Andres Hernandez

H&P #1 – Psychiatry

Identifying Data:
Full Name: C.A.
Address: Queens, NY
Date of Birth: 8/20/2005
Age: 18
Date: 4/18/2024, 2:00 pm
Location: Queens Hospital Center Psychiatric Emergency Room
Religion: Unspecified
Marital Status: Single
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Mother

CC: "afraid to touch things" x duration unknown.

HPI:
An 18-year-old Hispanic female, domiciled with her mother, and currently unemployed, presents to the Comprehensive Psychiatric Emergency Program (CPEP) with her mother due to progressively worsening compulsive rituals that are interfering with her daily functioning. Upon evaluation, the patient is calm, cooperative, with good eye contact, and speech at a normal rate and tone. The patient arrived wearing latex gloves, claiming the hospital is a dirty place, and she refuses to touch anything due to fear of contamination, admitting to over-washing her hands. The patient does not recall when these thoughts and behaviors started but admits that over-washing was worse in the past.

Collateral information was obtained from the patient's mother. Her mother noticed her daughter started showing concern over touching items after the patient's parent divorce in 2022. In August 2023, Carolyn's boyfriend joined the army and left, which resulted in the worsening of her symptoms. In addition to being concerned with touching objects, the patient no longer desires to leave the house. She refuses to wear clothes indoors, and her mother must insist she wear something. The patient refuses to sleep on her bed; her mother explains that a few months ago, her daughter stayed awake for two nights, causing both legs to swell. The patient now uses her bed while lying only on her upper half with her legs hanging off. She now completely disregards her hygiene; she refuses to take showers or brush her teeth. Her mother also reveals that the patient often starves herself, and when she does eat, she only eats snacks. Before 2022, the mother admits her daughter was normal and happy. She attended school, took care of herself, and socialized. In February 2024, the patient began seeing a therapist virtually and completed a total of 4-5 sessions. The patient's PCP suggested medication which she refuses to take. The patient denies any drug use, auditory or visual hallucinations, persecutory delusions, or thoughts or intentions of self-harm or harming others.

Past Psychiatric History:
-Anxiety, unknown onset, not medically managed.

-Depression, unknown onset, not medically managed.
Past Medical History:
-No past medical history.
-Denies childhood illnesses.
-Immunizations up to date.

Past Surgical History:
-No past surgical history.
-Denies blood transfusions and past injuries.

Medications:
-No medication use.

Allergies:
-Albuterol (palpitations)

Family History:
Mother- alive and healthy.
Father – alive and healthy.
No pertinent family history.

Social History:
Patient lives with mother.
Habits- denies alcohol, caffeine use, drug use.
Relationship status – relationship with boyfriend.
Sleep – unknown was not asked.
Appetite - unknown was not asked.
Exercise- does not exercise.
Past arrest/incarceration history – none

ROS:
General – Denies insomnia, recent weight loss, generalized weakness/fatigue, fever or chills, or night sweats.

Eyes – Denies photophobia, visual disturbances, lacrimation, pruritus, or use of contact lenses.

Ears – Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Pulmonary System - Denies shortness of breath or cough.

Cardiovascular System - Denies chest pain, HTN, palpitations.

Gastrointestinal system – Denies abdominal pain, and nausea.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain.

Nervous – Denies seizures, headache, dizziness, speech change, or weakness.

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter.

Psychiatric –Has history of depression, anxiety. Denies suicidal ideation attempt, homicidal thoughts, hallucinations, seeing a therapist.

Physical exam:
General: Young female, appears her stated age, height and weight, awake, fairly groomed, alert and oriented x 3, in no acute distress, responds quickly to questions, has good color. Can ambulate without assistance.

Vital signs:
BP: 113/78 mm Hg (BP location: Right arm)
R: 18 breaths/min, unlabored
P: 92 beats/min, regular
T: 98.4 degrees F (oral)
O2 Sat: 97% room air
Height: 1.549 m (5'1") Weight: 48.1 kg (106 lb) BMI: 1.44 m2

Mental Status Exam:
General
1. Appearance: casually groomed, well-nourished, good eye contact.
2. Behavior and Psychomotor Activity: Patient is guarded and anxious at times.
3. Attitude Towards Examiner: Patient is cooperative during the interview.

Sensorium and Cognition
1. Alertness and Consciousness: The patient was conscious and alert throughout the interview.
2. Orientation: Patent was oriented to the date, place, and time of the interview.
3. Concentration and Attention: Good concentration and unimpaired memory.
4. Capacity to read and write: Patient can read and write.
5. Abstract thinking: Proper ability to abstract think.
6. Memory: Memory was unimpaired.
7. Fund of information and knowledge: patient's intellectual performance consistent with level of education.

Mood and Affect
1. Mood: Anxious, Sad/Depressed
2. Affect: Appropriate, Full Range
3. Appropriateness: Mood and Affect were congruent throughout the interview

Motor
1. Speech: Patient's speech was normal
2. Eye Contact: Patient made good eye contact

3. Body Movements: No psychomotor abnormalities

Reasoning and Control
1. Impulse Control: Tenuous impulse control. Patient denies any suicidal ideations and plans.
2. Judgement: Patient had impaired judgement based on appreciating consequences of actions.
3. Insight: Patient has fair insight into her psychiatric condition.

Assessment:
An 18-year-old Hispanic female, with a past psychiatric history of anxiety and depression, is brought to the psychiatric emergency room by her mother due to concerns about deteriorating behavior impairing her functioning. The patient has a fear of contamination, preventing her from touching anything. On assessment, she appears guarded, anxious, and sad, with impaired impulse control, judgment, and insight at the time of evaluation. Vital signs are normal. Once stabilized, the patient will be admitted to inpatient psychiatric care and psychotherapy to address invasive thoughts severely impairing her.

Differential Diagnosis:
1.Obsessive-Compulsive Disorder – Recurrent and persistent thoughts, experienced as intrusive and unwanted, cause the patient significant distress and anxiety. These thoughts often lead to compulsive behaviors as attempts to neutralize them. Compulsive behaviors typically revolve around primal fears like contamination or harm. In OCD, these compulsions tend to be ritualistic, performed in a specific manner, and may not directly relate to the feared outcome or are clearly excessive.

2.Generalized Anxiety Disorder – Generalized Anxiety Disorder (GAD) is characterized by excessive and persistent worry that is difficult to control, causing significant distress or impairment, and occurs on more days than not for at least six months. It is associated with somatic symptoms such as muscle tension, irritability, and sleep disturbance, which are not attributed to the effects of substances or another medical condition.

The recurrent thoughts in GAD typically focus on real-life concerns such as work or school, whereas obsessions in OCD often involve content that is odd, irrational, of a magical nature, or unrealistically excessive. While GAD may involve a feared outcome, such as repeatedly checking locks to prevent break-ins, these behaviors are usually not as time-consuming or impairing compared to OCD.

In OCD, compulsions are always present and are directly linked to obsessions. These compulsions are typically ritualistic and may not logically relate to the feared outcome. This is in contrast to GAD, where compulsions are not characteristic and are not directly linked to obsessive thoughts.

3.Specific Phobia – Individuals with specific phobias experience high levels of anxiety and unreasonable fear triggered by exposure, anticipation, or even discussion of a feared stimulus. This fear reaction is typically focused on specific objects or situations, and patients often go to great lengths to avoid encountering the provoking stimulus.

Unlike OCD, where compulsive behaviors are present, specific phobias do not involve compulsions. The fear experienced in specific phobias is more circumscribed and can be categorized into subcategories, such as fear of animals, natural environments, medical procedures, or situational fears.

While both OCD and specific phobias involve anxiety and fear, specific phobias are characterized by a more focused fear reaction without the presence of compulsive behaviors.

4.Obsessive-Compulsive personality disorder- is characterized by excessive perfectionism and rigid control, often leading to substantial disability, particularly in the patient's relationships. While repetitive or inflexible behaviors can occur with OCPD, they are typically performed in relation to the individual's obsessions.

In OCD, patients usually perceive their drive to perform these behaviors as uncomfortable and problematic. However, in individuals with Obsessive-Compulsive Personality Disorder, the behavior is viewed as appropriate, and they may become irritated when others do not share the same perspective.

While both disorders involve repetitive behaviors, the perception and motivation behind these behaviors differ significantly between OCD and OCPD

Plan:
-SSRI is the initial pharmacologic option; starting at the lowest initial dose recommended for individual medication. Start at sertraline 50 mg.
-Admit patient to inpatient psych once medically cleared and stable. Titrate weekly or in twice monthly intervals in 50 mg increments until therapeutic dose range for OCD is reached which is 200 to 300 mg/day.
-Observe for sensitivity to side-effects.
-Cognitive -behavioral therapy using exposure and response prevention (CBT/ERP).