

## Comprehensive Focused SOAP Psychiatric Evaluation Presentation

The following are learning objectives related to this case study presentation. After this presentation, the audience should be able to:

1. Describe the difference between intermittent explosive disorder (IED), disruptive mood dysregulation disorder (DMDD), and conduct disorder.
2. Recognize the DSM-5-TR criteria for IED and similar disorders as they relate to this case.
3. Identify pharmacological and non-pharmacological treatments for IED.

### Subjective:

**CC:** "I need help with controlling my mood and my emotions."

**HPI:** AK is a 13 yo year old white female who presents for initial psych evaluation/intake interview for the Community Action Treatment (CAT) program. She is accompanied by her adoptive mom. She is having problems with anger outbursts that have progressed to aggressive and destructive behavior. She was told she has a mood disorder and is currently prescribed Abilify.

AK lives with her adoptive parents for the past 6 years. (They will be referenced as mom and dad). Her mom reports that since March, AK started having "tantrums" and "anger outbursts" where she would scream and yell, throw things, and sometimes hit others. She put a hole in the wall, has broken small objects, and hit herself in the head. The outbursts will last for several minutes, but sometimes last as long as 3-4 hours. If mom or dad tries to disengage, she will follow them and bang on their bedroom door to the point that it has cracks in it. Her mom stated AK is unable to calm down on her own. Mom would have to call the rapid response team (RRT) for help. AK would calm down with RRT presence but resume her tantrum when they left. Her dad, who was working from home, had to start going into the office to work because he was in danger of losing his job due the client's disruptive tantrums. He has had to leave the office a couple of times to go home and assist his wife with AK's outbursts. This, too, is putting him in jeopardy of losing his job. AK says that she does not like to be alone and will follow her mom around and become angry if she feels her mom is not paying enough attention to her. She was Baker Acted two times for her behaviors and threats to harm herself. The first time was in March, 2022, and the last time was in early August, 2022. Prior to her first Baker Act, she was mostly having only screaming episodes, without the aggression. She has been on citalopram and methylphenidate in the past and is currently only taking Abilify. Mom reported the other meds were not helping and seemed to make the outbursts worse. She reports the episodes are happening at least twice weekly on average. AK also lies sometimes about having done things like chores or homework.

AK's mom reports that she is defiant towards her and her husband and often loses her temper. Her behaviors occur only at home. She is well-behaved in school and makes good grades, but has only one good friend. She has changed groups of friends a couple

of times and they are not a good influence on AK. Her mom reports that sometimes AK does not brush her teeth or must be reminded a lot, and that she is in and out of the shower too quickly to have washed properly. She sometimes refuses to shower for 2-3 days. When mom tries to address AK's hygiene, she usually has an outburst of screaming/yelling and slams her bedroom door. When mom asks her to do chores at home, she sometimes says no. If asked again, she may have an outburst, go her room, slam the door, and go to bed instead. AK reports that after her tantrums she often feels tired. She does not know how she feels in between episodes. Her mom reports she seems mostly happy between episodes, is social, and typically pleasant. AK reports feeling sad at times that lasts about a day or two. This happens once or twice a month. She reports feeling worthless or guilty during her outbursts. She reports feeling like nobody loves her at times when she is upset. She also reported thoughts of self-harm sometimes when she is really upset, but denies self-harm behaviors. Denies a plan to self-harm. She reports frequent headaches, especially after an outburst. She sometimes has difficulty falling asleep but no problem staying asleep. Client denies AH/VH. She also denies current SI or self-harm behaviors. She said she would like help with her uncontrollable tantrums.

AK denies symptoms of mania but mom reports mood swings that might last a couple of days or change more rapidly. She also says that AK sometimes likes to stay busy doing things. AK said she worries excessively about a variety of things She feels it has been a problem for "a while now". Sometimes can control the worries, sometimes not. She sometimes has a hard time falling asleep due to racing thoughts but after falling asleep, she usually stays asleep. She denies panic attacks. She denies social anxiety, but doesn't like to be the center of attention and can still perform well. She is afraid of spiders and stinging insects, and she does not like being alone.

**Substance Current Use:** Denies substance use, no alcohol or tobacco use

**Medical History:** AK was born at 37 weeks gestation. Her bio mom used opiates while pregnant and AK suffered from opiate withdrawal and seizures at birth. She spent 30 days in the hospital. No other hospitalizations. No surgeries.

1. Amblyopia
2. Dermatographia
3. Seasonal asthma

- **Current Medications:**

1. Abilify 10 mg QHS for mood
2. Melatonin 5 mg QHS prn for insomnia

- **Medication Trials:** citalopram (ineffective) and Ritalin (possible appetite suppression and ineffective)
- **Allergies:** NKDA, has seasonal allergies

- **Reproductive Hx:** Not sexually active

**Family History:** Bio parents both abused drugs and bio father passed away two years ago of drug overdose. He was hospitalized for “mental issues,” possibly bipolar disorder. Bio mom reportedly has Hep C, bipolar disorder, and abuses substances. Her bio brother has developmental delays and possibly autism.

**Social History:** AK and her biological brother have lived with her currently family since 2016 and was adopted in 2018. Her 18 yo adoptive sister recently moved out. AK was neglected and suffered some physical abuse by her biological parents and previous foster parents. She was removed from bio parent’s custody two times, at age 3-4 and again at age 6-7. Their custody was terminated in 2015. She is in 7<sup>th</sup> grade and does not have an IEP plan. She is usually an A/B student but currently has a few Cs due to missing school after contracting COVID. AK is a Christian and is involved church activities twice a week. She is currently wanting to start playing volleyball. She likes art and likes to make bracelets. She has one long-term friend and other groups of friends that have changed a few times. Child protective services has been called to the home three different times due to an older adopted child making false accusations towards the parents. There are no open cases. Client has no legal issues. There are guns in the home that are locked in a safe. She has psychological trauma related to the abuse and neglect. She has received outpatient therapy.

**ROS:**

- **GENERAL:** No reported fever, chills, weakness, or fatigue. No weight changes
- **HEENT:** Reports history of frequent headaches
- **RESPIRATORY:** Recently COVID positive and no breathing difficulties

**Objective:**

**Diagnostic results:** No diagnostics available.

**Assessment:**

**Mental Status Examination:** This is a 13 yo female who appears her stated age. She appears neat and clean and is appropriately dressed in jeans and a t-shirt. She is A&O x4. She was hesitant in answering questions at first, but did cooperate with throughout the interview. Her mood was neutral to euthymic and her affect was congruent. No abnormal motor activity noted. Speech was clear and coherent with normal rate and tone, volume was quiet. Her answers were short. Eye contact was fair. Denies AH/VH and no evidence of responding to internal stimuli. Her thought process was goal directed. Thought content was appropriate without ideas of reference. Her recent and remote memory are intact. Her judgement and insight are fair based on her actions and her awareness of her problematic behavior and her need for treatment. She denies current SI/HI and is future oriented.

**Diagnostic Impression:**

**Intermittent Explosive Disorder (IED):** IED is the primary diagnosis for AK. She meets the DSM-5-TR required criteria based on her symptoms and length of time she has experienced the symptoms. Since March, she has experienced recurrent behavioral outbursts where she throws things, hits others, breaks small things, and puts holes in walls. She has displayed behavior that matches both one and two of criteria A. Her aggression is occurring at least twice a week on average (1), and she has had at least three behavioral outbursts in the past 12 months where the physical aggression has caused damage to things in the home (holes in walls and breaking things) (2). Her outbursts are grossly out of proportion to the precipitating stressor (criteria B), and they are impulsive and anger-based (criteria C). The outbursts are distressing to the client (she wants help in controlling her temper) and cause impairment to her ability to have healthy relationships within her family (criteria D). Her age of 13 meets criteria E, and the outbursts are not due to another mental health condition, is not attributable to a known medical condition, and is not related to known drug use (criteria F). Also, as a part of criteria F, her aggressive behavior is not part of an adjustment disorder.

**Disruptive mood dysregulation disorder (DMDD):** The criteria for this diagnosis does not apply to AK. For DMDD to be applicable, the person's mood must be angry and irritable for most of the day, nearly every day. The recurrent aggressive behavior must have started before age 10. AK's mom reported her mood is generally happy, social, and pleasant between episodes. According to the information provided, her aggressive symptoms started at age 11 or 12.

**Conduct disorder:** The DSM-5-TR describes behaviors associated with conduct disorder as violating the basic rights of others, societal norms, or rules. Behaviors are typically present in a variety of settings, not just at home. And the behaviors are intentional and cruel or vindictive. The DSM-5-TR's description of conduct disorder does not align with the reported symptoms/behaviors displayed by AK.

### **Case Formulation and Treatment Plan:**

Cognitive behavioral therapy (CBT), specifically cognitive restructuring, relaxation, and coping skills training (CRCST) is my plan for treatment. This type of therapy produces positive results in treating symptoms of IED. CBT helps reduce the expression of anger, as well as aggressive behavior and assault against others. AK could learn to recognize her triggers and regulate and control her emotional responses. Also, the use of CBT shows a decrease in existing depressive symptoms and anxiety levels over the progression of therapy, both of which are comorbidities of IED (McCloskey et al., 2022).

Adolescence is a crucial time for the occurrence of IED, with the conventional age of onset for people with IED between ages 12 and 21 (McCloskey & Drabick, 2018). Improvement of the quality of relationships is central to decreasing episodes of IED, especially in family relationships. Structural Family Therapy (SFT) declares that symptoms of IED are created due to a malfunctioning family configuration which could include blurred boundaries and an unhealthy chain of command (Fisher, 2017). The focus of treatment is for the patient to develop an understanding of rules and patterns acquired

within the family, and to comprehend the role of boundaries in family relationships. This approach can help decrease the client's hostility and improve her functioning and overall well-being.

Teaching the patient to use an anger meter, is one way that unproductive thoughts can be minimized. The patient assigns a stress weight to actions made by her family. In doing so, the patient can see that minor arguments may have been given the same weight as major arguments. In seeing this, the patient can better control how she reacts to stressful situations brought about by interactions with her family (Fisher, 2017)

One of the most notable and successful pharmacological treatment to reduce impulsive and aggressive behaviors in the treatment of IED is with selective serotonin reuptake inhibitors (SSRIs), particularly Prozac. Decreased serotonin levels are associated with an increase in aggression and anger (Coccaro & Grant, 2019). And Prozac has been shown to increase functional presynaptic serotonin transporters, increasing available serotonin in the blood and brain. Mood stabilizers and antipsychotics are used as adjunct treatment when needed. When AK came for treatment, she was told she had a mood disorder and was already taking Abilify. Although there was some reported improvement, the benefits were minimal. Guanfacine 1 mg QHS was added to AK's medication regimen. In a review of clinical effectiveness, guanfacine was found to reduce anger, impulsivity, and aggressive behaviors (Harricharan & Adcock, 2018). Her next med review is in 3 weeks. If little to no improvement is reported, will discuss changing meds to something different, like Prozac and possibly a mood stabilizer.

One social determinate for AK is her social environment. In a study by Puhalla et al. (2020), the authors showed that people with a history of childhood abuse have a greater risk of IED and overall aggression. AK was doubly neglected and physically abused, first, by her biological parents and second, by foster parents. Both biological parents abused substances and both seem to have suffered from mental illness. AK was born addicted to opiates and suffered withdrawals and seizures. She has a hard time trusting her adoptive parents. Her past experiences are huge factors in her ability to regulate her emotions. The CAT program, as mentioned earlier, is a community-based program that consists of a team of professionals, including medication management, therapy services, including in-home therapy, mentoring services, parental support and family resources, and case management.

AK likes art and likes making bracelets. Rastogi and Kempf (2022) show that art therapy helps many psychiatric conditions, including IED. Hands-on activities requiring physical movement increases a positive emotional state. In making art, the client tries something new and increases self-efficiency, a belief in her capacity to act in the ways necessary to reach specific goals. Art therapy also affords a benign way to discover emotions she might be evading, and can help her see herself as greater than her diagnosis. It can be a great way to open avenues to socialize with others, thus enriching her individuality and lessening feelings of isolation.

**Reflections:** In reflecting on this case, my preceptor and I discussed other possible diagnoses and other possible medications. The interview with the client and her mother lasted longer than the time allotted. Therefore, additional questions pertaining to potential symptoms and the etiology of her symptoms will be explored at her next visit to ensure she receives an accurate diagnoses and proper treatment.

Consider the following questions when providing your responses to the case study presentation:

1. Based on this client's reported symptoms and her background history, what other diagnoses could be given, and why?
2. What other pharmacological and/or nonpharmacological treatments might this client benefit from? Provide an explanation.
3. What types of community resources are available in your area that would meet this client's emotional and/or social needs?

### References

- Coccaro, E. F., & Grant, J. E. (2019). Pharmacological treatment of impulse control disorders. In *APA handbook of psychopharmacology*. (pp. 267–280). American Psychological Association. <https://doi.org/10.1037/0000133-012>Links to an external site.
- Fisher, U. (2017). Use of structural family therapy with an individual client diagnosed with intermittent explosive disorder: A case study. *Journal of Family Psychotherapy*, 28(2), 150–169. <https://doi.org/10.1080/08975353.2017.1288989>Links to an external site.
- Harricharan, S. & Adcock, L. (2018). Guanfacine Hydrochloride Extended-Release for Attention Deficit Hyperactivity Disorder: A Review of Clinical Effectiveness, Cost-Effectiveness, and Guidelines. *Canadian Agency for Drugs and Technologies in Health*. <https://www.ncbi.nlm.nih.gov/books/NBK532204/#!po=1.04167>Links to an external site.
- McCloskey, M. S., Chen, E. Y., Olino, T. M., & Coccaro, E. F. (2022). Cognitive-behavioral versus supportive psychotherapy for intermittent explosive disorder: A randomized controlled trial. *Behavior Therapy*, 53(6), 1133–1146. <https://doi.org/10.1016/j.beth.2022.05.001>Links to an external site.
- McCloskey, M. S., & Drabick, D. A. G. (2018). Understanding the development and management of antisocial disorders in adolescents. In *APA Handbook of Psychopathology: Child and Adolescent Psychopathology*, 2. American Psychological Association. <https://doi.org/10.1037/0000065-018>Links to an external site.
- Puhalla, A. A., Berman, M. E., Coccaro, E. F., Fahlgren, M. K., & McCloskey, M. S. (2020). History of childhood abuse and alcohol use disorder: Relationship with intermittent

explosive disorder and intoxicated aggression frequency. *Journal of Psychiatric Research*, 125. <https://doi.org/10.1016/j.jpsychires.2020.02.025>[Links to an external site.](#)  
Rastogi, M. & Kempf, J.K. (2022). Chapter 11 - Art therapy for psychological disorders and mental health. *Foundations of Art Therapy*. Academic Press. <https://doi.org/10.1016/B978-0-12-824308-4.00008-9>[Links to an external site.](#)  
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