

**Human Behavior Course  
2004**

**DIAGNOSIS &  
FORMULATION I  
INTRODUCTION TO PATIENT  
FORMULATION & CLINICAL  
DIAGNOSIS**

**SMALL GROUP DISCUSSION ONE**

*HUMAN BEHAVIOR COURSE 2004*  
**SMALL GROUP 1 - DIAGNOSIS & FORMULATION**

**If you have not read the section from the syllabus on the biopsychosocial formulation, it is important that you do so before this small group.**

**LEARNING OBJECTIVES.**

1. Define the "four P's" of biopsychosocial formulation. Recognize examples of each.
2. List examples of biological, psychological, and social factors that shape risk, onset, and outcomes associated with psychiatric illness.
3. Review the objectives for the classroom lecture on diagnostic assessment and biopsychosocial formulation. Make sure you have accomplished them.
4. Develop rudimentary skills for writing up and orally presenting a biopsychosocial formulation based on written patient vignettes.

*HUMAN BEHAVIOR COURSE 2004*  
**VIGNETTE 1:1 - "MISERY"**

An orthopedic surgeon in Seattle requested a psychiatric consultation on Peggy S., a 28-year-old, single, graduate student who was recovering from a recent spinal fusion, because he thought she was not complying with physical therapy.

The psychiatrist noted that Ms. S. was an attractive young woman with a below-the-knee amputation of her left leg. She was oddly ingratiating and cheerful, and didn't seem to be appropriately troubled by her deteriorating medical condition. She reported that 5 years previously she had been thrown to the ground by a boyfriend, injuring her back. Over the next 2 years she had multiple surgical procedures on her back. Finally, a fusion left her pain free until 6 months ago, when she was diagnosed with spinal degenerative changes and was referred for physical therapy.

Amazed that she didn't volunteer any information about her amputation, the psychiatrist asked how it happened and learned that shortly after the original surgery to her back, she had been in a motorcycle accident, sustaining burns to her left ankle. This became a chronic injury and ultimately led to amputation of her leg, a year and a half ago. She reported this calmly and denied any distress over the disfigurement or disability. She also calmly reported that fluctuating swelling of her stump and recurrent ulcers had interfered with her being successfully fitted with a prosthesis. Thus, she had remained in a wheelchair. She had also been hospitalized several times many years earlier for colitis and kidney stones.

The psychiatrist called the surgeon who had performed her amputation. He reported that the original burn had quickly progressed to a chronic injury, with chronic pain and swelling of the left leg. When the leg proved unresponsive to medical management, the patient received a series of skin grafts, all of which failed because of infection and edema. She was instructed to keep her leg elevated, but did not comply, and her leg continued to deteriorate. She saw many doctors, and was followed in a pain clinic, but continued to experience pain, massive edema, and recurrent infections. Ms. S. repeatedly urged her surgeon to amputate her leg, claiming that it was painful and of no use to her. Ultimately he complied.

The surgeon who performed the amputation also reported that Ms. S. had recently had several admissions for left-sided weakness and numbness. Physical findings were inconsistent, the workup was negative, and she was discharged with a diagnosis of "conversion disorder." It was shortly thereafter that her

back pain recurred. The surgeon also commented that various physicians involved in the management of her leg injury had raised the possibility that her symptoms might be self-induced.

Ms. S. is an only child, born to a middle-class family. By her own account, after graduating from college, she moved from job to job for a number of years, generally leaving because of medical problems and repeated hospitalizations. At the time of admission, she was a part-time graduate student, being supported by social security. No one had accompanied her to the hospital, and she had no visitors during her hospitalization. She asked that her doctors not contact her family.

Ms. S. was transferred to an inpatient rehabilitation unit, where she quickly developed a string of largely unexplained medical problems, including a urinary tract infection, gastroenteritis with diarrhea and fever, painful swelling of the right hand and wrist, a rash on her back and torso, and atypical mental status changes, including difficulty doing rudimentary calculations and inconsistent memory deficits. Meanwhile, she repeatedly refused to comply with safety procedures on the unit, leaving her wheelchair unlocked and her bed rail down, despite constant reminders by the staff. Over time she generated a good deal of anger and frustration among most staff members, although a few found her a particularly sad and pathetic case.

After her previous surgeon had been contacted, the staff became suspicious about the role that she might be playing in the development of her symptoms. Ms. S.'s room was searched and furosemide (a diuretic), cathartics, and an exercise band that could serve as a tourniquet were found. These were believed possibly to explain many of her symptoms as well as the unexplained metabolic abnormalities that had been noted in her chart. Careful review of her chart revealed that her urinary tract infection had been diagnosed on the basis of positive cultures in the absence of cells in the urine, most consistent with a fecal contaminant. It remained unclear if or how she might have factitiously elevated her temperature, even while observed, or how she might have induced the bite like lesions on her back and torso.

A team meeting was convened, and Ms. S. was told that it was suspected that she had factitious symptoms, implying that she was actively involved in inducing at least some of her symptoms. She was informed that this is a serious potentially life-threatening mental illness, and that inpatient psychiatric hospitalization was recommended for further evaluation and management. She did not comment on the diagnosis, appeared unconcerned, and agreed to transfer to a psychiatric ward.

Ms. S. was in an acute psychiatric unit for 4 months. During that time she developed no new medical problems and made no complaints of pain or physical discomfort. Instead, she developed a series of psychiatric symptoms. She initially presented with rapid alternations of mood, appearing first hypomanic, racing around the unit in her wheelchair and claiming to be up all night, then depressed, curling up on her bed with the lights out, refusing to eat or interact with others. Her presentation was thought by some staff members to result from factitious Bipolar Disorder, whereas others attributed her symptoms to genuine affective instability or true dissociative phenomena.

Ms. S.'s behavior on the unit was provocative and impulsive. She was labile and suspicious. She split staff, threw tantrums, said she was suicidal, and barricaded herself in her room. She improved on an anticonvulsive medication and an antipsychotic, but nevertheless spent the second half of her hospitalization refusing to participate in activities and with restricted privileges because of her threats of self-destructive behavior if she was allowed to leave the unit.

In psychotherapy, she gradually revealed a history of daily physical abuse at the hands of her parents throughout childhood and early adolescence. Her therapist believed this history was genuine, but other clinical staff remained unconvinced of the veracity of her story of childhood abuse, but were impressed with the chronic and pervasive nature of her poor coping and history of dysfunctional relationships.

Ms. S. agreed to a voluntary transfer to long-term hospitalization. One day before the planned transfer, she changed her mind, saying she wanted to "get on with my life," and submitted a sign-out letter. She went to court, where she was granted discharge by the judge. She signed out against medical advice, and was lost to follow-up.

*HUMAN BEHAVIOR COURSE 2004*  
**VIGNETTE 1:1 DISCUSSION QUESTIONS**

**Questions for Discussion 1:1**

This small group will tackle two basic elements psychiatrists use to understand patients, predict their prognosis, and develop appropriate treatment strategies. These two elements are the **multiaxial diagnostic assessment** and the **patient formulation**. This clinical vignette will be used to discuss multiaxial diagnostic assessment as it is described in DSM-IV.

First, let's review the diagnostic axes and assess Ms. S. on each axis using the information we've been given.

1. Axis I:

- A. What diagnostic information is generally recorded on Axis I?
  
- B. What diagnosis or diagnoses seem most appropriate for Ms. S. on Axis I?

2. Axis II:

- A. Personality disorders and mental retardation are recorded on Axis II when appropriate.
  - 1) What is a "personality disorder"?
  
  - 2) How is a personality disorder different from the type of diagnoses commonly recorded on axis I?
  
- B. What diagnosis or diagnoses seem most appropriate for Ms. S. on Axis II?

3. Axis III:

- A. What diagnostic information is generally recorded on Axis III?
  
- B. What diagnosis or diagnoses seem appropriate for Ms. S. on Axis III?

4. Axis IV:

- A. What information is generally recorded on Axis IV?
  
- B. What information seems appropriate to record for Ms. S. on Axis IV?

5. Axis V:

- A. What information is generally recorded on Axis V?
  
- B. What information seems appropriate to record for Ms. S. on Axis V?

**VIGNETTE 1:2 - "JUNIOR ENLISTEE WITH UNIT PROBLEMS"**

Chief Complaint. 21 year-old ADAF E-3 single white man referred for command-requested psychiatric evaluation because he "continually questions orders on the flight line."

History of Present Illness. You are the psychiatrist at Barksdale AFB and receive this request for psychiatric evaluation from this loadmaster's commanding officer. In addition to frequently challenging orders and instructions, he has on occasion refused to obey orders related to loading bombs on B-52s. He sometimes says disrespectful things to his supervisors (e.g., "you're not my father"). He is sometimes late for work, and last week a co-worker reported that he smelled alcohol on the young man's breath when he reported for day shift duty at 0710. He denied daily drinking, but admits to drinking on most days, but "never at work." He has one DUI arrest, on base, about six months ago. He was visibly annoyed at your asking about his alcohol use. He denied any current drug use.

The patient admits to problems with supervisors, and says that a significant portion of the blame is his own--"I know I piss people off and want to stop, but just can't help it sometimes." He goes on to say "but I work with such stupid supervisors." There are apparently no delusions, hallucinations, manic behaviors, physical complaints, memory problems, significant anxiety or panic symptoms, and his sleep is "about as good as it can be with all these shift changes. Why can't they just leave us on one shift?"

Past Medical History. No history of hospitalizations; not followed for any current acute or ongoing medical problems.

Review of Systems. No specific physical complaints in any body system, except "I feel like I have a hangover when I have to change shifts."

Past Psychiatric History. Heavy drinking as per HPI, admits to marijuana use during high school; denies any drug use while in the military. No other history of formal psychiatric evaluation or treatment; he refused his mother's request to "get help" on several occasions.

Family Psychiatric History. History of 3-4 inpatient alcohol treatment programs in father, but no contact with him for several years. No formal psychiatric history in his mother or siblings.

Social History. The workplace is the active flight line at a busy Air Combat Command base. He and his co-workers work in shifts, changing shifts every two weeks. He lives in the dormitory, is mostly a loner, but is sexually active with women--admits to a number of "one-night stands." The patient has two younger sisters, who he says he is close to ("I had to help my mother raise them---I was kinda their protector"). He remains close to his mother, and feels "guilty because she is my mom and deserves better." His mother tells you that "I wish he could change; I really hoped the military could help. I guess nothing can be done for him, huh?"

Personal History. The patient was raised in a family where his father was a severe alcoholic, an authoritarian, and physically abusive to the patient, his siblings, and his mother. The patient's mother left his father when the patient was five years old. He joined the military at his mother's insistence because of frequent run-ins with teachers and law enforcement officials. He had ongoing trouble with skipping school and causing problems for his teachers. There were teenage arrests for shoplifting and racing cars in a dangerous manner. He admits to fighting frequently in junior high and high school, and began smoking cigarettes when he was 13 years old. He began drinking to get drunk when he was 15 years old. He first had sexual intercourse at 14 years old. He said he used drugs in experimental ways (marijuana and cocaine) in high school a few times, but has not used any drugs since he came in the military. Despite his school absences and trouble there, he managed to graduate from high school with a 3.5 grade-point average--he explains this by claiming that he was told by a school counselor that his "IQ is more than 125."

Current Medications. None

Physical Examination. Vital signs normal. Has one tattoo and a few old scars. Otherwise, physical examination normal.

Mental Status Examination. Suspicious at first and angry at having to be evaluated, but became less anxious and more open when talking about wanting help and when talking about his family. No delusions, hallucinations, or suicidal/homicidal ideation. Cognitive examination normal.

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**VIGNETTE 1:2 DISCUSSION QUESTIONS**

**Questions for Discussion 1:2**

1. Describe the airman's diagnoses using the DSM-IV multiaxial system:
  - A. Axis I?
  
  - B. Axis II?
  
  - C. Axis III?
  
  - D. Axis IV?
  
  - E. Axis V?
  
2. Place this patient's clinical data into a biopsychosocial formulation.
  - A. Biological Predispositions
  
  - B. Psychological Predispositions
  
  - C. Social Predispositions
  
  - D. Biological Precipitants
  
  - E. Psychological Precipitants
  
  - F. Social Precipitants
  
2. What are the predominant issues from your formulation resulting in the signs and symptoms leading to this psychiatric consultation?
  
3. What strengths (i.e., potential perpetuating factors that are likely to be protective from future problems) does this patient have that might argue against a rapid move to separate him from the military?
  
4. What negative factors (i.e., potential perpetuating factors that are may well sustain difficulties) suggest that he might not be able to overcome his interpersonal problems soon enough or to the degree necessary to save his military career?