

SAMPLE PSYCHIATRIC WRITE-UP WITH OUTLINE FORMULATION AND PLAN—“ANNE MERCER” CASE #1

ID: Patient is a 35-year old married woman who gave birth to her third child 8 weeks ago. She was referred by her obstetrician for increasing feelings of **sadness, decreased energy** and **interest** that has not responded to 5 weeks of low-dose medication treatment with sertraline (Zoloft).

CC: “My obstetrician thinks I need to see a psychiatrist.”

HPI: The patient is a G3P3 female with no previous history of postpartum depression or other psychiatric illness. She was started on a low dose (unknown amount) of Sertraline (Zoloft) about five weeks ago but says that although she has been taking it as directed, she doesn't feel that it is helping her. She was originally told that “the baby blues” were common and would go away. Patient reports that she and her husband had hoped for a girl as they have two sons. She was extremely happy when her daughter was born and can't imagine why she is feeling this way.

She breast fed her two older children but is not breast feeding this infant because she has no **energy** and feels that she ‘can’t’. She has increased **guilt** and feels **worthless** as a mother because she isn't breastfeeding this child. Patient is having trouble **sleeping** not related to awakening of the baby. She falls asleep easily, but awakens frequently during the night and, in the morning, is unable to pull herself out of bed because she ‘dreads’ facing the day. In fact, this **feeling of ‘dread’** overwhelms her most of the time. She has no **appetite** and reports that she has lost more weight than she gained during the pregnancy. She has no desire for sexual relations (**libido**) even though she is able to have intercourse again. Prior to this, she and her husband had an active, satisfying sex life. She is having difficulty performing routine tasks, such as showering and grooming. She describes the house as ‘messy’. Her husband is helping out with the children and is taking care of the baby. She is still able to take care of the baby's needs when her husband is not available. She reports that she ‘enjoys nothing’ (**anhedonia**), and nothing gives her any relief. She feels **hopeless**, and says that she can “imagine why people could want to end their life” when feeling this badly. On direct questioning, she denies wanting to hurt herself or end her life; however, she indicates that the family ‘would be better off without her’ (**passive suicidal thoughts**). She denies wanting to hurt her baby (**homicidal ideation**), denies feeling angry with her baby, and feels very guilty that she can't seem to connect as she did with her other children. She denies wanting to harm her husband or other children. The patient denies any prior history of suicide attempts or self-harming behaviors. The patient also denies hearing voices or having visions previously or at this time (**auditory, visual hallucinations**).

The patient is having trouble **concentrating** on simple tasks at home and doesn't watch the TV anymore because it makes her anxious. She is very **worried** about having to return to work soon. She says that even routine tasks are becoming hard for her. She **denies panic attacks** with physical symptoms, however does **complain of ‘sense of dread’ and ‘inner turmoil’** that is worse in the morning. Even the thought of having to

do such straightforward things as meeting with her son's teachers seems just to be 'too much.'

(Pertinent negatives) She denies having had anxiety problems prior to this pregnancy. Patient denies previous depression, mania or hypomania by review of symptoms. She denies history of sexual, physical and emotional trauma; she denies having specific rituals, checking behaviors, obsessive thoughts or visions. The patient denies alcohol and substance use. She believes that she is in "OK physical health."

Shortly after her daughter was born, her husband was hospitalized for chest pain and diagnosed with hypertension. The patient worries about his health and feels guilty that she is adding to his stress. The house is in disarray as they had started a major renovation before the delivery that had not been completed in time. She admits that she is somewhat of a perfectionist and likes 'everything' in its place but does not believe this has really affected her mood that much.

Past Psychiatric History: None, except as mentioned above.

Past Medical History: Unremarkable except for being 8 weeks postpartum, G3 P3
No known drug allergies

Medications: Zoloft (Sertraline) every day, unknown amount

Family Medical History: Noncontributory

Family Psychiatric History: Patient reports that father attempted suicide when she was age 4 by OD on pills. He had multiple hospitalizations over his life and was treated with 'shock therapy'. He is now treated with Effexor (Venlafaxine) for depression and is doing well. No other known family history of depression, bipolar disorder, alcoholism

HABITS: The patient denies use of illicit drugs, alcohol and tobacco. She drank alcohol rarely prior to being pregnant. Minimal caffeine use-at most 1 cup of coffee or tea/day.

Current Social History:

Work-Pt worked as an insurance agent for State Farm Life Insurance company handling corporate contracts for employee life insurance up until time of delivery.

Education- B.A in Business from the University of Maryland, College Park, Maryland.

Family-She just gave birth to a wanted, planned, third child, Carrie Anne. The patient has two other children-Robert, age 8 and Josh age 5. Her sister-in-law came and helped for the first week with the children, but she is without any close family nearby. The patient's husband is a Colonel in the USA, and he is 15 years older than she. They have been married for ten years and the patient describes the relationship as "good". Shortly after Carrie Anne was born, her husband was hospitalized for chest pain. He was diagnosed with high blood pressure, placed on medication, and started in an exercise program for 'heart patients'. The patient is very concerned about her husband's health.

They have lived in this area for 3 years. She preferred living in Maine because it was colder and she seemed to have more friends.

Developmental Social History:

The patient was raised in Florida by her mother after her parents divorced when she was six years old. She has two younger brothers, Louis and Joseph. She describes her mother, a teacher and clinical social worker, as being 'critical' and having 'intense moods' when she was growing up. Her mother worked long hours and expected the patient to look after her brothers, help them with their homework, and keep things 'under control'. Patient never felt she was as attractive or as socially adept as her mother, although she did exceptionally well at school. The patient feels that her father, a professional scientist who suffers from lifelong depression, favored her brothers. She denied emotional, physical and sexual abuse. She had friends in adolescence and reports nothing 'out of the ordinary'. She wasn't teased or ostracized. She had a few dates in high school but was more focused on schoolwork and getting into college. She met and married her husband when she was in her mid-twenties.

Mental Status Exam: Patient is **alert and oriented** to person, place, time and situation. She has fair **grooming**, poor **eye contact**, appears sad and tired with marked **psychomotor retardation**. She has paucity of **speech**, an increased latency of response, and speaks in a soft, low volume, monotone voice. She is **cooperative** and attempts **rapport**, but her despair is evident in her depressed **affect** and somber **mood**. She describes her mood as 'anxious' and her affect is intense, restricted, non-labile and could be described as depressed or flat. Her **thought process** is linear, logical and goal directed. Her **thought content** is without any **active suicidal ideation**, but she does express an awareness of despair that might lead someone to want to die. She is without any **homicidal ideation** toward anyone, including her children. She denies any **auditory or visual hallucinations**. She has no evidence of delusions. **Insight**-fair, she is aware that she needs help; **Judgment**- good, she is actively seeking help. **Impulsivity**, none evident
Mini-mental status exam: not performed.

IMPRESSION:**AXIS I: Major Depressive Disorder, Single Episode, Post Partum Onset, with Melancholic Features**

Rule Out Depressive disorder Due to a General Medical Condition

Rule Out Bipolar Disorder, Type II, Current Episode Depressed

Rule Out Anxiety Disorder NOS

AXIS II: Deferred but possible obsessive-compulsive traits**AXIS III: 8 weeks post partum G3P3****AXIS IV: Moderate/Severe- Postpartum, spouse's health problems, pending return to work, house remodeling****AXIS V: GAF 55**

DIFFERENTIAL DIAGNOSIS: Discussion—DSM IV-TR (full text) section on Major Depressive Disorder is an excellent resource

BIO-PSYCHO-SOCIAL FORMULATION:

	Biological	Psychological	Social
Predisposing Factors	<p>Family history of depression</p> <p>Postpartum Status</p> <p>Worsening nutritional status</p> <p>Possible endocrinologic disorder (e.g. Sheehan’s syndrome)</p> <p>Inadequately treated depression</p>	<p>Parental loss (father) and reorganization of the family, age 4-6</p> <p>Paternal suicide attempt</p> <p>Loss of protected time as child as patient assumed childcare duties</p> <p>Mother experienced as critical and not available, also as achieving success unattainable to the patient as she was more “attractive and competent”</p>	<p>Single-parent household; patient forced to assume childcare duties</p> <p>Father unavailable and institutionalized for chronic depressive illness</p>
Precipitating Factors	<p>Childbirth</p>	<p>Birth of a daughter (potential recapitulation of childhood issues with respect to her relationship with her own mother)</p> <p>Husband’s illness (potential parallel to loss issues experienced as a child with her own father)</p>	<p>Limited social support outside immediate family (sister-in-law helped briefly, but has left)</p>
Perpetuating Factors	<p>Nutritional status (weight loss)</p> <p>R/O endocrinologic abnormalities</p>	<p>Feelings of inadequacy as a mother (unable to breastfeed her daughter and unable to attend to her older children’s needs)</p>	<p>Limited social support</p> <p>Hesitant to return to work</p>
Preventive Factors	<p>In good health prior to and throughout pregnancy</p> <p>Partially treated depression</p> <p>Known familial response to venlafaxine and ECT</p>	<p>Highly self-motivated</p> <p>High academic and occupational achiever</p>	<p>Supportive husband</p>

ASSESSMENT: The patient is a 35-year old married female, G3P3, with an 8-week history of symptoms consistent with major depressive disorder, post-partum onset.

Biologically, the patient is predisposed to mood disorders by a paternal history of severe recurrent depression, including a suicide attempt, which was refractory to many treatment modalities but responsive to ECT and venlafaxine. While the patient was started on antidepressant therapy (sertraline), her response has been poor. She enjoyed good health prior to and during her pregnancy, but now in a questionable nutritional state, having lost more weight postpartum than she had gained during pregnancy. An endocrinologic abnormality (e.g. hypothyroidism) cannot be ruled out based on available studies. The patient has no substance use history of concern and denies any co-morbid substance use.

Psychologically, the patient reflects a chronic sense of inadequacy and poor self-esteem, despite high personal and occupational achievement, which is likely rooted in her childhood relationship with her own mother, who she experienced as critical and demanding. Her current fears of failing to measure up as a parent (caregiver) are likely recapitulations of her childhood fears of inadequacy. Her historical obsessive-compulsive personality traits also suggest a harsh and critical maternal introject, defended against by rigid control of her surrounding environment. Her early childhood experience of feared paternal loss may also be a recurrent issue, re-experienced in the fear of losing her husband after he experienced chest pain.

Socially, the patient's family of origin and present nuclear family offer only limited support. While the patient was assisted after her daughter's birth by her sister-in-law, she now has only her husband to assist with childcare. The patient has historically been highly self-motivated academically and occupationally, but is currently hesitant about returning to work.

TREATMENT PLAN

Inpatient or outpatient treatment – What is her risk (i.e., for suicide, homicide, further deterioration of her condition) and current severity of symptoms? Is she voluntary for inpatient admission? If you treated her as an outpatient, what would you like to do and when would you like to follow her up?

Medical work-up – What specific labs and/or studies would be appropriate (remember, she is post-partum)?

Biological treatment – What medication regimen is appropriate (i.e., increasing the dosage, changing of medications, sleep aid)? Would it make a difference if she were breastfeeding?

Psychological treatment – Would she be a good candidate for therapy? If so, what kind (i.e., cognitive behavioral, interpersonal, group) would be most appropriate?

Social interventions – How much assistance is required at home? How educated is the husband and her family regarding her illness? What about her job – is she ready to return?