

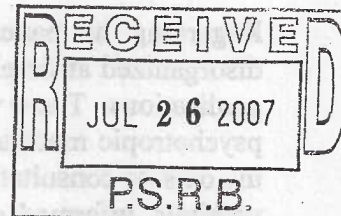
JULY 19, 2007:

**TREATMENT TEAM REVIEW**

On July 19, 2007, the Unit 41A treatment team met with the patient and his grandparents, Gladys and Clyde Giffen.

**TREATMENT TEAM MEMBERS PRESENT**

Steven Fritz, MD, Psychiatrist  
Michelle McGraw-Hunter, PhD, Unit Director  
Donna Bartle, RN, Registered Nurse  
Jamal Al-Awaj, BA, Mental Health Specialist  
John Baker, MHT-2, Mental Health Therapist



**PROBLEM LIST:** The patient's Treatment Care Plan includes:

1A **TODD HAS BEEN DIAGNOSED WITH DEPRESSIVE DISORDER, NOT OTHERWISE SPECIFIED; PSYCHOTIC DISORDER, NOT OTHERWISE SPECIFIED; AND POSTTRAUMATIC STRESS DISORDER:** Todd has recurrent symptoms of depression and delusions. Todd has a history of physical, sexual, and emotional abuse with posttraumatic stress disorder. Todd has had frequent suicidal thoughts and attempts. Todd feels uncomfortable around peers at times. He tends to keep to himself.

3B **MR. GIFFEN RECENTLY EARNED HIS GENERAL EDUCATIONAL DEVELOPMENT CERTIFICATE:** Mr. Giffen has verbalized difficulty attending scheduled classes and following directions and rules in the Academic Services Department of Oregon State Hospital.

**CURRENT MEDICATIONS:** The current medications for this patient include:

Celecoxib 200 mg p.o. b.i.d., to be reduced to 100 mg p.o. b.i.d. today  
Methylphenidate 10 mg p.o. at noon and 5 mg p.o. q.a.m.  
Paroxetine 30 mg p.o. q.a.m.  
Minocycline 100 mg p.o. q.a.m.  
Quetiapine 200 mg p.o. q.h.s., to be decreased to 100 mg p.o. q.h.s. on July 23, 2007, for seven days, then to be discontinued on July 30, 2007  
Diazepam (Valium) 5 mg p.o. q.8h. p.r.n. for agitation or panic attacks  
Benadryl 50 mg p.o. q.6h. as a p.r.n. for extrapyramidal symptoms or allergies

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It is notable that the patient made no use of the p.r.n. Valium (diazepam) in the month of June 2007.

Regarding this patient's medications, the patient has a notable tendency to be vague and disorganized at times. Following his transfer to Unit 41A, he began refusing some of his medications. There was a question about whether he was able to give informed consent for psychotropic medications. An outside consult was obtained and the ultimate decision of the outside consultation process was that the patient does indeed have the ability to give or withhold informed consent for psychotropic medications. The patient has made fairly frequent requests to adjust, discontinue, or be put on different medications in the month that followed. It has been challenging to assess his requests and take action in a reasonable manner. In particular, it is generally important to not change too many medicines at once and the patient has been counseled regarding this. Some of the medication changes which have occurred over the last few months include the discontinuance of lamotrigine. The patient had been put on lamotrigine to treat depressive symptoms which were believed to be a part of bipolar disorder in this patient. The patient has also asked to taper and discontinue quetiapine, an antipsychotic medicine. As noted above, the patient is currently tapering off of this medicine. There has been considerable discussion with the patient that he has indeed reported and experienced psychotic symptoms in the past and discontinuing an antipsychotic medication could result in a reoccurrence of psychotic symptoms. Please keep in mind that the hospital consultation process has indicated that the patient is able to give and withhold informed consent for his medicines. Another medication change which has occurred has been the addition of methylphenidate (Ritalin) for attention deficit hyperactivity disorder. This medication was added after Dr. Fritz conferred with family members regarding a past history of attention deficit hyperactivity disorder and successful treatment with Ritalin (methylphenidate). Of note, following the addition of Ritalin to the patient's medication regimen, the patient appeared to be substantially more organized, less circumstantial, and more direct in his ability to communicate with staff. Finally, the antidepressant medicine, paroxetine, was increased to 30 mg per day on July 10, 2007. In making this medication change, it was discussed with the patient that if a prior diagnosis of bipolar disorder was correct, an increased dose of paroxetine could place the patient at more risk for having a manic episode. However, there is reason to believe that prior diagnoses of bipolar disorder may have not been accurate. Please see the discussion later in this report regarding diagnostic issues.

Psychosocial treatment interventions for this patient include Cultural Diversity Group, Cooking Group, Relapse Prevention Group, Psychiatric Security Review Board

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Orientation Group, Medication Education Group, Men's Group, and Consumer Group. The patient was also attending a Bipolar Group. The patient has been receiving individual psychotherapy, first from Dr. McGraw-Hunter and now Dr. Lundblad, the unit psychologist. He attends school at Oregon State Hospital to improve his English skills. The patient has a problem with temporomandibular joint pain and he was seen in the Oregon State Hospital Dental Clinic today for this issue.

Overall, the patient has adjusted fairly well to Unit 41A. He does tend to be reclusive at times. At other times he may appear to be upset and have an inability to express himself. For example, he may approach staff and then be unable to explain what might be upsetting him, even though he appears to be distressed. In a recent example of this behavior, the patient was later able to explain that he was worried about his peers and their use of notebook computers to access the Internet. Please note that these fears or concerns are reality-based and that patients on Unit 41A have been able to access the Internet using a wireless connection. However, it is notable that the patient had a great deal of difficulty in making his concerns known even though they were reality-based.

Diagnostic issues with this patient have been difficult. This difficulty has not only been experienced at Oregon State Hospital but is also notable in this patient's work with outpatient providers. For example, a Lane County Mental Health Progress Note by Tom Akins, PMHNP, dated March 18, 2004, offers Axis I diagnoses of generalized anxiety disorder, rule out posttraumatic stress disorder, rule out major depressive disorder, rule out dysthymia, rule out delusional disorder, and rule out schizophrenia. Indeed, here at Oregon State Hospital, there have been similar difficulties establishing a firm set of diagnoses for this patient. Part of this difficulty stems from the patient's difficulty in elaborating consistent symptoms in history. Furthermore, attempts to clarify the history with relatives via the telephone have not been particularly useful either.

As such, today's meeting with the grandparents represented a perfect opportunity to take the time with the patient and family members who know him well to help clarify the patient's history and symptomatology over time. Prior to today's meeting, Dr. Fritz spent time with Mr. Giffen reviewing the diagnostic criteria for bipolar disorder. In addition, a mood disorder questionnaire was given to the patient. The patient responded "yes" to three of the questions in the mood disorder questionnaire. A cut-off for bipolar disorder would be a score of 7 or more "yes" questions. As a result, the mood disorder questionnaire suggested that the patient does not meet sufficient criteria for a diagnosis of bipolar

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disorder. Indeed, in talking with the patient's family today, there is a lack of any well-defined manic episode in this patient's history.

In meeting with the patient and his grandparents, we reviewed diagnostic criteria for borderline personality disorder. It appears the patient does meet criteria for borderline personality disorder. In particular, he meets DSM-IV-TR criteria 1, 2, 3, 5, 6, and 9. It is interesting that the patient does meet criteria for borderline personality disorder given that he does not currently appear to have an ongoing difficulty with self-mutilating behavior and his interpersonal relationships are not currently particularly intense, if anything he tends to be somewhat detached. Still, it is our understanding that he does meet enough criteria to be given a diagnosis of borderline personality disorder.

We looked at a diagnosis of posttraumatic stress disorder. We believe the patient meets the A criterion for posttraumatic stress disorder. The patient experienced physical abuse from his father. The father would hit him and the grandparents have seen marks left by the father after the patient was hit. The father's girlfriend's sister made an unwanted sexual contact with the patient. Regarding the B criterion for posttraumatic stress disorder, the patient does report flashback experiences, although he does not report otherwise intrusive thoughts or nightmares. Regarding group C criterion for posttraumatic stress disorder, the patient appears to meet C1, C2, C4, and C5. Regarding the D set of criteria, the patient has had D1, D2, and D4. Reviewing the above, it does appear that the patient has posttraumatic stress disorder.

I reviewed the diagnosis of social phobia with the patient and his grandparents. After reviewing the DSM-IV-TR criteria, it is my opinion that the patient does meet criteria for social phobia. There may be some question about whether this particular diagnosis should be given in that the patient also appears to meet criteria for panic disorder without agoraphobia. For now, both diagnoses will be given in that the panic disorder as reported by the patient occurs just as much, if not more, when the patient is alone and in his room in comparison to social situations.

As discussed above, the diagnosis of panic disorder was reviewed. The patient does experience panic attacks and these panic attacks do not appear to be closely linked to being in the outside world or in social situations. Therefore, they do not appear to be specific to agoraphobia. In looking at the diagnostic criteria for a panic attack, the patient reports physical symptoms, including criteria 1, 3, 4, 6, 8, 12, and 13.

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We reviewed diagnostic criteria for schizotypal personality disorder. The patient appears to meet criteria 2, 4, 5, and 8 under schizotypal personality disorder. However, five or more criteria are required in order to give this diagnosis. The patient falls just short of meeting the criteria for schizotypal personality disorder.

Finally, we discussed the presence or absence of psychotic symptomatology. This was a difficult area for Mr. Giffen. He did share that at times he feels as though there may be cameras placed around the hospital which are watching him. These would be cameras other than those which are obviously present such as in the entryways and sally ports to the hospital. The patient reports that there are times when he believes that other people around him can know what he is thinking without telling them. The grandparents report that the patient would occasionally refuse to eat meals that they prepared. They stated that the patient believed that the meals had something put in them that would be harmful to Mr. Giffen. Initially, it sounded as though these meal refusals were isolated but then the patient and his grandparents shared that the patient would sometimes go for as much as a month without eating food, partly out of a concern that a dangerous substance could be in the food. I shared with the patient and his grandparents that this degree of paranoia or psychosis was beyond what could be considered a part of borderline personality disorder. It is my opinion that the patient has a psychotic disorder which is manifested by delusional ideas on an episodic or intermittent basis. Although the patient has some insight into these being nonreality-based ideas, he is reluctant to accept the idea that they represent a psychotic disorder and that psychotropic medication, specifically antipsychotic medicine, can prevent such symptoms. Again, please keep in mind that the consultation process has confirmed that the patient is able to give or withhold consent for psychotropic medications.

**DIAGNOSES (DSM-IV-TR/ICD-9-CM):** In summary, the following diagnoses are offered for Mr. Giffen.

Axis I      Attention deficit hyperactivity disorder  
              Posttraumatic stress disorder  
              Social phobia  
              Panic disorder, without agoraphobia  
              Psychotic disorder, not otherwise specified

Axis II      Borderline personality disorder

Axis III     Temporomandibular joint disease

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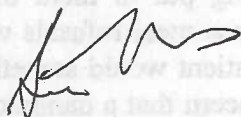
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The patient's county of responsibility is Lane County. Oregon State Hospital social worker, Michael Godfrey, has been in touch with the Psychiatric Security Review Board coordinator from Lane County for a discussion about potential placement opportunities. At this time, as discussed above, we are still elaborating the diagnostic picture for Mr. Giffen, although we made substantial progress today. Furthermore, we are still processing through various treatment options for this patient. In particular, there is a concern that he is being tapered off antipsychotic medications despite having a history of psychotic symptoms. It will take some time to see if we can have the patient remain on a stable medication regimen with or without antipsychotic medications. The patient seems to understand the need for a stable set of diagnoses and treatment approaches before a referral for community placement.



Steven E. Fritz, MD /rp

D. 07/19/07

R. 07/19/07

T. 07/20/07

cc: PSRB

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