideations pending medical clearance in the MER for overnight observation and re-evaluation in the morning.

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Differential Diagnosis:

1. *Borderline Personality Disorder* – Based on the information obtained from the patient and collateral contacts, this is the most likely diagnosis. She appears to be manipulative in her interpersonal relationships and displays impulsivity (cutting herself, threatening to jump of the balcony, swallowing pills), self-mutilating behavior, affective instability due to a marked reactivity of mood, stress-related paranoid ideation, unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. Since this is a personality disorder, this is a difficult diagnosis to make based on one encounter, but it appears that she meets criteria for diagnosis.
2. *Delusional Disorder, Jealous Type* – Since most of the incidents described by the patient and collateral contacts stem from the patient's belief that her boyfriend is cheating on her, it is possible that she is suffering from Delusional Disorder of the jealous subtype. Of course, this may be true despite the boyfriend's claims that it is not. This differential also becomes less likely because the patient has not described marked impairment in daily functioning.
3. *Minor Depressive Disorder* – Since the patient described feeling "depressed," has engaged in at least one episode of self-harm, and claims to be the victim of intimate partner violence, it is possible that she is suffering from Minor Depressive Disorder since she does not at this time and based on the information she provided meet criteria for Major Depressive Disorder.

Diagnosis:

- Borderline Personality Disorder

Plan:

- Admit patient to Comprehensive Psychiatric Emergency Program under Mental Hygiene Law 9.40 legal status for observation and re-evaluation in the morning due questionable insight and judgment and suicidal ideations
- CBC, CMP, urine toxicology completed in Medical Emergency Room and reviewed
    - Within normal limits
- Repeat vital signs in the morning
- 1-to-1 supervision with monitoring every 15 minutes
- Consult Social Work team to arrange safe discharge away from patient's boyfriend and outpatient follow-up with the Queens Hospital Center Adult Outpatient Mental Health Clinic.
- Contact patient's boyfriend's mother when cleared for discharge

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Morning Re-Evaluation:

Patient re-evaluated the following morning in the unit. Patient slept well and ate breakfast. She was dressed appropriately in a hospital gown and maintained good grooming and hygiene. Patient continues to make good eye contact and exhibits no changes in speech and thought processes. Patient's insight and judgment are maintained. Patient reports that she spoke with her boyfriend's mother and confirmed that her boyfriend will be staying at his parents' home upon the patient's discharge. The patient's children will also stay with the patient's boyfriend and his parents for the time being. Patient continues to deny suicidal/homicidal ideations, plan/intent, and auditory/visual hallucinations. Patient is deemed psychiatrically stable at this time and can be safely discharged with scheduled follow-up in the Queens Hospital Center Adult Outpatient Mental Health Clinic on 8/20/2020 at 12:30 PM as per Social Work Team. *** was contacted and agrees to the discharge plan and will pick the patient up from the psychiatric emergency department.