The Case of J

PATIENT SUMMARY—J

DEMOGRAPHIC DATA: J is a 39-year-old white Jewish male on his first admission to a psychiatric hospital. The client's wife is age 40. They have three children: a son (15), a daughter (12), and a second son (9). J is currently employed as a certified public accountant in northern New Jersey. J has been married for 19 years.

CHIEF COMPLAINT: Anxiety and depression.

HISTORY OF PRESENT ILLNESS: J stated that this year has been very trying for him. His mother-in-law-died suddenly, and the three children were sick with chickenpox and the flu.

J has been moody and depressed since late fall and reported that in January he had the flu. He was recently treated with Erythromycin for chronic colitis. His age 40 physical was coming up, and he was very worried about it. In February he was also treated with Lontronex.

In the fall, J claimed he was getting more "rough" with the kids and being "grouchy." J was also worried because his father had a history of mood swings and depression and was treated with electroconvulsive therapy (ECT). J was hospitalized at a general hospital's psychiatric unit, but according to J he was released prematurely. He wasn't ready to go home, and once home, he gradually "again got rough with the kids." He was taken by ambulance back to the general hospital's emergency room, where he was, according to his wife, "paranoid." His wife also said that J was "psychotic" in the ambulance, thinking there was a plot against him and claiming that he was poisoned.

J said he "couldn't cope" after discharge from the general hospital and that he was still "depressed." He said his concentration was off, he lost 24 lbs. quickly, and he was always anxious and suspicious of people. He equated this to job stress, being that he was a managerial accountant at a large food processing corporation. He blamed the start of the whole episode of "depression" on the flu and aggravation of his inflammatory bowel disease. He said this also caused marital difficulties. Another problem was that he always worried about his job and possibly being fired.

J also described being plagued with bad habits. He said that his habits included: having to bang up against the refrigerator door 4 times each time he closed it; having to look under all the living room furniture each evening for dust, and if he found any dust having to vacuum the whole living room; and having to count the cans of food in his kitchen cabinets, making sure there were always an even number of cans in the cabinets. He said he would think about these things until he did his "bad habit," and then he would feel better.

J described his childhood as pleasant, growing up in Brooklyn and commuting to Manhattan to a private school. He described his adulthood as constantly worrying about losing his job. He said he also constantly worries about his large mortgage payment and the fact that his wife doesn't work. He said that they have a new luxury car and that he

has to work very hard to keep this lifestyle. He commutes 1 1/4 hours to work in northern New Jersey every day. He worried that his job will be in jeopardy, and this is a possibility.

J was able to discuss many of his childhood traumas. His mother died just before his 11th birthday, and this made him very sad. His father remarried for a third time, and J did not like his stepmother. She was apparently very compulsive and always “on him” to clean his room, etc. J claims he was always shy, even as a teenager. He blamed this on his stepmother. He was interested in stamp collecting.

J claimed that the reason he was hospitalized was that he was “out of hand,” yelling at his kids and “pushing them.” He also said he was depressed and suspicious. He said he would watch TV, never get much exercise, and do very little when not working, which is a change from his previously active life before last fall. He was, however, very proud of his education, obtaining a bachelor’s degree, following immediately with a master’s degree.

PAST PSYCHIATRIC HISTORY: J was treated at a general hospital’s psychiatric unit for 3 weeks. However, J was no better when he left than when he arrived. He was treated with Lontronex and Desyrel, which did not seem to help him too much. He was also given Xanax.

MEDICAL HISTORY: J has had all the childhood diseases including chickenpox. He denied high fevers, seizures, or head injuries. He denied medical or surgical hospitalizations. His only significant medical problem was chronic colitis. J denied use of illicit drugs and reported drinking rarely.

MENTAL STATUS EXAMINATION: J was oriented to time, place, and person and had an excellent fund of knowledge. He could do serial 7’s and all memory tests. Since J is a college graduate, fund of knowledge would be that high. Short- and long-term memory seemed adequate, but concentration was impaired. Patient denied homicidality but was ambivalent about suicidality. His affect was flat, and his mood was dysphoric. He had not made a suicide attempt since his hospitalization at the general hospital, but while at the general hospital he banged his head and tried to choke himself, allegedly with a toothbrush. He indicated that prior to and after his suicide attempt, he was only sleeping 2–3 hours per night, waking up and worrying. Proverb interpretation was correct, and if he had three wishes, they would be “to leave here, go home, and go back to my job.” When asked how he sees himself in 5 years, he said, “In a good career position, only healthier.” When asked what he would change about himself, he said, “My personality.”

While on the evaluation unit, J appeared to be very suspicious and was at times afraid something bad was going to happen to him. He also was markedly anxious about losing his job or his wife and family because he thought the newspapers were preparing a story about him and how sick he was. J thought the mental health aides were FBI agents observing him for the newspapers.