EDICAL CENTER HOSPITAL OF VERMON

CASE NO. 000-027-242-7

Burlington, Vermont

HOSPITAL DISCHARGE SUMMARY

PATIENT & AGE Clark, William 30 ADDRESS Whiting, Vermont

ADMITTED TO Psychiatry DATE 07/01/87 ATTENDING DOCTOR John O. Ives, M.D.

TRANSFERRED TO _____ DATE _____ PRIVATE _____ WARD _____

DISCHARGED 07/31/87

PROBLEM #1: Schizophrenia, Undifferentiated

PATIENT PROFILE: Mr. William Clark is a 30-year-old white male who lives and works with a friend/employer on a dairy farm in Whiting, Vermont. He was born and raised in Texas and came up to Vermont in approximately April of 1987 from Austin, Texas, with arrangements made by a friend to work on this dairy farm on a trial basis. He is single and never previously married. His mother still continues to live in Austin, Texas, as do most of his siblings. His father died in 1979.

HISTORY OF THE PRESENT ILLNESS: As noted previously, the patient came to Vermont in April of 1987 from Austin, Texas, with arrangements made by his friend to live and work on a dairy farm in Whiting, Vermont. The patient had graduated from college in Texas with a degree in engineering. He worked just briefly after graduation with the Exxon Corporation. After approximately one year of employment with that company, he attempted to establish a business of his own with a friend. The business went bankrupt and he joined the Army. During this tour with the Army, he reported some fellow soldiers for drug abuse and after this incident became concerned that the fellow soldiers that he had turned in were out to get him. Additionally, on one occasion he reported that he heard an "almost demonic" scream out of a dead tree which he thought had a human dimension. From January through June of 1984, the patient was in outpatient treatment with a psychiatric social worker while he was still in the Army. He was then hospitalized at a medical center from July to December of 1984 with a diagnosis of paranoid schizophrenia. He was discharged from the Army with a 10% disability. After the time of his discharge, the patient then returned to college to do some graduate work. During this period of time, the patient reported some suicidal ideation and although he felt that it was not necessary that he be hospitalized he was involuntarily committed by the courts becaue of the belief that he was a danger to himself. He states that during this time he was given a diagnosis of dysthymic disorder with depression. Also during this time, he was not treated with any antidepressant medication or any electroconvulsive therapy. Records of this period are still not available.

In the Spring of 1987, the patient claims to have heard voices. However, he noted that these were heard when he was falling off to sleep or awakening in the morning. He believes this has happened on only two occasions. He denied any other episodes of auditory hallucinations during this period of time. He also denies having been delusional at any time. Since his discharge from his court-ordered admission to the hospital in Texas, the patient has been working with a church group in Austin, Texas, where he met the brother of the farmer with whom he is currently living. He thereafter came to Vermont with the intention of starting over by working as a farmhand.

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During this period of time, the patient was seen by the Addision County Crisis Service, social worker, and Dr. Covey. The patient reported increasing and excessive worries about how things were run on the farm. He described himself as a conscientious and hard worker, but he had a significant amount of trouble concentrating. He was getting bogged down in details. His mind was noted to be wandering and he almost wished that he was back in the hospital again. He was treated with low doses of Trilafon, up to four milligrams a day, but the patient was resistant to any larger amounts of medication and concerned about the possibility of side effects. As noted previously, suicidal ideation was recurrent shortly after his move to Vermont. Immediately prior to the present hospitalization, the patient became increasingly concerned about suicide. He claimed that on more than one occasion he flushed his medications down the drain because of his concern that he would overdose on them.

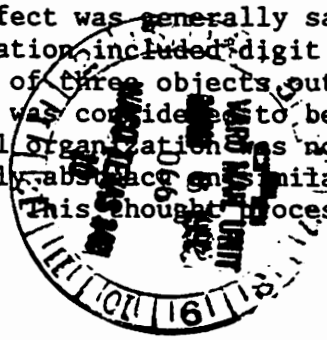
Neurovegetative signs at the time of admission included decreased concentration and he denied problems with memory, appetite, weight changes, or changes in his sleep pattern. He denied change in his libido or energy level.

Precipitants to this admission were felt to include conflicts with his employer and a feeling of helplessness and anxiety about his mental illness.

Past psychiatric history was as noted above. This included treatment at the Addison County Crisis Service from April to July of 1987. He was admitted to the hospital in Austin, Texas, in 1986, where he was diagnosed as having dysthymia and depression. He was given no medications during that hospitalization. He was also admitted to an Army hospital in 1984 with a diagnosis made of paranoid schizophrenia. The patient denied any previous significant medical history or any previous surgical history. His medications at the time of this admission included Trilafon 4 milligrams p.o. QHS. The patient denied any true medical allergies. The patient denied the use of tobacco or drugs or alcohol.

FAMILY HISTORY: The patient is the fourth of five children, the oldest son, with all of the children living. His mother is alive and well. His father died of a myocardial infarction in 1979. The family is described as a good and hard-working, intelligent bunch of people with significant successful achievements. His developmental history is fairly difficult to obtain at this time secondary to the patient's feelings of unreality. The patient is claiming that he felt as though he did not belong to the family. He did report finishing college with his degree in engineering. He has never married.

OBJECTIVE: On admission mental status examination, in appearance the patient was casually dressed. He was neat and clean. He appeared as a 30-year-old white male. He was very cooperative and friendly. His attitude was hopeless and his speech was slow and thoughtful. His sensorium was judged to be alert and he was oriented times three. He was focused and he had limited insight. His affect was generally sad and blunted. His mood was sad. His cognitive examination included digit span of five forward and four backward. The recent recall of three objects out of three in five minutes was noted. His remote memory was considered to be intact. He did serial sevens without errors. His spatial organization was not examined at this time, however. The patient was properly abstracting similarities. The proverbs were somewhat concrete, however. His thought processes were without loose associations, tangentiality,



circumstantiality, blocking, flight of ideas. His thought content was noted to be significant for reported feelings of unreality. He denied any auditory or visual hallucinations. He denied current paranoia, phobias, or obsessions at this time. His self-concept was very low. Suicidal ideation revealed that the patient denied this at present. This was positive, however, by the recent history from his therapist. Homicidal ideation was denied.

Physical examination at the time of admission revealed that the patient had a blood pressure of 118/70 with a pulse of 68 and respirations 18. He was afebrile. The patient's physical examination was otherwise unremarkable in its entirety. He appeared to be within normal limits for a 30-year-old man.

LABORATORY EXAMINATION: On admission, his serum electrolytes including the sodium, potassium, bicarbonate and chloride were within normal limits. His calcium and magnesium were normal. The glucose was normal. The liver function tests including SGOT and SGPT, alkaline phosphatase and bilirubin were within normal limits. The patient's thyroid function tests by T-3 resin uptake, T-4 and T-7, and the thyroid stimulating hormone were also within normal limits. His renal functions as measured by blood urea nitrogen and creatinine were additionally within normal limits at this time. His complete blood cell count revealed a white blood cell count of 4,200 and hematocrit of 44.9%. The MCV was 97. The red blood cell width was 12.2. The granulocytes were 65% and lymphocytes 31%, with mononuclears 3%, all considered to be within the normal limits. Additionally, a routine admission urinalysis was normal.

The routine admission electrocardiogram was done on July 9, 1987, and this revealed a normal sinus rhythm with a rate of 72, PR interval .14, and a QRS interval of .06. The QT interval was .36. The axis was 30 degrees and was considered normal. There was an electroencephalogram performed on the date of July 6, 1987, and this revealed no evidence of disturbances in the cerebral function. There were no other abnormalities noted.

HOSPITAL COURSE: When the patient was admitted to the hospital it was felt that his presentation was consistent with paranoid schizophrenia, with also plus/minus dysthymic disorder. It was felt that he also had an element of depression. His suicide risk at the time of admission was considered to be relatively high and elopement risk was felt to be low. The patient, at that time, was felt to be committable. His depression did seem to be largely situational at this time with the absence of significant neurovegetative signs and he was not begun on any antidepressant medications. The patient was begun on Haldol 5 milligrams p.o. QHS instead of the previous dose of Trilafon. He was placed on prn Ativan for sedation therapy.

Medical psychological testing was performed by July 9, 1987. On the Wechsler Adult Intelligence Scale, Revised, the patient obtained a verbal IQ of 125. His verbal abilities were consistently above average and showed significant strengths in general fund of knowledge and mathematical reasoning. He also obtained a performance IQ of 113. His full-scale IQ was 124, placing him in the 95th percentile, considered to be superior. The Wechsler Memory Scale showed a memory quotient of 108, which fell within the average range. It did show some impairment of the immediate recall for verbal material. He had Halstead Impairment Index of .1 and this was within normal limits. He showed

mild sensory and perceptual abnormalities with minimal right-sided finger agnosia and mild, predominantly right-sided dysgraphesthesia. Examination with the MMPI revealed findings consistent with individual experiencing notable psychic distress with difficulties in concentrating and anxiety. It was noted that in these people, suicide attempts are not uncommon. It should be noted that on further testing his stories were characterized by fairy tale-type endings and on the Rorschach testing, his responses indicated constricted thought and affect at this time. There was conflict pertaining to aggressive competition over the necessities of life.

In summary, it was felt that the patient's evaluation was consistent with either a schizoid personality disorder or diagnosis of schizophrenia. No acute psychotic evidence was obtained. It was also felt that the patient did not have a primary depression at this time.

The patient spoke repeatedly of anxiety and difficulties dealing with people. He noted the stress of working on the dairy farm. His anxiety was noted to be present at all times, from the moment of awakening. This was such that he often found it difficult to come out of his room. It was additionally felt that the history of chronic and gradual decompensation from a college-educated engineer to an individual working on a dairy farm was consistent with his diagnosis of schizophrenia. Regarding the issue of depression, and until the results of the medical psychology testing were available, it was felt that there may be an element of situational depression and imipramine was begun, initially at 75 milligrams p.o. QHS. This was later increased to 100 milligrams p.o. QHS. It was felt that even if the patient was not depressed that this might help with some of anxiety problems.

The patient continued to ruminate about his prognosis with schizophrenia and was concerned about the effects of this hospitalization on his ability to return to his farm. On July 5, 1987, the patient was complaining of feeling dizzy and weak. On July 7, 1987, the patient noted that his previous suicide attempts were a device on his part to reunite himself with his father. He was requesting a family meeting with his farm family and was not any longer considered committable at that point in time.

The patient continued to deny auditory or visual hallucinations. His affect on July 8, 1987, was noted to be somewhat fuller than it had been in the past, although it was still somewhat blunted. He was felt to be pleasant and appropriate but somewhat restrained. On July 9, 1987, the patient also complained of a "blackout" in the morning. During this time, he was walking in the hallway and had to hang onto the wall for support. He said that he felt as though he were going to faint. He claimed that he had several of these episodes prior to this, although these were not reported. Possibilities included hypoglycemia, vasovagal response, panic disorder, hyperventilation, and orthostasis and these were considered. The patient was noted to be quite orthostatic with vital signs of blood pressure 110/70, pulse 60 while the patient was lying down. He had a blood pressure of 68/50 with a pulse of over 110 when the patient was standing. He was afebrile and his respiratory rate was 12. His eyes revealed pupils that were three millimeters and reactive. The heart examination and lung examination were both normal. An electroencephalogram revealed a normal sinus rhythm at a rate of 72 with normal intervals and axis of 45 degrees. On closer questioning, the patient admitted

to having taken 10 to 12 Trilafon tablets, four milligrams each, on the previous evening during a suicide attempt after the housecleaning personnel found an empty medication vial in his trash can. The patient was placed on frequent checks with one-hour neurological checks. His vital signs and temperature were checked every two hours for 12 hours, and then every four hours for the next 24 hours. Later, the patient also admitted to feeling somewhat discouraged about his future. He was feeling that the people who owned the farm hinted indirectly that he could not return there. He had feelings that his disease is chronic and downhill in nature.

The patient subsequently recovered from his overdose and, as noted previously, on neuropsychological testing there was no evidence of depression. For this reason, on July 10, 1987, his nortriptyline therapy was stopped. He was then restarted on Haldol which had been held for a day after his overdose. The patient continued to be orthostatic for some time and on July 13, 1987, his vital signs showed blood pressure of 138/90 with pulse of 64 while sitting. This dropped to 70/50 with pulse of 104 while standing. However, he did become less and less subjectively aware of the orthostasis. Additionally, the patient was given Cogentin 1 milligram p.o. BID as needed for agitation, which he was beginning to complain of. On July 14, 1987, the patient met with his social worker and with his employer. The employer noted many, many complaints including forgetfulness, taking on independent projects without permission, and not completing projects at work. It was also noted by the employer that the patient needed continual supervision. The employer did agree to continue Mr. Clark's employment through to at least the end of August and to work on concrete ways of making this situation more satisfactory including explicit directions. The patient at this time also began ruminating about the possibility of staying in the hospital for the rest of his life, and if not here then at the Vermont State Hospital or the hospital in Texas. He was assured that he would be able to return to life and employment outside of the hospital and that the hospital was not an appropriate place for him at this time. Regarding the issues of employment and living, the patient and the employer began to look for rooms or apartments in the Whiting/Middlebury area which would be appropriate for the patient.

As the hospitalization continued, it then became apparent that the employer was significantly disenchanted with Mr. Clark and was feeling that he was impaired enough that he became too much of a burden for the employer to handle. For that reason, the patient was approached repeatedly about what his options for employment and living would be outside the hospital after his discharge. Suggestions were made that he consider options such as Spring Lake Ranch or another program and this was additionally discussed with his counselor at the Addison County Crisis Service. By July 15, 1987, the patient was feeling quite a bit better. He had fuller range of affect at this time and he denied any suicidal ideation. He had no loose associations and no delusions. At this time, he was complaining of less difficulty with his concentration. It appeared that he continued to be appropriate and without bizarre character, although he did continue to need reiteration and repetition of concrete arrangements. He was, at this time, begun on two-hour passes after agreeing to his no-suicide contract. On Monday, July 20, 1987, the patient was given a full-day pass in order to return to the Middlebury area and see a therapist at the Addison County Crisis Service, and additionally to work on issues in

regard to his housing. He was also to spend some time with his employer in Whiting. The patient did meet with his counselor at the appropriate time and apparently spent the bulk of the rest of the time working on his current employer's farm. He complained of feeling tired after this work and had little insight at that time regarding the need to work on these other issues. During this period of time in the hospital, the patient was noted to be participating in all group activities appropriately. During these, he was occasionally noted to be tense and inappropriate, but otherwise his attitude was considered to be quite positive.

The patient reported that his pass went fairly well, but asked for further overnight passes and it became apparent that the patient continued to have difficulties following plans. This was even when the plans were clearly outlined for him. However, these ruminations and difficulties did appear to be improving. After several weeks, the increased levels of the neuroleptics, further testing was completed on July 22, 1987, and this was negative for any abnormal movements. The patient was then allowed further overnight pass. On this second pass, the patient was told by his employer that he had made a number of mistakes which made the patient both angry and also somewhat depressed. He had the feeling that he was not wanted at the farm. Then, the patient had an additional weekend pass over the last weekend in July. At this point, it was noted that the patient and his employer had still not worked on schedule. The employer seemed to feel that this was not necessary as the patient not only knew his major daily tasks but the employer was more open regarding his intention to not continue the patient's employment past the end of August. Therefore, the patient saw his therapist and she then began to help him find other employment. However, the patient continued to hold out hopes that he could work things out with his employer and maintain employment there through the winter months. Over his last pass, on July 29, 1987, he was told by his employer that his employment was now going to be terminated. The patient was very angry about this and depressed and confused about this. However, he denied any suicidal ideation and his discharge was arranged as previously scheduled on July 31, 1987.

ASSESSMENT:

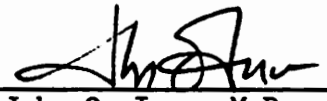
Axis 1: Schizophrenia. This is consistent with long-term deterioration in function of this individual who had previously been high functioning and well educated.
Axis 2: No diagnosis at this time
Axis 3: No diagnosis at this time

PLANS: The patient was discharged on July 31, 1987. He was to have a follow-up appointment at the Addison County Mental Health Service at 2:00 PM on Tuesday, August 4, 1987. He had no medical follow-up planned at this time, secondary to no known medical problems at this time.

The patient's medications at the time of his discharge included Haldol at 5 milligrams p.o. QHS (he was dispensed 30 pills, without a refill); and Cogentin .5 milligrams p.o. BID (He was dispensed 60 pills, without a refill).

The patient was to return to the farm in Whiting where he had previously been employed. He was to continue to look for housing outside of the farm. At the time of the patient's discharge, an opportunity seemed to be to move to a boarding house in Middlebury at the end of July or beginning of August. Additionally, the patient was looking for farmhouse rooms in the Whiting area. He was to go to the Evergreen Program one day per week and if needed he may go there five days per week following potential termination of his employment. Additionally, Addison County Mental Health was to investigate the possibility of his going to Spring Lake Ranch, where it was thought he would be a positive attribute to that program there.

DICTATED 08/16/87 BY: Robert W. Duncan, M.D., Resident in Psychiatry

APPROVED BY: 

John O. Ives, M.D., Attending Physician

CC: John O. Ives, M.D.
Addison County Mental Health
Robert W. Duncan, M.D.

TRANSCRIBED 09/04/87
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