**CASE PRESENTATION – F**

**INTAKE DATE: May 2014**

**IDENTIFYING/DEMOGRAPHIC DATA:**

     This is a voluntary admission for this 32 year old Black male. This is F’s first psychiatric hospitalization. F has been married for 13 years and has been separated from his wife for the past three months. He has currently been with his sister. His family residence is in Miami, Fl., where his wife, two daughters and son reside. F has had a 12th grade education plus education to complete an LPN program. In the past, F worked for seven years as an LPN. For the past three years F has been employed at a local print shop. Religious affiliation is agnostic.

**CHIEF COMPLAINT/PRESENTING PROBLEM:**

     "I need to learn to deal with losing my wife and children."

**HISTORY OF PRESENT ILLNESS:**

     This admission was precipitated by F’s increased depression with passive suicidal ideation in the past three months prior to admission. He identifies a major stressor of his wife and three children leaving him three months prior to admission. F has had a past history of alcohol binges and these binges are intensified when there is a need for coping mechanisms in times of stress. F was starting vacation from work just prior to admission and recognized that if he did not come to the hospital for treatment of depression and alcoholism, he would expect to have a serious alcohol binge. F reports that in the past three months since separating from his wife, he has experienced sad mood, fearfulness, and passive suicidal ideation. He denies specific suicidal plan. Wife reports that during these past three months prior to admission, F made a verbal suicidal threat.

     F reports he has been increasingly withdrawn/non-communicative. His motivation has decreased and he finds himself "sitting around and not interested in doing chores at home". He reports decreased concentration at work and increased distractibility. F has experienced increased irritability, decreased self esteem, and feelings of guilt/self blame. There is no change in appetite, but F reports an intentional weight loss of 20 pounds since 5 months ago with dieting. F states for many years he doesn’t sleep, having a past history of working double shifts when requested. F reports his normal sleep pattern for many years has been generally three hours of unbroken sleep. F reports past history of euphoria, although wife reports to intake worker observing periods when F’s mood is elevated, and then in the next few hours, F appears out of control with poor impulse control, increased arguing, temper tantrums and alleged shoving and pushing her and the children. He then feels tired and ends up sleeping more than his average pattern.  Wife reports he has not been violent with her since they have been separated.

     F denies suicidal ideation at the present time while on the evaluation unit.

**PAST PSYCHIATRIC HISTORY:**

     F was seen on an outpatient basis by Dr. S, for a period of two months prior to admission. He was being seen for individual counseling because of the marital problems and depression. Dr. S recently referred F for inpatient rehabilitation.

**SUBSTANCE USE HISTORY:**

 F reports a history of some alcohol binges in the past. He began drinking beer in 1999.  When he turned 21 years old, F reports that until two years prior to admission, his pattern of drinking was to get drunk with his social group approximately twice per month. He denies a history of blackouts. He admits to the alcohol binges and heavy use of cocaine (snorting and freebasing on weekends) for a period of three months in 2010. F has received a charge of driving while intoxicated in 3/02 and had lost his driver’s license for six months. Since his marital breakup, F reports using alcohol as a coping mechanism for stress (reporting that he will only drink on weekends now).

**PAST MEDICAL HISTORY:**

     F reports having been involved in a motor vehicle accident with loss of consciousness in 1991. He states he has no memory of the accident. In 1993, F sustained a head injury when he hit his head on a coffee table. F had a past history of fractured toes with pins being inserted in the third and fourth digits in his right foot after an accident in which he crushed his foot at work. F denies a past history of seizures.

     F has had a weight loss of approximately 20 pounds secondary to dieting since 1/99. F smokes approximately two packs of cigarettes per day. F is allergic to Codeine.

**FAMILY MEDICAL AND PSYCHIATRIC HISTORY:**

     Father and grandfather have a history of cardiovascular disease.

    F reports that while growing up his parents maintained a satisfactory relationship. Father reportedly worked nights and slept during the day. F did not have much contact with his father but now enjoys a close relationship with his father. He states he has always had his parents support.

     During F’s school years, he reports he was an underachiever in elementary school. He denies having had a history of discipline problems or hyperactivity. He states he did well in high school and earned grades of A’s and B’s. F played football in HS. In his senior year of high school, F began using marijuana and alcohol during the spring term. After completing high school, F earned his license as a practical nurse. He states he graduated at the top of his class from nursing school.

    F worked as and LPN for approximately seven years. For the past three years he has been employed as a machine operator for a local printer.

     F was married for 13 years and has recently been separated for the past three months. F and his wife have three children including a daughter, age 12, a daughter, age 8, and a son age 7. F states he feels very invested as a parent and feels close to his children.

     Leisure time activities F has enjoyed in the past include playing softball, skiing, reading, playing poker, and watching football.  His wife has complained that he is doing less of that now since he is drinking more.  F states he has several close friends.

**CURRENT FAMILY ISSUES AND DYNAMICS (OPTIONAL):**

 Wife reports that F’s difficulties began to get worse a few months ago when she decided to move out of the house due to F’s increasing erratic behavior. She moved into her parents’ house and F is living with his sister. Wife states that F has been suffering from mood swings where he is "very up" and feeling great, firm in his direction and then within the next few hours, he is often out of control, arguing, throwing temper tantrums, pushing and shoving, and becoming verbally abusive.

    Wife states that F has been drinking for several years in the amount of a 12 pack of beer per day plus shots of hard liquor. Although F reported he has been using cocaine on and off for about two years, wife states she does not think that F is presently using cocaine. At one point, after threats from his wife, F told her that he had gone to a clinic for outpatient rehabilitation, but she did not believe him.

     Wife describes F as "extremely depressed" now and says F states, "life is over…I wish I was dead…don’t send the kids over to visit because I don’t want them to find my dead body…everything I tough turns to garbage. Wife adds that F suffers from poor self esteem, lack of sleep and an extremely boastful attitude. On the positive side he is a good father, compassionate, creative, and could be an outstanding person.

     Wife reports F always had a bad relationship with his mother. F is close to his father who is reported to have an alcohol problem and was allegedly loud and intimidating.

     F is currently employed by his wife’s father. F states he has financial problems now due to paying for counseling and child support.

**MENTAL STATUS EXAM:**

(Include the nine areas to the best of your ability)

 F presents as a casually dressed male who appears his stated age of 32. Posture is relaxed. Facial expressions are appropriate to thought content. Motor activity is appropriate. Speech is clear and there are no speech impediments noted. Thoughts are logical and organized. There is no evidence of delusions or hallucinations. F denies any hallucinations. F admits to a recent history of passive suicidal ideation without a plan, but denies suicidal or homicidal ideation at the present time. F admits to a history of decreased need for sleep but denies euphoric episodes. His wife has observed a history of notable mood swings. No manic-like symptoms are observed at the time of this examination.

     On formal mental status examination, F is found to be oriented to three spheres. Fund of knowledge is appropriate to educational level. Recent and remote memory appear intact. F was able to calculate serial 7’s. In response to three wishes, F replied "I wish that my marriage would work out and that my kids would be happy and that someone would give me a million dollars.