PERSONAL OUTPATIENT ASSESSMENT REPORT

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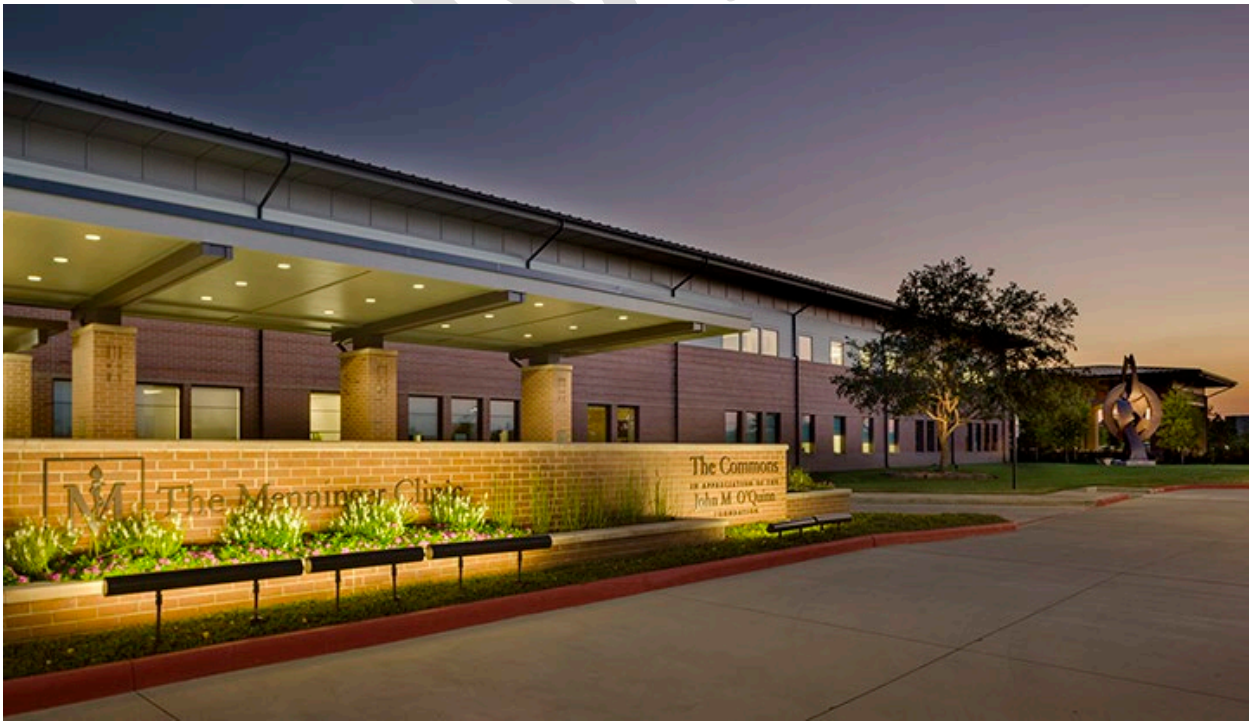
CONTENTS

OUTPATIENT ASSESSMENT CONSULTATION TEAM

Jane Doe (DOB: 1/1/1997) comprehensive psychiatric outpatient assessment took place from October 11, 2021 to October 15, 2021.

Her outpatient assessment included the following:

- Psychiatric Evaluation with David Smith, MD on 10/11/2021
- Team Lead Care Coordination and Psychosocial Assessment with Shawn Hirsch, PhD on 10/11, 10/12, 10/13, 10/14, and 10/15/2021
- Psychological Evaluation with Orion Mosko, PhD on 10/11/2021
- Sleep Consultation with Chester Wu, MD on 10/11/2021
- Trauma Consultation with Keisha Moore, LCSW on 10/12/2021
- History and Physical with Elizabeth Yanoff, MD on 10/13/2021
- Anxiety Consultation with Harrell Woodson, PhD on 10/13/2021
- Multidisciplinary Team Meeting on 10/14/2021
- Diagnostic Feedback and Recommendation review with David Smith, MD and Shawn Hirsch, PhD on 10/15/2021



BACKGROUND INFORMATION

IDENTIFYING INFORMATION

Jane Doe is a 25-year-old Hispanic female who presents for this comprehensive outpatient psychiatric evaluation for diagnostic clarification and treatment recommendations. She denied any pending legal proceedings.

CHIEF COMPLAINT

“I need help.”—the patient.

HISTORY OF PRESENT ILLNESS

Jane reported that she has been struggling with significant symptoms of anxiety since childhood. She reported having the following symptoms of anxiety all the time: constant rumination, worrying, shortness of breath, tightness in her stomach, neck pain, feeling bloated in her stomach, nausea, and chest tightness. Her anxiety appears to be exacerbated when she is in large crowds or when she feels like she has hurt other people’s feelings. Per mom, when Jane gets excessively anxious, she has a hard time regulating herself and relies on everyone else to take care of her. She eventually ends up having an anger outburst which leads to significant conflict in the family.

With regards to anxiety symptoms

Please see the HPI above. In addition to her symptoms of generalized anxiety as mentioned above Jane reported having panic attacks in the past. She described these as periods of sustained anxiety associated with shortness of breath, rapid heart rate, worrying about the future and feelings of impending doom etc. She also reported significant problems falling and staying asleep and sleeps only five to six hours. She denied any recurrent intrusive memory, nightmares, or flashbacks associated with the traumatic incidents in the past. She denied any recurrent intrusive thoughts or behaviors to compensate for those thoughts.

With regards to mood symptoms

Jane reported having some symptoms of depression after her father passed away nine years ago. She said she felt down and depressed for a month but still managed to function. She also reported feeling down for a few days after her mom got married to her stepdad three years ago. She however denied persistent symptoms of depression like persistently depressed mood, lack of energy, poor focus and concentration, lack of interest in activities of pleasure or any active or passive suicidal or homicidal ideations. She died any current active or passive suicidal or homicidal ideation and was able to contract for safety. She denied symptoms suggestive of mania, like persistently elevated mood lasting for more than one week, racing thoughts, grandiosity, excessive talkativeness, or getting easily distracted during these periods.

With regards to psychotic symptoms

Jane denied any extensive auditory or visual hallucinations, receiving messages at present, feeling that there are plots or schemes against her, or a feeling that others are trying to specifically harm her.

With regards to other psychiatric symptoms

Jane denied any symptoms suggestive of an eating disorder, like restricting, binge eating or purging. She reported significant issues with her body image from a very young age. She stated, “I always feel like I'm overweight and fat even though I know I am not.” She also reported a tendency to over exercise and currently exercises five to six times a week for 1- 1.5 hours. About three years ago, she was exercising about 10 kilometers a day six times a week and ended up breaking her ankle.

With regards to her personality

Please see the HPI for details. Jane has an excessively negative view of herself. She notes having the following symptoms: Difficulties with conflict, excessively relying on others to take care of her feelings and her anxiety, excessive perfectionism, hiding her emotions, rigidity with rules, obsessive ruminating thoughts, anger outbursts and internalizing her anger.

PAST PSYCHIATRIC HISTORY

Jane’s mother noted that Jane has always had problems with performance anxiety and being somewhat perfectionistic. When she was 11 years old, she was struggling with a lot of anxiety and migraine headaches due to which she was seen at the Diamond clinic in the US. When she was 13 years old, Jane reported having some symptoms of social anxiety and sought help with a therapist. She saw the same therapist after her Dad passed away but only ended up seeing the therapist for a for a few months as the therapist felt she was doing fine. She said, “I wasn't doing fine but I just ignored my feelings.” She restarted seeing her therapist 5 years ago.

Jane denied any previous suicide attempts, psychological testing, or psychiatric hospitalizations.

Current Psychiatrist

Jane’s current psychiatrist is Dr. Denise Taylor. She has been seeing her for the last year and seen her about 3 times.

Current Therapist

Jane’s current therapist is Danielle Thompson who she has been seeing for the last 5 yrs.

SUBSTANCE USE HISTORY

Jane denied any recreational drug use like cigarettes, cannabis, cocaine, LSD, PCP, pain pills etc. She reported drinking Alcohol occasionally around 2 drinks every weekend.

MEDICATION HISTORY

- Imipramine 25 mg qhs
    - Prescribed by her Gastroenterologist in July. Jane did not find it helpful and stopped taking it 1 month ago.
- Lexapro 5 mg daily
    - This was started in 2019 after her cousin's death. Did not find it helpful so stopped after few months.
- Alprazolam and Sulipride (antipsychotic)
    - Prescribed 2 years ago. Jane did not find it helpful and stopped.
- Luvox 100 mg daily (current)

FAMILY MEDICAL AND PSYCHIATRIC HISTORY

Mother, father, uncle and brother all significant for anxiety. 1st cousin completed suicide in 2019.

PSYCHOSOCIAL HISTORY

DEVELOPMENTAL AND SOCIAL HISTORY

Jane is the first child born to Teresa in 1997. She has two younger brothers, Mark (24) and Brad (20). Pregnancy was significant for mother contracting salmonella. Jane was born 3 weeks early, and both Jane and her mother were in good health at birth. Early childhood development was reportedly unremarkable.

Jane was noted to be a perfectionistic and anxious child. She strived for high achievement, and events like forgetting her homework or not making perfect grades on exams could be very emotionally upsetting. Both Jane and her mother explained that her anxiety became more acute during adolescence. Her father's death in 2012 further exacerbated Jane's emotional distress.

Jane engaged in therapy for approximately 3 months, to address her grief and depression following her father's death. Jane ended therapy at that time, as she convinced herself and the therapist that she had made adequate gains. At that point, her anxiety again resurfaced as the primary concern. However, after 3-4 years, her emotional distress worsened, and she reengaged in therapy.

Jane also displays a significant amount of resilience. Her mother explained that although Jane is very anxious, this anxiety does not prevent her from engaging in social, academic, or vocational activities. However, she has difficulty relaxing and enjoying activities. Her mother described this phenomenon as Jane having "fun, but with limitations." Constructive criticism is also difficult for Jane to receive.

Specific anxiety concerns will be more fully articulated within other sections of this report, but themes of perfectionism, panic symptoms, body image concerns, and excessive exercise were noted. While Jane is able to regulate her behavior and function better outside of the home, the cumulative toll of her anxiety results in irritability and negative interactions with her family, specifically her mother and brothers.

Socially, Jane has historically been well-liked, with multiple sustained friendships from childhood. Her anxiety can cause difficulties in social interactions, as her internal critic can distract her and keep her from remaining present during conversations.

Jane recently (legally) married her long-term boyfriend of 6 years, Gonzalo, in September. They are not yet cohabitating but plan to after their celebratory wedding scheduled for March 2022.

EDUCATIONAL AND VOCATIONAL HISTORY

Jane and her mother reported no significant educational difficulties. She attended private Catholic schools through high school. As stated above, Jane displayed perfectionistic tendencies and was a high achieving student. Jane was involved in many activities, such as student counsel, debate team, and volunteering. She attended college at St. Thomas University from 2015-2019, earning a degree in international commerce. In the fall of 2017, Jane spent a semester abroad in Paris.

After graduation, Jane obtained a job at her step-father's company. She enjoyed this job and performed well at her assigned tasks. Two weeks ago, Jane left the company to focus on this assessment and her wedding plans. The choice to resign was a difficult one and required support from her mother to follow through, as Jane worried that "people are going to think I'm lazy."

FAMILY HISTORY

Jane explained that her father was anxious and perfectionistic, and suffered from frequent migraines. Her mother, uncle, and brothers also display anxious behaviors.

In September of 2012, Jane's father was murdered. Jane's death has greatly impacted the family. As stated above, Jane sought therapy for this tragedy and associated grief. Fortunately, not only were each of the nuclear family members supportive of each other, they had significant support from extended family. In addition to her father's death, Jane's family also suffered another loss when her oldest 1st cousin completed suicide in 2019. These tragedies and their impact on Jane will be more fully examined in subsequent sections of the comprehensive evaluation, particularly within the trauma consultation.

Another significant change to the family system came when Jane's mother established a romantic relationship. Teresa (mother) and Dave began dating in 2016, then married in 2018. Although Jane likes her step-father, it was a difficult adjustment. When her mother informed her of the engagement, Jane experienced anger and sadness. Her grief regarding her father's death also resurfaced more significantly at this time.

Dave moved in to the family home after their marriage. He has three children from a prior marriage, (21, 18, and 15 years of age). The middle child lives with them, while the other two stay with them off and on.

Dave is Catholic but doesn't attend mass on a regular basis.

LEGAL HISTORY

Unremarkable

HISTORY AND PHYSICAL EXAMINATION

MEDICAL HISTORY

Jane has been in generally good physical health throughout her life. Her medical history is notable for a tonsillectomy (childhood) and an episode of pneumonia at age 12 or 13 for which she was hospitalized. Since that time, she feels like she gets a stronger cough when she has an upper respiratory infection. She does not have asthma or any other sequelae of this bout of pneumonia. She does have occasional seasonal allergy symptoms to triggers such as dust mites and takes over the counter medications for this. She does sometimes have episodes of shortness of breath with anxiety, but never with physical exertion.

Jane has a history of headaches for which she was evaluated at the Diamond Clinic in Chicago, IL. She was diagnosed with rebound headaches from use of Excedrin Migraine. Since then, she has not had frequent headaches.

Jane does note urinary frequency which has been present for several years (at least since she was in high school). She urinates approximately every hour during the day and 2-3 times at night. She states she usually has a significant volume of urine. She often feels anxious when in a place with no toilets. She denies symptoms of stress incontinence such as leaking urine with coughing or sneezing. She also denies a sudden urge to urinate. She states she does frequently drink water but notes the frequent urination is present even when not drinking. She denies pain with urination and blood in her urine.

Jane also has episodes of abdominal pain and bloating after meals. She was evaluated by a gastroenterologist who performed food allergy testing that did not reveal any allergies. The gastroenterologist felt her symptoms were more “emotional.” She did try a low FODMAP diet but found this to be restrictive. She has not tried other elimination diets such as dairy or gluten. She denies associated abdominal symptoms such as nausea, vomiting, reflux, constipation, or diarrhea.

Jane also reported heavy cramping associated with her menstrual cycle. She is still able to do her normal activities but does have significant pain with cramping.

Jane has also noticed fatigue which she attributes to poor sleep due to her anxiety. She has been noted to snore but only when congested or having URI symptoms. Sleep issues will be discussed more fully in the sleep consultation section.

Review of Systems

- General: Denies weight change, appetite change, weakness, fever, night sweats. Endorses fatigue.
- Skin: Denies rash, pruritus, wounds, lesions.
- HEENT: Denies nasal drainage, nasal congestion, sinus pain/pressure, sore throat, ear pain.
- Cardiac: Denies chest pain, palpitations, tachycardia, lower extremity edema, dyspnea on exertion.
- Respiratory: Denies dry cough, productive cough, shortness of breath, hemoptysis, snoring, apnea.
- Endocrine: Denies polydipsia, polyphagia, heat/cold intolerance. Endorses polyuria.
- Neurological: Denies dizziness, vertigo, syncope, weakness, tremor, acute visual changes, seizures, frequent headaches.

- GI: Denies reflux, abdominal pain, constipation, diarrhea, vomiting, nausea, melena. Endorses bloating and abdominal discomfort.
- GU (General): Denies dysuria, increased frequency, urgency, hesitancy.
- No history of sexually transmitted infections or stated symptoms of concern.

EXAMINATIONS

Vital Signs

- Blood Pressure: 97/59
- Heart Rate: 79
- Respiratory Rate: 16
- Height: 5’3’’ (160 cm)
- Weight: 123 pounds (55.7 kg)
- BMI: 21.8

Physical Exam

- General Appearance: Normal. Well-developed, well-nourished, appears stated age, in no acute distress.
- Skin/Nails: Warm and dry, no rashes, no lesions, no clubbing, no thick/discolored nails, no splinter hemorrhages.
- Hair/Scalp: Normal texture and distribution, no hair loss.
- Head: Normocephalic, atraumatic.
- Eyes: EOMs intact, pupils are equal, round and reactive to light, sclerae anicteric.
- Ears: Tympanic membranes intact bilaterally.
- Throat: No erythema or exudates. No visible post-nasal drip.
- Dentition: Good dentition with good oral hygiene
- Neck: Supple. No lymphadenopathy, no thyromegaly.
- Heart/Chest: Regular rate and rhythm without murmur, gallop or rub.
- Lungs: Clear to auscultation bilaterally, no wheezing or rhonchi.
- Back: No scoliosis or abnormal kyphosis or lordosis.
- Abdomen: Soft, nondistended, nontender, no hepatosplenomegaly, no guarding or rebound tenderness, normal bowel sounds.
- Extremities: No clubbing, cyanosis, or edema, full range of motion of all joints.

Neurological Exam

- Cranial Nerves: Vision grossly intact, extraocular movements intact. Facial sensation intact to light touch. Eyebrow raise and cheek puff intact. Hearing intact to finger rub. Palate raise symmetric, tongue midline, shoulder shrug intact.
- Motor: Normal. 5/5 bilateral upper and lower extremity strength. Good tone, no atrophy.
- Sensory: Grossly intact.
- Reflexes: Normal. 2+ bilateral biceps/patella.
- Gait/Station: Normal. Grossly intact.

MRI FINDINGS

A 3.0-Tesla MRI of the brain without contrast was done on 10/11/2021. There were no intracranial abnormalities. There were no significant intracranial white matter lesions. There were no acute infarcts, ischemic changes, or hemorrhages. There was no evidence of acute restriction of diffusion sequences. No evidence of any intra-axial or extra-axial masses. There was no hydrocephalus. The brainstem and cerebellum were normal. Bilateral internal auditory canals were normal and symmetric. No air-fluid levels are seen in the sinuses. Mastoid air cells are clear. In summary, this was a normal study as read by Dr. Alicia Scott.

LAB FINDINGS

White blood cell count: 3.l thousand/uL (mildly low – likely no clinical significance).

GENOMICS FINDINGS

Jane underwent pharmacogenetic testing using the Genomind Professional PGx 3.0 on 10/11/202.

With regards to pharmacodynamic gene variations

Jane had a genetic variation L(A)/S of the serotonin transporter (SLC6A4) that is responsible for serotonin reuptake. This variation equates to intermediate activity at the serotonin transporter, increasing the risk of gastrointestinal side effects of these medications. Brain-derived Neurotrophic Factor (BDNF) which is involved in neuronal development and neural plasticity was Val/ Met. Met carriers of Caucasian ancestry may have a poorer response to SSRIS and improved response to SNRIS and TCAs. Met carriers also show a more improvements in cognition and stress after exercise. MTHFR enzyme which is responsible for converting folic acid to methyl folate had low activity which suggests L-Methylfolate supplementation of SSRIs and SNRIS may result in greater symptom reduction. Alpha-2A Adrenergic Receptor (ADRA2A) which is involved in norepinephrine signaling was C/C which equates to DECREASED response to stimulants (mostly methylphenidate) in children and adolescents with ADHD. Dopamine Receptor (DRD2) a receptor activated by dopamine in the brain was C/DEL which is associated with a higher risk of poor/delayed response and weight gain with antipsychotics. Association between DEL allele and Opioid Dependence has been noted in patients of Asian Ancestry however many factors contribute to the risk of opioid dependence. Glutamate receptor kainite 1 (GRIK1) was C/C which suggests improved response to Topiramate for Alcohol use disorder in patients of European Descent.

Normal activity was demonstrated for, Catechol-O-Methyltransferase (COMT) histocompatibility complex class 1A, histocompatibility complex class 1B, Serotonin Receptor 2A (HTR2A), Melanocortin 4 Receptor (MC4R), Serotonin Receptor 2C (5HT2C), Calcium Channel (CACNA1C), Mu-opioid receptor (OPRM1) and Sodium Channel (ANK3).

With regards to pharmacokinetic gene variations

Intermediate activity was found in CYP2B6 meaning medications primarily metabolized by CYP2B6 will be metabolized slower and thus have an increased serum level. This can affect medications such as Sertraline, Bupropion, Esketamine and Selegiline. Intermediate activity was found in CYP2D6 meaning medications primarily metabolized by CYP2D6 will be metabolized slower and thus have an increased serum level. This can affect medications such as Prozac, Fluvoxamine, Paxil, Effexor, Remeron, Vortioxetine, Haloperidol, Chlorpromazine, Abilify, Risperidone. High activity was found in CYP3A4/3A5 meaning medications primarily

metabolized by CYP3A4/3A5 will be metabolized faster and thus have a decreased serum level. This can affect medications such as Venlafaxine, Esketamine, Trazodone, Vilazodone, Vortioxetine, Carbamazepine, Abilify, Quetiapine, Alprazolam, Buspirone.

Normal activity was found in CYP1A2, CYP2C9, CYP2C19, UGT1A4, UGT2B15, ABCB1 (rs2032583) and ABCB1 (rs1045642).

MEDICAL DIAGNOSTIC ASSESSMENT

Jane's history and current labs indicate the following: Polyuria by history and Leukopenia, mild.

MENTAL STATUS EXAMINATION

General Appearance: She appeared well groomed and was casually dressed.
Behavior: Appropriate.
Attitude: Cooperative.
Orientation: Oriented to person, place, and time.
Speech: Regular rate and rhythm.
Mood: "I'm feeling sad."
Affect: Appropriate and congruent. Weepy multiple times throughout the interview.
Thought process: Linear, coherent, and goal-directed.
Thought content: No abnormalities noted.
Risk of self-harm: She denied any active suicidal or homicidal ideation at present and was able to contract for safety.
Risk of violence: She denied any homicidal ideation.
Psychosis: She denied any psychotic symptoms at present during the interview
Memory: Fair.
Attention: Fair for the interview.
Insight: Fair.
Judgment: Fair.
Gait: Stable.

SAFETY ASSESSMENT

A detailed Suicide Behavior Questionnaire-Revised (SBQ-R) was done.

1. When questioned have you ever thought about or attempted to kill yourself? She said, "Never."
2. When questioned how often have you thought about killing yourself in the past year, she said "Never."
3. When questioned have you ever told someone that you are going to commit suicide or that you might do it, she said "No"
4. When questioned how likely is that she will attempt suicide some day, she said "Never."

Based on this, Jane's SBQ-R score was 3/18 which puts her at a low suicide risk. She has numerous protective factors including: intelligence, hope for the future, care for her family and no suicidal ideation.

SLEEP CONSULTATION

HISTORY

Jane reports she has always had trouble sleeping and is used to not having many hours of sleep. However, about 3 years ago, she had more problems with sleep where she could not sleep for 3 nights in the context of significant psychosocial stressors. She says she is very conscientious of what time she has to get up and puts pressure on herself, especially as the night progresses and it get closer to the morning. Currently she says her sleep is not a nightly issue, but there are times where it is every single night that she is having difficulties with her sleep. She notices when her anxiety is very high it is difficult to sleep. Also, when she has to wake up early, she cannot sleep well because she pressures herself to sleep quickly and early.

On a normal day, Jane wakes up at 7am. She used to work from 8am to 6pm but she left her work 2 weeks ago. She would exercise before or after work, then hang out with her boyfriend/friends in the evening. Dinner is usually around 7:30-8pm. After socializing, she is normally back home by 10:30pm and starts her bedtime routine. She states it is harder in the morning when she wants to exercise or has something to do such as catching a flight at 5am.

Her normal bedtime is about 12am, it takes 30 minutes up to an hour to fall asleep due to rumination. She does not have a structured wind down routine but avoids music or TV at bedtime. She has tried to read, use relaxation apps, walk, count sheep, and use a white noise app. She has never tried weighted blankets or aromatherapy.

Jane reports setting approximately 15 alarms but always wakes up with the first one. She recalled a school experience where the power went out and her alarm didn't go off, resulting in her being late for an exam, as the inciting event for this behavior.

Jane wakes up approximately 3 times per night to use the bathroom but returns to sleep quickly. She is usually out of bed by 7am on weekdays when she was working but on weekends likes to sleep in until 9am. She estimates 6 hours of sleep per night that is not very restful. She would ideally like to sleep 8 hours. She usually does not nap. She has 2 cups of coffee per day, one at 8am, another after lunch. She exercises every day. She does not take medications for sleep. She has never done a sleep study.

Jane's sleep is better when she has fewer stressors such as while on vacation or since leaving her work 2 weeks ago. On vacations, she will stay up later to 1am and wake up at 8-9am. At these times she is more consistently able to fall asleep in around 30 minutes.

Jane reported that her brother has a history of sleep talking, sleep walking and sleep punching.

SLEEP REVIEW OF SYMPTOMS

Sleep Disordered Breathing

- Denies witnessed apnea, gasping/choking, daytime sleepiness, mouth breathing/dry mouth/sore throat, morning headaches, and teeth biting/grinding.
- Endorses occasional snoring (possibly because of allergies), nocturia >3x/night, and night sweats.

RLS

- Endorses discomfort in her legs which affects her ability to fall asleep less than once per week.

Narcolepsy

- Denies cataplexy, sleep attacks, disruptive sleep, and sleep paralysis.
- Endorses that she feels like she sees things (e.g. animals) when she wakes mid night sometimes.

Sleep Related Behaviors

- Denies nightmares, night terrors, sleepwalking (past history), sleep violence, sleep eating, sleep groaning, bedwetting, head banging and leg jerking.
- Endorses sleep talking or laughing most nights.

SUMMARY

Jane has a significant history of anxiety and reports some sleep difficulties that seem very much related to her mental state, as exemplified by her increased sleep difficulties when she has to wake up early and the fact that she has so much hypervigilance about not waking.

ANXIETY CONSULTATION

INTERVIEW

Jane described a life-long struggle with anxiety, that intensified after her father's death. Although she stated being very functional academically, career-wise, and socially, she acknowledged being very high-strung and obsessive in her thought process, often worrying about how she performs, her looks, the perceptions of others, and outcomes over which she has little to no control. This sometimes affects her sleep, makes her seek reassurance from others about how she "performs", leaving her feeling exhausted in putting up a front in terms of what she is really feeling and thinking. She commented how people outside of her family don't really see how distressed or anxious she might be because of she works so hard to project a "perfect" image that is culturally reinforced by her family. "Negative" emotions such as anger or sadness are generally discouraged from being expressed which often makes her feel emotionally alienated, isolated and alone even when she is with other people.

From an early age, Jane described herself as very self-demanding in terms of her academic and social performance with several perfectionistic tendencies which have eased somewhat since entering adulthood. She acknowledged that having a "plan" for every situation brings some sense of control and comfort for her. She reports experiencing somatic symptoms associated with anxiety, but she did not appear to meet full criteria for panic attacks based on her interview responses. Although she experiences social anxiety around how she presents or is perceived by others, this does not prevent her from attending social engagements, being with friends or other people, stating that she is more extroverted than introverted. She also noted that her social anxiety tends to correlate with her overall mood or level of distress.

Post-traumatic symptoms are also a consideration, but she did not provide much evidence for significant symptoms at present or in the past. Although she acknowledged some periods of sadness and grief, she was not certain as to the severity of those low moods as compared to her anxiety which is more chronic. The lowest period was right after her father's death where she saw a therapist for a couple of months and terminated treatment after convincing herself and the therapist that she was "fine".

Jane reports a good working alliance with her therapist that she's been seeing for the last few years. She carries a diagnosis of Generalized Anxiety Disorder with her current therapist. She is prescribed psychiatric medication, but she doesn't find her current regimen as beneficial.

Multidimensional Anxiety Questionnaire (MAQ)

Scale	T-Score	T-Score Clinical Cutoff	Percentile
Physiological-Panic	80	66	98
Social Phobia	89	63	99
Worry-Fears	76	65	98
Negative Affectivity	69	64	97
MAQ Total	84	64	99

On the Multidimensional Anxiety Questionnaire, Jane scored well into the clinical range on all subscales including Social Phobia (SP), Physiological-Panic (PP) and Negative Affectivity (NA), the Worry-Fears (WF) scales as well as for the overall (Total MAQ) anxiety score. This measure references anxiety over the last month. Surprisingly, Jane barely missed the clinical cutoff the Overall Anxiety Severity and Impairment Scale (7/20; clinical cutoff, 8) which measures anxiety over the last week. This suggests that her overall anxiety has decreased somewhat over the last month. This could possibly be attributed the recent stressor of work being removed.

On a screener for OCD – related symptoms, she denied having obsessions, but endorsed having "compulsions". However, she denied that they cause her significant distress or consume too much time, but then endorsed that they seem excessive.

SUMMARY

Jane's reported levels of anxiety are globally high which is mostly consistent with her presentation. Although she reports significant social anxiety, she denied a pattern of social avoidance and withdrawal typically seen with individuals suffering from this disorder, noting that she sometimes enjoys social interactions and engagements.

Evidence for panic attacks is a possibility, but it was difficult to obtain enough specifics about the nature of these episodes to be conclusive enough for a diagnosis of Panic Disorder.

There is enough evidence to support a Generalized Anxiety Disorder diagnosis especially given the global endorsement of anxiety which is consistent with her self-report.

Somatic Symptom Disorder is another consideration given the degree that her anxiety is represented somatically.

One confounding issue is her personality functioning which seems to be mostly represented by significant traits in the obsessive-compulsive and histrionic personality spectrums. This may inform the contributing factors to her anxiety as well as the coping strategies she adopts in response to escalating anxiety. These features will be also discussed in subsequent sections.

TRAUMA CONSULTATION

REPORTED TRAUMA HISTORY

Sudden Loss of Father

Jane noted her father, Jane was kidnapped and murdered in 2012, when she was 16 years old. She shared that due to concerns of financial loss that derived from the 2008 financial crises, her father changed his career path and began a political career as a local congressman. He completed a successful three-year term and at the encouragement of his staff and community he considered running for a higher ranked government position. Jane recalled hearing her father express some fear about his position and knew he could be a target, as the system can be corrupt. Prior to moving forward with any decisions, in September 2012, her father was set to travel with her mother but was required to attend a planning meeting. As Jane's mom waited for her father at the airport she received a call from government officials informing her that her husband had been kidnapped. Jane and her brothers were then picked up from school and taken to her grandparents' home.

Jane spoke about seeing her mother being trained by kidnapping specialist in case she received a call about her father. About three days later her family learned that Jane had been murdered the day he was kidnapped. When authorities found his body, it was reportedly decomposed indicating he was killed days prior and the perpetrators wanted to extort money from the family.

Jane spoke about the devastating effects and feelings she experienced when learning that her father would not be returning home. She also spoke about receiving little to no privacy to process her father's death due to the press being involved.

Sudden Loss of Cousin

Jane shared that her younger cousin, Fernando died by suicide in 2019. She spoke about the day her aunt found her cousin's body and how she tried to be a comfort to Fernando's siblings. She noted how shocked her family was and the difficulties they faced when attempted to navigate his death. Jane also recalled being extremely sorrowful when she would spend time with her deceased cousin's twin.

Jane considers her family to be close-knit and supportive and they also reside close to one another. Although Jane described intense feelings during the year her cousin passed away she noted being less affected by his death at present. She also described ways in which her family makes attempts to honor and process the loss of her cousin.

SCREENING MEASURES

PTSD Check List for DSM-V

Jane completed Part 3 of the PTSD Check List for DSM-V (PCL-5 with LEC-5 and Criterion A) which screens for symptoms of posttraumatic stress disorder (PTSD). Jane's report resulted in a score of 20, falling below the clinical cutoff of 33.

Dissociative Experiences Scale – II (DES-II)

Jane also completed the Dissociative Experiences Scale (DES-II), which screens for symptoms of dissociative amnesia, absorption and imaginative involvement, depersonalization, derealization, passive influence/interference experiences, and identity alteration. Jane scored a 5.71 and did not endorse significant experiences of dissociation or depersonalization. High levels of dissociation associated with trauma are indicated by scores of 30 or more.

The Structured Clinical Interview for Complicated Grief (SCI-CG)

The SCI-CG is a 31-item instrument used to further assess the presence of Complicated Grief symptoms.

Jane talked about having intense emotional reactions when she encounters some reminders of her father and reported physical reactions (trouble breathing, lump in her throat and stomach). Although these somatic reactions are present, Jane also experiences these as anxiety responses when feeling stressed and overwhelmed. She also endorsed fluctuating periods when she has trouble accepting her father's death. She often has a desire to be with him and see him again. Presently she may think about the "what ifs" in regard to the day she found out he was kidnapped.

Jane also expressed some regrets in how she would communicate with her father. She noted feeling frustrated as a teenager when her father attempted to address her anxiety and coping.

SUMMARY

Jane noted her worst traumatic experience was her father's kidnapping/murder. She currently denies grief disturbances which cause significant impairment in her current functioning. She also doesn't seem consistently preoccupied with her father's death at this time. While not meeting the criteria of posttraumatic stress disorder (mainly due to the lack of intrusion and reactivity symptoms), a diagnosis of Rule Out Other specified trauma and stressor related disorder (persistent complex bereavement disorder) can be considered.

PSYCHOLOGICAL TESTING

TESTS ADMINISTERED

Millon Clinical Multiaxial Inventory – IV (MCMI-IV)
Minnesota Multiphasic Personality Inventory – 2 (MMPI-2)
Sentence Completion Test

BEHAVIORAL OBSERVATIONS AND APPROACH TO EVALUATION

Jane's approach to the evaluation and interview combined a level of openness and cooperation, with a character-based (and possibly cultural/familial-endorsed) tendency to minimize and distance herself from negative affect. During the interview, she was able to access feelings of true sadness, grief, and regret surrounding the loss of her father; while also needing to move away from these feelings as soon as she could. This was viewed by the examiner as Jane's accessing authentic parts of her experience, feeling the acute pain, then defensively moving away from them to re-establish her affective balance, and preferred level of control.

On self-report instruments, Jane responded with a very unsophisticated response bias attempting to present herself in an overly virtuous manner. This level of conscious or unconscious distortion threatens the validity of some of her results and suggests that she lacks psychological sophistication and may suffer from rigid neurotic adjustment. Further, despite her attempts to present herself in this more favorable light, her psychological dynamics still came through her testing, further validating impressions of her personality style and conflicts during

the interview. Taken together, the results of this evaluation likely represent an accurate picture of her current approach to mental health assessment and treatment, with less acuity concerning her full psychiatric status, personality organization, and central conflicts.

CLINICAL FINDINGS

Jane presented to the evaluation with a core concern over her "social anxiety," concerns about her physical appearance, and conflicted feelings about her household since her mother remarried. She denied struggling with the tragic and abrupt loss of her father, when she was 16-years-old, to kidnapping and murder. Through the course of the evaluation, she appeared to register that although anxiety is her paramount concern, and most interfering set of symptoms, she does have unresolved grief about her father, and may benefit from owning her experience of anger as a means of attenuating her high levels of anxiety.

Although Jane characterized herself having "generalized anxiety that triggers social anxiety," she was able to relay her concerns with appearing perfect, doing everything well, and living up to her own internal standards (as opposed to being preoccupied with other people's impressions of her). Jane expressed being like her deceased father in this regard, "He saw himself in me," being both anxious about people's view of them and highly perfectionistic. While this parallel could represent a similarity in temperament, it could also reflect a powerful identification for Jane with her father. To the extent this may be the case, Jane may be exhibit significant resistance to letting go of this lost object. Having lost her father in real life, Jane may unconsciously wish to keep him alive, and believe she can do that by being like him. Importantly, Jane's high levels of anxiety, somatic complaints, and perfectionistic standards are all causing her significant distress and interference in her life. While she expresses an openness to addressing her surface-level symptoms, she may be more conflicted to lose too much of these characteristics if they bear upon her experience of, identification with, and connection to her father.

These hypotheses receive some support from Jane's psychological testing. Jane's responses indicate that she is struggling with chronic psychological maladjustment, marked by her tendency to overreact to stress by becoming ill, overconcern with physical complaints, and pronounced symptoms of disruptive anxiety. Physical symptoms likely represent a form of symbolic expression of her underlying conflicts. These symptoms may reflect deficits in her learned capacity to self-regulate (anxiety and other affects), and excessive use of denial and repression defenses. She may have a strong need to turn away from overwhelming emotional pain, and to remain positive in the face of pain.

By coping in this way, Jane likely believes she can seek approval from others, which appears to mark a clear and core element of her personality. Despite clear indices of Jane's functionality and capacities (e.g., her success at university and in her career), others may find her somatic preoccupations troublesome, and experience her as immature and self-centered. Jane expressed that her brothers often call her "*dramatic*," and seem to view her in this light more generally. In this regard, Jane may be seeking out or demanding attention, affection, approval and support from others.

While she may be especially emotionally giving herself, Jane appears to have strong needs to be nurtured and supported. These characteristics are likely to impact her marriage and relational functioning. Her responses point to Jane both fearing abandonment and struggling with intimacy – finding it both highly appealing and rather frightening. Given that Jane showed some alienation from herself (limited intimacy with self), it is likely this will impact her other

relationships as well. Given her strong need to be liked, Jane is inclined to struggle with conflict, and is clearly limited in her capacity to recognize and express her own resentments and anger. When she does feel hostility, she most likely expresses her feelings in passive ways, or through somatic channels; however, as she keeps a tight lid on her frustrations, periodically Jane may erupt with intense and antagonistic or accusatory behavior, for which she is likely to take limited responsibility.

DIAGNOSES

1. Generalized Anxiety Disorder
2. Other specified Personality Disorder with prominent obsessive-compulsive and hysterical personality traits
3. Rule Out Other specified trauma and stressor related disorder (persistent complex bereavement disorder)

FORMULATION AND PROVISIONAL TREATMENT PLAN

FORMULATION

Jane a 25-year-old Hispanic female who presents to our clinic in the context of worsening symptoms of anxiety. Based on her history, we would propose diagnoses as mentioned above.

Biologically, she is at high risk for an anxiety disorder considering the history in her family.

Psychologically, she has poor-to-fair insight into her symptoms. Her triangle of conflict could be summarized as follows. She has difficulties tolerating mixed feelings towards people she loves. She deals with these complex mixed emotions with the help of the following defense mechanisms: identification, weepiness, putting other people's feelings above her own, turning on self, self-attack, internalizing her anger, somatic symptoms, discharging her anger, denial, avoidance, and obsessive rumination. These defense mechanisms appeared to have helped deal with difficult feelings in the past but at present cause her tremendous emotional pain.

She reported having the following symptoms of anxiety all the time: constant rumination, worrying, shortness of breath, tightness in her stomach, neck pain, feeling bloated in her stomach, nausea, problems falling and staying asleep and chest tightness. Her anxiety appears to be exacerbated when she is in large crowds or when she feels like she has hurt other people's feelings, but she always has a baseline anxiety. Based on this she meets criteria for Generalized Anxiety Disorder.

She has reported having the following symptoms throughout her life: Difficulties with conflict, excessively relying on others to take care of her feelings and her anxiety, excessive perfectionism, hiding her emotions, rigidity with rules, obsessive ruminating thoughts, anger outbursts and internalizing her anger. Based on this she meets criteria for Other specified Personality Disorder with prominent obsessive-compulsive and hysterical personality traits.

Another diagnostic consideration of the team was persistent complex bereavement disorder (formerly known as complicated grief disorder). At this time, the diagnosis was not given as Jane's response to her father's death can be viewed as a normal response to the loss of a primary attachment figure. However, some of Jane's symptoms related to grief have been triggered or heightened at various points during her development when certain needs arise that

would have been supplied by her father. Jane's personality traits also seem to be exacerbating her current symptom presentation, as she may unconsciously minimize symptoms related to her trauma as a form of protection. It is recommended that future providers rule out this diagnosis, once the more prominent concerns of anxiety are addressed.

LEVEL OF CARE

We recommend Jane continue treatment at an outpatient level of care comprised of psychiatry and psychotherapy. A higher level of care may be considered if her symptoms do not improve with outpatient treatment or they significantly worsen over time.

PSYCHIATRIC INTERVENTION AND MEDICATION RECOMMENDATIONS

Generalized Anxiety Disorder and Personality Disorders are potentially chronic illnesses, fluctuating in symptom severity over time. Currently, there are several U.S. Food and Drug Administration-approved medications for the treatment of Generalized Anxiety Disorder. Our recommended treatment approach to Jane's medicine regimen is to pair pharmacologic interventions with psychotherapy.

For her Generalized Anxiety Disorder (GAD)

Since Jane has been on 2 SSRIs with limited benefit, we would recommend a trial of a SNRI like Venlafaxine or Duloxetine. Her Brain-derived Neurotrophic Factor (BDNF) was Val/ Met which suggests a poorer response to SSRIS and improved response to SNRIS and TCAs.

Buspirone is another agent which may be considered particularly for her GAD. If she does not respond to these medications a trial of a newer medication like Vortioxetine or Vilazodone may also be considered. Her MTHFR enzyme had low activity which suggests L-Methylfolate supplementation of a SNRI may also be considered.

PSYCHOTHERAPY CONSIDERATIONS AND RECOMMENDATIONS

Jane presents as an intelligent, hard-working and dedicated young woman who struggles with chronic generalized anxiety. She has a strong need to be viewed in a positive light and perceived by others favorably. Jane has learned to push through her anxiety states and present a mask to the world, where even though she relates like an extrovert, internally she feels conflicted emotions she believes (rightly or wrongly) cannot safely express to others. Her psychological organization is designed to help her avoid emotional pain, which she tends to experience consciously as anxiety, somatic distress, and self-alienation working so hard to distance herself from her anger and grief.

Considering these factors, we recommend skills-based interventions designed to assist Jane with managing her anxiety and anger. Cognitive Behavioral Therapy (CBT) has been the most intensely studied in anxiety disorders and found to be most effective.

The basic premise underlying the CBT approach is that thoughts, feelings and behaviors are inter-related, so altering one can help to alleviate problems in another (e.g., changing negative thinking will lead to less anxiety). The excessive, uncontrollable worry that is the hallmark of GAD is thought to be maintained through maladaptive thinking about the utility of worrying, a tendency to repeat worries instead of problem-solving, difficulties relaxing, and unhealthy behaviors, including attempted avoidance of negative thoughts and images, as well as

situations that might provoke worry. The cognitive therapy techniques focus on modifying the catastrophic thinking patterns and beliefs that worrying is serving a useful function (termed cognitive restructuring). The behavioral techniques include relaxation training, scheduling specific 'worry time' as well as planning pleasurable activities, and controlled exposure to thoughts and situations that are being avoided. The purpose of these exposures is to help the person learn that their feared outcomes do not come true, and to experience a reduction in anxiety over time. Studies have found that the treatment is more powerful when therapy involves cognitive work, exposures and relaxation. Typically, CBT will be conducted in weekly sessions of 1–2 hours over the course of approximately 4 months, for a total of 16–20 hours of treatment.

An additional psychosocial approach to consider is Acceptance and Commitment Therapy (ACT). This approach may be more effective than traditional talk therapy when addressing Jane's concomitant obsessive-compulsive personality traits, as she has become quite proficient in repressing/denying her inner negative experience. Group therapy should be considered, though availability in Monterrey may be limited. In our experience, group treatment can be useful in providing support and information, as well as reducing isolation and stigma. Group therapy could also be helpful because it permits others to point out bothersome behaviors and call for change.

Although anxiety is the most pressing concern to address in therapy, it will be important for Jane to explore and come to terms with accepting her hostility and angry feelings. As long as she avoids processing verbally her inner conflicts, Jane is very likely to continue to struggle with anxiety and somatic complaints. As she begins to do so in therapy, it is likely that her unresolved grief will surface, including feelings of loss, anger, and possible de-identification with her father. Once anxiety symptoms are better managed, we recommend that she move to more in-depth work to process her grief and achieve greater ownership of her own identity and intrapsychic experience.

As Jane places an immense amount of pressure on herself, it will be important for her to show kindness and compassion to herself as she continues to embark on her healing journey.

MEDICAL INTERVENTION RECOMMENDATIONS

It is recommended that Jane continue to collaborate with a primary care provider regarding preventative health. We recommend that she follow up with her Primary Care Physician (PCP) for health maintenance including a Pap smear, tetanus vaccine booster, and seasonal influenza vaccine.

She should also follow up with PCP for repeat complete blood count (CBC) in 4-6 weeks. The mildly low white blood cell count seen on Menninger labs will likely improve spontaneously, but if not, it should be investigated further.

For Jane's abdominal cramping and bloating, we recommend trying sequential elimination diets. Some foods can be triggers even if there is no actual food allergy. Start by removing dairy (milk, cheese, yogurt, etc) from the diet for two weeks. If there is improvement, she can either refrain from dairy or try to slowly reintroduce it. The next step would be to eliminate gluten for two weeks.

To help with menstrual cramps, we recommend a lower dose oral contraceptive such as norethindrone/ethinyl estradiol 1 mg-20 mcg (some brand names include Aurovela, Gildess,

Larin, and Loestrin). This should minimize potential weight gain with the most improvement in cramps.

If frequent urination begins interfering with daily life, we recommend following up with a nephrologist or endocrinologist. Further testing would include a 24-hour urine collection (to first see if Jane does produce an abnormally high amount of urine) as well as electrolyte testing on this urine to help elucidate a potential cause.

In the meantime, two strategies that that can help with frequent urination is to keep a bladder diary and try "double-voiding."

A bladder diary can help you understand your body better by identifying times of urination as well as variables that make your symptoms worse. For example, are symptoms worse after eating or drinking a certain kind of food? Are they worse when you don't drink enough liquids?

Double voiding is a strategy where you try to urinate again immediately after urinating. To double-void, after completing urination, slowly count to 10 and then try to urinate again. She can try rocking back and forth or rubbing your abdomen over her bladder to help the bladder relax. Wait at least 90 seconds to try to urinate again. It's okay if you don't urinate again. If the cause of frequent urination is incomplete emptying of the bladder, this can help.

Other strategies to discuss with your physician, could include:

- Bladder retraining: This involves increasing the intervals between using the bathroom over the course of about 12 weeks. This helps retrain your bladder to hold urine longer and to urinate less frequently.
- Diet modification: You should avoid any food that appears to irritate your bladder or acts as a diuretic. These may include caffeine, alcohol, carbonated drinks, tomato-based products, chocolate, artificial sweeteners, and spicy foods. It's also important to eat high-fiber foods, because constipation may worsen the symptoms of overactive bladder.
- Monitoring fluid food intake: You should drink enough to prevent constipation and over-concentration of urine. Avoid drinking just before bedtime, which can lead to nighttime urination.
- Kegel exercises: These exercises help strengthen the muscles around the bladder and urethra to improve bladder control and reduce urinary urgency and frequency. Exercising pelvic muscles for five minutes three times a day can make a difference in bladder control.

RESOURCES

Outpatient Clinics (United States)

The Menninger Clinic
Outpatient Services - Bellaire
713-275-5400
https://www.menningerclinic.org/treatment/treatment-for-adults/outpatient-programs/outpatient-therapy

Specific clinicians:
Kaitlyn Coffey, MA, LPC, AAC
https://www.menningerclinic.org/staff/kaitlyn-coffey

Lindsay Walsh, LCSW, LCDC
https://www.menningerclinic.org/staff/lindsay-walsh
Elysée Virginia Miller Caballaro, LPC
https://www.menningerclinic.org/staff/elys-e-caballaro

McLean OCD Institute at Houston
Online Outpatient Clinic
https://houstonocdprogram.org/outpatient-clinic/
713-526-5055

Specific clinicians:
Alejandra Sequeira, PhD
https://houstonocdprogram.org/about-us-staff-alejandra-sequeira/

John Hart, PhD
Behavior Therapy of Houston
3730 Kirby Drive Suite 520
Houston, Texas 77098
832-264-8152
johnhartphd@btofh.org
https://btofh.org/contact-dr-john-hart

The Center for OCD and Anxiety at Sheppard Pratt
6501 North Charles Street
Baltimore, Maryland 21204
410-927-5462
https://iocdf.org/clinics/the-center-for-ocd-and-anxiety-at-sheppard-pratt/

Johns Hopkins Bayview Medical Center
Anxiety Disorders Program
4940 Eastern Ave
Baltimore, MD 21224
410-550-0104
https://www.hopkinsmedicine.org/psychiatry/patient_information/bayview/medical_services/adult/anxiety.html

Rogers Behavioral Health
OCD and Anxiety Outpatient Care
Multiple Clinics in the United States
800-767-4411
https://rogersbh.org/what-we-treat/ocd-anxiety/ocd-anxiety-outpatient-services

Information on CBT and GAD

https://div12.org/treatment/cognitive-and-behavioral-therapies-for-generalized-anxiety-disorder/

https://www.nimh.nih.gov/health/topics/anxiety-disorders

Anxiety and Grief Self-Study

The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free from Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy. Forsyth & Eifert, New Harbinger, 2016.

Complicated Grief: https://complicatedgrief.columbia.edu/for-the-public/complicated-grief-public/overview/

Mindfulness for Prolonged Grief: A Guide to Healing after Loss When Depression, Anxiety, and Anger Won't Go Away. Sameet M. Kumar, New Harbinger, 2013.

Encountering Grief: A 10-Minute Guided Meditation with Joan Halifax [Audio]. Leem, S., 2012. http://www.onbeing.org/blog/encountering-grief-guided-meditation/4983

CONCLUSION

On behalf of the Outpatient Services team at The Menninger Clinic, we wish you well and hope that you and your loved ones have felt supported during this intensive assessment process. We hope that your assessment provides clarity and direction as you move forward toward healing and recovery.

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Assistant Professor of Psychiatry and Behavioral Sciences,
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THANK YOU!

We appreciate having the opportunity to get to know you and your needs.
We are honored that you have trusted us in the assessment process and partnering with you and your family on recommendations that will be important in a healthier life's journey.

Alton Bozeman, PsyD
Director of Outpatient Assessments