12301 Main Street
Houston, TX 77035
713-275-5000 ■ 800-351-9058
www.MenningerClinic.com

Date: 2/6/15

FINAL RESULTS OF OUTPATIENT ASSESSMENT

EXAMPLE OPA

Name: Jane Doe
DOB: 03/11/1956

Executive Summary of Findings

Dates and Assessments

Ms. Doe's psychiatric assessment was conducted from February 2-6, 2015.

The following assessments and informational sources were referenced in completing this report:

- Psychiatric Evaluation. Dr. Stevens, February 2
- Individual Assessment. Dr. Woodson, February 2, 3, 4, 5
- Neuropsychological Assessment. Dr. Bradshaw, February 4
- Psychosocial Assessment. Chris Grimes, LCSW, February 3
- Psychopharmacology Review. Dr. Powell, February 4
- Nutrition Consult. Kim George, MS, RD, February 2
- Addiction Assessment. Dr. O'Neill, LCSW, February 3
- Diagnostic Conference, Dr. Stevens and Dr. Woodson, February 6
- Lab work and physical exam
- MRI; read by Dr. Rodgers
- Genetic Testing (Genomind)
- Collateral information.

Diagnostic Impressions

F10.20 Alcohol Use Disorder, moderate
F33.00 Major Depressive Disorder, recurrent, currently mild
F17.200 Tobacco Use Disorder, severe
Relationship Distress with Intimate Partner

Summary and Recommendations

Case Overview: Jane is a 59-year-old woman who currently lives with her male partner of 18 years in Savannah, GA. She has worked professionally as an art librarian and currently works in an art gallery which is a primary source of personal satisfaction at this stage in her life. Her relationship with her partner has been strained over the last three years, especially after the death of his brother and his subsequent health problems including extensive substance use. The home in which they live is owned by her partner, though she tries to care for him despite their lack of physical and emotional intimacy. In addition to caring for her partner, she travels to care for both of her parents who have dementia. Worsening depression has been a recurring issue for Jane. She sees her therapist on occasion, but mostly when there is a crisis and not on a routine basis. She does not see a psychiatrist despite her psychiatric concerns and current medication regimen; her primary care physician manages her medications.

Jane presented for this outpatient psychiatric assessment at the urging of her younger brother. She has had two prior psychiatric hospitalizations related to excessive alcohol use, most recently on Labor Day, 2014. The event leading to this evaluation was an argument with her partner related to her drinking (approximately one-half of the fifth of vodka) last Wednesday evening, her sleeping through Thursday, and waking up on Friday. She feared that he would again insist that she receive inpatient alcohol treatment and as a result, left town to stay with her brother in Houston. As noted earlier, her relationship with her partner has deteriorated over the past few years as he struggles with Crohn's disease and a variety of foot ailments. Reportedly, he can be verbally and emotionally abusive. Significantly, she reports how his addiction to prescribed narcotics and other psychoactive substances (e.g., cannabis products) has become unmanageable. She has taken on a care-giving role with him similar to the one she has also assumed for her ageing parents. She appears to be held hostage in this role by both excessive guilt as well as becoming overly dependent on this role in defining herself within the family structure. Over the last several years, Jane has relied on alcohol to deal with these stressors. She says that she is often able to drink one to two glasses of wine every evening in order to fall asleep. She says it is difficult for her to fall asleep without the use of alcohol. However, she says on certain occasions, she is prone to drinking more heavily, particularly when she uses vodka. She blames her excessive use of vodka to her subsequent hospitalizations. For example, on Labor Day 2014, she inadvertently mixed a large amount of vodka with prescription lorazepam obtained from her partner. She says that they began arguing, and ultimately, he called EMS to take her to an inpatient facility where she was hospitalized for the next three days. She had one similar stay related to alcohol detoxification at Jackson Hospital under similar circumstances five to six years ago.

Jane describes longstanding difficulties in relationships with men. She met her first husband when she was 17 and married early. She and her ex-husband have two daughters and had a fairly happy marriage. However, approaching their 25th wedding anniversary, she had an affair with another man who was also in the art field. This came after becoming aware that her husband bought himself a Corvette instead of taking her to France as he had long

promised. At the recommendation of her therapist, she disclosed this affair and her husband eventually filed for divorce. Notably after the divorce, she continued to maintain a close relationship with him, even physically. Approximately two years after her divorce, she met her current partner. Jane stated that the first several years of this relationship were pleasant; however, his progressive health issues have made it difficult, if not impossible, for him to leave the home for any consistent length of time. She, on the other hand, frequently drives into Atlanta to support her ageing parents. During parts of their relationship, Jane has chosen to live away from her partner (which was associated with a decrease in her drinking). She noted that both her therapist and one of her daughters have strongly recommended that she end this relationship with him. Jane is aware of her enmeshment with him and is still ambivalent about leaving him; she expresses guilt associated with abandoning her role as his primarily caregiver. Though the role of care-giver has been critically important to her self-esteem and self-image, she views herself as failing in that role for her partner as well as her parents.

2. Psychiatric and Medical Summary

- **Safety Issues**
  During this evaluation, we performed a suicide risk inventory, which revealed Jane's predisposing factors to suicide, including being Caucasian and a history of prior psychiatric hospitalizations. She describes a history of alcohol use disorder, which is active. She also endorses chronic pain related to a degenerative hip condition. Activating states include depressive symptoms and to a lesser extent, anxiety symptoms. She endorses feelings of burdensomeness to others. However, she denies most activating states (e.g., active suicidal ideation or plan to end her life) for suicide. Protective factors include family support, including the support of her two daughters, as well as her brother (with whom she is currently staying). She is forward-thinking and enjoys spending time with her grandchildren. She is actively engaged in her job and describes a history of good problem-solving skills. One critical safety issue for Jane is the risk of an accidental death due to binge-drinking and/or mixing alcohol with other medications (e.g. lorazepam).

- **Substance Use**
  Jane presents with a clear pattern of binge drinking. Typically, she binges after significant stress—usually when she is tired, frustrated, and depressed. She needs a hip replacement, but is fearful that she will be unable to meet her obligations to care for her family. She has a history of at least three blackouts as well as two hospitalizations. During her last blackout on January 20, 2016, she lost a complete day after drinking an unknown amount of vodka. As noted earlier, she currently consumes wine most evenings, but reported that wine is not her problem as she only binge drinks on vodka. Jane indicated that she did not consume alcohol until 1998, after a divorce. She started using alcohol to assist her with sleep and found that she could numb her feelings. The stress of living with her partner appears to intensify her use of alcohol as well as use of other psychoactive substances prescribed to him. Alcohol has become her major coping strategy at home. As noted by Jane, excessive drinking is a problem area in her family.

Jane exhibits all the symptoms of an alcohol use disorder and tobacco use disorder. Though she denied routine use of other drugs per se, she is at risk for use due to her current living environment. She exhibits symptoms of depression, burnout, and anxiety, all significant risk factors for continued use. Jane is dedicated to helping others, but is often unable to help herself in this regard.

- **Mood and Anxiety**
  As expected, the results of this evaluation confirms a Major Depressive Disorder that is recurrent within the context of severe psychosocial stressors including relationship issues with her partner as well as caring for her parents. Chronic pain is also a concern as related to her hip. Acute and chronic stress can make an individual more susceptible to depressive episodes as well as exacerbating their severity and length. More importantly, how such stressors are recognized and managed internally and externally is a critical concern. Significantly, excessive alcohol use is an important risk factor for developing depression which can become chronic with continued use. In other words, such depressive episodes can be substance induced rendering any form of treatment including medication or therapy as much less effective.

  The development of anxiety with depression is not uncommon, sometimes as a major symptom of depression or as a separate diagnosis. Both sets of disorders share a common neurobiology that is often amenable to similar psychopharmacological and psychotherapeutic treatments. Though Jane has significant anxiety, she did not conclusively meet criteria for a separate diagnosis at this time, though she may have done so in the past. Her personality and relational style tends be more anxious-fearful, so her propensity to develop anxiety-based disorders is increased.

- **Cognitive Functioning**
  On cognitive testing, Jane's performance was generally in the average range or above. Exceptions to this level of performance included impaired performance on a measure of speeded inhibition and low average scores for mental arithmetic, forward and backward digit span, and copying of a complex design. Relative strengths were seen for word knowledge, which was very superior, reading/decoding of single words which was high average, and verbal memory, which was commonly high average to superior. Given her reported concern for development of Alzheimer's disease, the finding of fully intact scores for memory, word finding, and semantic fluency should be reassuring. While including instances of mild difficulty, these findings to not provide any compelling evidence for significant cognitive decline or a prodromal state to dementia. Cortical atrophy is concerning and changeable dementia risk factors including those related to cardiovascular health such as excessive alcohol consumption, smoking, diet and exercise should be addressed.

- **Personality Functioning**
  Everyone has a personality style or characteristic patterns in coping with internal states such as emotions and thoughts as well as the external environment including relationships and the work environment. The areas of functioning that are typically

evaluated include the sense of self (identity and self-direction) and interpersonal relationships (empathy and intimacy).

In terms of personality functioning, Jane exhibits significant dependent and avoidant personality traits. Her profile suggests someone who is concerned about the reliability of her relationships and whether those closest to her will be available when needed. Her stance with others can be characterized as more passive-dependent with a reluctance to assert her own needs in relationships for fear of creating any rupture or distance in those relationships. Physically and emotionally, she may not see herself as desirable or even worthy of support. In terms of relationships, she may become easily dependent on others, in this case only seeing her value in being a care-giver while sacrificing her needs to maintain this stance. Such individuals tend to be conflict-avoidant in many of their relationships in which they fear the loss of support, particularly involving any direct expression of anger or resentment which they mostly direct at themselves when there is a problem exacerbating symptoms of depression. Interpersonally, such individuals may also express their anger passive-aggressively which is common. Some people with this profile can be more socially inhibited with feelings of inadequacy or sensitivity to negative evaluation often leading to avoidance of social interaction. They may consider themselves to be socially or physically less appealing than other people and avoid social interaction for fear of being rejected or disliked. Such individuals tend to primarily rely on family members or maybe a few close friends rather than a wider circle.

- **Other Medical Findings**

  Imaging: a MRI of the brain was performed. The radiologist's impression was consistent with moderate cortical atrophy. There were no mass or lesions seen in the brain and no acute intracranial abnormalities evident. However, there was a possible right temporal bone abnormality. Correlation with bilateral temporal bone CT was recommended. There was no evidence of intracranial demyelinating lesions. There was no evidence of acute ischemia in the brain. Dr. Rodgers, a Menninger neuropsychiatrist, also reviewed this image and concurred with the radiologist's read. We recommend a bi-temporal CT scan of the brain for further diagnostic clarification.

  Laboratory values: Results indicated normal hepatic functioning. Lipid panel revealed elevated cholesterol (= 226) with normal triglyceride and HDL cholesterol (HDL = 80). CBC with differential was unremarkable. Sedimentation rate was normal (= 2). Urinalysis was within normal limits with the exception of trace ketones. Thyroid studies were also within normal limits. A hepatitis panel was nonreactive. RPR was nonreactive. Comprehensive metabolic panel revealed mildly elevated glucose (= 107), but was otherwise within normal limits.

  Genomics: A Genecept assay report was performed. The patient displayed abnormalities, including variant in the serotonin transporter consistent with high risk of nonresponse to SSRIs that act by blocking this transporter to produce a therapeutic response. Her genotype suggested a higher risk of poor response, slow response, or intolerance to SSRIs. In addition, she was C/C at the serotonin receptor

2C, which confers the highest risk of weight gain to atypical antipsychotics that act by blocking this receptor. She had a genotype variant consistent with intermediate risk for poor response at the dopamine-2 receptor. She had intermediate activity at the MTHFR enzyme, an enzyme responsible for the conversion of folic acid to methylfolate (which is a precursor for serotonin, norepinephrine, and dopamine synthesis). She was an ultrarapid metabolizer at the CYP1A2 enzyme, which could lead to increased metabolism of drugs leading to decreased serum levels and poor efficacy in the presence of inducers. She had intermediate activity at CYP2C19 but normal activity at all other CYP enzymes tested (e.g., 2C9, 2D6, 3A4, and 3A5).

3. Treatment Recommendations.

- **Level of Care**
  At this stage, we recommend an intensive outpatient or a day program (i.e., partial hospitalization program) that is focused on addressing Jane's alcohol use disorder along with her mood symptoms. We recommend attendance at a 12-step or other similar support groups (e.g., SMART Recovery) to augment her ongoing recovery. However, as she indicated to most consultants, Jane is ambivalent about abstinence and may not be ready to stop drinking despite the serious consequences of her use to her health and safety. At a minimum, she should intensify her current outpatient level of care by routinely working with a psychiatrist and a therapist on a regular basis. As suggested earlier, continued use of alcohol or any psychoactive, addictive substances would undermine any form of treatment for her ongoing depression.

- **Medication Interventions**
  Optimized treatment for depression would include a significant reduction in or – preferably – abstinence from alcohol. There are currently four FDA-approved agents for relapse prevention and alcohol use disorders: disulfiram, acamprosate, oral naltrexone, or a once monthly injectable, extended-release naltrexone. Disulfiram alters all metabolism ingested alcohol to produce a mildly toxic acetaldehyde, resulting in an adverse reaction characterized by vomiting, flushing, headache, and anxiety. Clinical studies do not clearly support the efficacy of disulfiram for the treatment of problematic alcohol use in comparison to placebo; however, none of the larger studies investigating the use of disulfiram used systemic techniques to enhance adherence. One advantage of disulfiram is that it fosters complete abstinence several studies suggest that it can be effective in some patients of combined with monitored dosing ingestion to ensure adherence.

  One alternative is naltrexone, a mu receptor opiate antagonist that has demonstrated efficacy in decreasing alcohol "craving," drinks consumed per occasion, drinking days, and lower rates of relapse as compared to placebo in alcohol-dependent patients. While 50 mg per day is the most commonly used dose for alcohol relapse prevention, women appear to be more sensitive to naltrexone-induced nausea, and dose reduction may be important to improving adherence. Alternatively, studies have demonstrated that 100 mg per day is well-tolerated by many individuals, so dose escalation should be considered in any individual who is tolerating the medication well but has some optimal outcomes.

The extended-release formulation of naltrexone may be preferable to oral naltrexone for a number of reasons. By maintaining relatively constant plasma levels through slow but regular release of naltrexone, depot naltrexone may be associated with fewer side effects and relatively greater exposure to the therapeutic dose of the drug. In addition, depot naltrexone is useful in addressing problems with medication adherence.

There are several other agents under investigation which have shown considerable promise in the treatment of problematic alcohol use. Topiramate, an anticonvulsant agent that works through the GABA system, has been shown in two large, placebo-controlled studies to reduce heavy drinking and increase abstinence.

In terms of antidepressant therapy, Jane's genomic profile suggests that a switch from sertraline to another agent should be considered. In particular, attractive options include a switch to duloxetine, which is currently FDA-approved not only for depression but for chronic pain (which may decrease pain associated with her degenerative hip condition and, by extension, her use of oral pain reducers or cannabis). Her genomic profile suggests that a trial of bupropion would be well tolerated for treatment of her depression; of note, a combination pill containing bupropion and naltrexone was recently FDA-approved for treatment of obesity. Each medicine is associated with weight loss and the combination may have a synergistic effect. Other alternatives I would consider include a trial of venlafaxine/desvenlafaxine (keeping in mind that these agents could increase blood pressure), vilazodone, or vortioxetine.

For a variety of reasons, I would avoid second-generation antipsychotics (dopamine antagonist) or benzodiazepine medicines. Given the complexity of Jane's issues, her psychotropic regimen should likely be managed by a psychiatrist as opposed to an internist.

There are a number of medications with proven efficacy in smoking cessation. Current public health service clinical practice guidelines for tobacco use disorders have found five nicotine replacement therapies and two nonnicotine replacement medications (e.g., bupropion and varenicline) to increase abstinence rates relative to placebo. Nicotine replacement therapies include nicotine gum, lozenge, nasal spray, and inhaler, as well as a nicotine patch for transdermal administration. As above, bupropion is an antidepressant medicine which also has demonstrated efficacy in smoking cessation. A review of bupropion indicates that it doubles quit rates compared to placebo with overall quit rates similar to nicotine replacement therapy. Varenicline is a partial agonist at the nicotinic receptor with demonstrated efficacy and smoking cessation; it may quadruple the odds of quitting smoking compared to placebo and double the quit rates compared to bupropion. It is necessary to monitor for four unusual psychiatric side effects with varenicline treatment including nightmares, disinhibition, and suicidal ideation.

- **Psychosocial and Psychotherapeutic Interventions**
  Regarding her **alcohol use disorder**, Jane would benefit with interventions that are oriented toward motivational enhancement, skills development and goal setting especially in the areas of distress tolerance and coping with her emotions as alternatives to the use of alcohol or other substances.

  Motivational Enhancement Therapy (MET) is a counseling approach that helps individuals resolves their ambivalence about engaging in treatment and stopping their drug or alcohol use. This approach aims to evoke rapid and internally motivated change, rather than guide the patient stepwise through the recovery process. Research on MET suggests that its effects depend on the type of drug used by participants and on the goal of the intervention. This approach has been used successfully with people addicted to alcohol to both improve their engagement in treatment and reduce their problem drinking. MET has also been used successfully with marijuana-dependent adults when combined with cognitive-behavioral therapy, constituting a more comprehensive treatment approach.

  Cognitive-Behavioral Therapy (CBT) was developed as a method to prevent relapse when treating problem drinking. Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drinking and to address a range of other problems that often co-occur with it. Research indicates that the skills individuals learn through cognitive-behavioral approaches remain after the completion of treatment. Current research focuses on how to produce even more powerful effects by combining CBT with medications for alcohol/drug abuse and with other types of behavioral therapies.

  Regarding her **depressive disorder**, CBT protocols for treating depression are the most recognized evidence-based approach available. However, other approaches might be better suited to addressing Jane's distress particularly in the context of important relationships.

  Interpersonal therapy (IPT) is an evidenced-based approach for depression that focuses on the relationships between a person and significant others. It is based on the idea that individuals often have their personal relationships at the center of psychological problems. Although a person's depression may not be caused by any interpersonal event or relationship, it usually affects relationships and creates problems in interpersonal connections. The goal of IPT is to improve communication skills so that a person with depression is better able to communicate with others. Unlike some other forms of psychotherapy, IPT does not seek to find an unconscious origin in the patient's past as a way to explain current behavior. Instead, it focuses on the present reality of depression and how more immediate difficulties may better explain symptoms. Symptoms of depression may further complicate interpersonal relationships. This often causes the depressed person to seek resolution by turning inward or acting out. Depressive episodes or depression

often follow a major shift in a person's interpersonal environment. These changes usually fall into one of four categories:

- complicated bereavement — the death of a loved one or unresolved grief
- role transition — the beginning or ending of a relationship or marriage or diagnosis of a disease
- role dispute — a struggle in a relationship
- interpersonal deficit — the absence of a major life event

Behavioral Activation Therapy is another evidence-based treatment for depression. Behavioral activation is based on the theory that, as individuals become depressed, they tend to engage in increasing avoidance and isolation, which serves to maintain or worsen their symptoms. The goal of treatment, therefore, is to work with depressed individuals to gradually decrease their avoidance and isolation and increase their engagement in activities that have been shown to improve mood. Many times, this includes activities that they enjoyed before becoming depressed.

Regarding **tobacco use**, there are several behavioral interventions or programs available to assist with smoking cessation, often in combination with medication.
Individual behavioral counseling involves scheduled face-to-face appointments with a trained smoking cessation counselor. In addition to other behavior change techniques, motivational interviewing is generally incorporated into this form of behavioral intervention and is designed to enhance a person's impetus to change their behavior. This patient-centered approach enhances an individual's motivation for change through self-examination and identification of ambivalence to change and the subsequent resolution leading to sustained positive behavior change. Usually sessions are weekly over a period of at least 4 weeks after a quit date, and this is normally combined with prescribed pharmacotherapy. Multiple and longer sessions appear to be more effective. Individual behavioral counseling can also include advice regarding how to cut down to quit (i.e., gradually reducing the number of cigarettes smoked before eventually quitting).

Group behavior therapy for smoking cession is offered to small groups of clients, and information, advice and, in most cases, behavioral intervention is provided. Group support allows individuals to learn behavioral techniques, and group participants provide peer support. Similar to individual counseling, group therapy is normally combined with pharmacotherapy. The chances of quitting are doubled for those who attend group behavioral programs compared with those who receive self-help material but no face-to-face behavioral support. It is currently unclear whether groups are more effective than individual counseling.

Referrals:
Jackson Hospital
Alcohol and Drug Abuse Partial Hospital Program
11 Mill Street
Savannah, GA 31401
912-835-3403

Memorial Hermann Prevention & Recovery Center
3043 Gessner
Houston, TX 77080
713- 939-7272
1-877-464-7272
http://parc.memorialhermann.org/

Center for Recovering Families
303 Jackson Hill Street
Houston, Texas 77007
713-914-0556
http://www.councilonrecovery.org/center-for-recovery-families/

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Jonathan Stevens, MD, MPH
Vice President and Medical Director, Outpatient Services
Date Signed: 5/17/2016 at 13:58

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Harrell Woodson, PhD
Administrative Director and Senior Psychologist, Outpatient Services
Date Signed: 5/17/2016 at 13:58