

IGDA. II: Illustrative clinical case

IGDA WORKGROUP, WPA

DEMOGRAPHIC IDENTIFICATION, SOURCES OF INFORMATION AND REASONS FOR EVALUATION

Ms Y is a 28-year-old monolingual Spanish-speaking woman of Mexican origin living for 2 years in the USA and married to a Mexican man self-employed in the construction business. She presents for care to the emergency room accompanied by a female friend, complaining of 'nervios', feeling guilty for not being able to perform her duties as a wife, and concerned that there may be some type of imbalance in her body. The interviewer is a female psychiatrist, born in South America and trained in the USA.

HISTORY OF PSYCHIATRIC AND GENERAL MEDICAL ILLNESS

Ms Y reports that she has been having 'nervios' for the past few months. She describes this condition as feeling desperate, 'like having a knot in my throat'. Upon further questioning, she acknowledges feeling sad for the past 6 months. She attributes her sadness to feelings of loneliness. Additionally, she acknowledges frequent crying, usually in relation to remembering her family in Mexico. She has been experiencing insomnia and decreased appetite, with a 5-kg weight loss. Her energy has decreased, and she has to make an effort to complete her daily routine, which includes doing all the household chores. She verbalises some anger towards her husband for expecting her to have a full meal prepared by the time he gets home. At the same time, she is proud to explain that she makes her own *masa* for her tortillas. She denies having had homicidal or suicidal thoughts. She has also complained of headaches, occasional palpitations and

generalised muscle aches for the past 2 weeks. These symptoms occur throughout the day and are usually relieved by rest and non-prescription non-steroidal anti-inflammatory agents. She denies having had any manifestations of psychotic disturbances, alcohol or drug use. She has been taking oral contraceptive medication for 2 years.

FAMILY, DEVELOPMENTAL AND SOCIAL HISTORY

Ms Y was born in a small town in Mexico. She was the eldest and only girl in a sibship of three. Her father left the family when she was 6 years old and her mother took them to live with grandparents. She has not had any contact with her father since then. Her brothers and mother still live in Mexico. She reports good memories from her childhood and that her grandparents were very supportive.

She grew up in a lower middle-class neighbourhood and was raised as a Catholic, attending church every Sunday with her family. Her mother had to work hard in order to support all the children and was therefore often absent from home, but devoted all her available time to her children.

Ms Y completed high school and then went to work as a secretary for a large company in town. She assumed increasing responsibilities within the company and achieved the position of supervisor for a whole floor. She stayed with the company for a total of 6 years.

Ms Y met her husband through her job while he was doing business with her company. They dated for 2 years and finally decided to marry when the company went bankrupt after the devaluation of the Mexican peso in 1994. Her family approved of the marriage, following which the couple moved to the USA.

Ms Y lives with her husband in a rented house. Her husband is self-employed and works in the construction business. She describes her husband as hard-working and very 'traditional' in his views of marriage, and denies any type of abuse from him. She states that she is happy with her marriage although she recognises that they have some problems. She feels that marriage is forever, and that she needs to work on making it better. She is taking oral contraception but has been discussing with her husband the possibility of having children. They are currently saving all the money they can to buy a house.

Ms Y has been working as a maid for a family for the past year and she enjoys her job, stating that her employer is very supportive and encourages her to learn English. However, she has been unable to attend any classes 'because of lack of time'. She keeps contact with her family in Mexico, but has not made them aware of her job situation because she is concerned that they would be upset if they knew that she was working as a maid. She misses her family, particularly because they were very close to each other, and remembers fondly getting together every Sunday.

Her current social relations are limited (restricted to the friend who accompanied her to the emergency room), owing to her inability to drive. She does not have a driver's licence because her permit to stay in the USA has expired and she is afraid of detection by the immigration service. Her husband is a legal resident in the USA and she wants him to volunteer to take the steps to make her stay legal. He has not offered to do this so far, and she has not explicitly requested it because she does not want him to think that all she wants is a 'green card'. They have no health insurance.

SYMPTOMS AND MENTAL STATE EVALUATION

Ms Y is a young-looking and attractive Mexican woman who wears a long, simple dress. She has no make-up on and her hair is combed in a ponytail. She is pleasant in her interactions, initially inhibited but becoming more talkative as the interview progresses.

Her speech is spontaneous and somewhat slow. Her thought processes are coherent, logical and goal-directed. There is no evidence of hallucinations, delusions, flight-of-ideas or loose associations.

Her mood is moderately depressed and she expresses multiple worries. She does not voice any homicidal or suicidal ideation. She moves her hands nervously.

She is alert and oriented to place and time. Her concentration and memory are somewhat impaired. Her intellectual functioning is in the average range as suggested by the vocabulary she uses. Her judgement and insight on having clinical problems are good.

PHYSICAL EXAMINATION

The results of this examination appear to be within normal limits, except that the patient looks pale, and her skin is cold and dry.

SUPPLEMENTARY ASSESSMENTS

The patient's blood cell count shows mild microcytic anaemia. Iron studies show that

the level of serum ferritin is decreased, the iron-binding capacity of the serum is increased, and total iron concentration is decreased. Thyroid-stimulating hormone concentration is mildly elevated.

DIAGNOSIS AND TREATMENT

The diagnostic formulations and treatment plan for Ms Y are given in Appendices 1–3.

APPENDIX I
COMPREHENSIVE DIAGNOSTIC FORMULATION

WPA International Guidelines for Diagnostic Assessment

Name: _____ Ms Y _____ Record no: _____ V001 _____ Date (d/m/y): 19 March 2001

Age: 28 Gender: M F Marital status: Married Occupation Domestic worker

FIRST COMPONENT: STANDARDISED MULTI-AXIAL FORMULATION

Axis I: Clinical disorders (as classified in ICD-10)

A Mental disorders (mental disorders in general, including personality and development disorders) Code

Moderate depressive episode	F32.1

B General medical disorders Code

Iron-deficiency anaemia	D50.9
Hypothyroidism	E03.9

Axis II: Disabilities

Area of disability	Disability scale					
	0	1	2	3	4	5 U
A Personal care			×			
B Occupational (wage earner, student, etc.)					×	
C With family					×	
D Social in general					×	

0, none; 1, minimal; 2, moderate; 3, substantial; 4, severe; 5, massive; U, unknown; according to the intensity and frequency of disabilities recently present.

Axis III: Contextual factors (psychosocial problems pertinent to the presentation, course or treatment of the patient's disorders or relevant to clinical care, as well as personal problems, such as hazardous, violent, abusive and suicidal behaviours, that do not amount to a standard disorder)

Problem areas (check areas with significant problems and then specify them)	Z code
× 1 Family/housing: Marital conflict, separation from family of origin	Z63
× 2 Education/work: Language limitations, underemployment	Z56, Z60.3
× 3 Economic/legal: Not a legal resident, no health insurance	Z65.3, Z59.7
× 4 Cultural/environmental: Gender role and cultural adaptation conflicts	Z60.8
5 Personal:	

Axis IV: Quality of life (to indicate the level of quality of life perceived by the patient, from poor to excellent, mark one of the ten points on the line below; this level can be determined through an appropriate multi-dimensional instrument or by direct global rating)

Poor	×	Excellent								
0	1	2	3	4	5	6	7	8	9	10

APPENDIX 2
COMPREHENSIVE DIAGNOSTIC FORMULATION

WPA International Guidelines for Diagnostic Assessment

SECOND COMPONENT: IDIOGRAPHIC FORMULATION

- I Clinical problems and their contextualisation** (include disorders, symptoms and problems, based on the standardised multi-axial formulation, in language shared by the clinician, patient and family, as well as complementary key information, mechanisms and explanations from biological, psychological, social and cultural perspectives)

Patient consults for ‘nerves’, feeling ‘desperate’, experiencing symptoms of clinical depression (sadness, insomnia, anxiety, appetite and weight loss, decreased energy, concentration and memory, palpitations, headaches, and generalised muscle aches) associated with substantial impairment in social functioning. Clinician and patient agree that this condition is related in part to her social history and situation (isolation derived from separation from family of origin, language barriers and transportation limitations; lack of legal residence, security and health insurance; underemployment, marital difficulties and cultural conflicts). Anaemia and hypothyroidism are additionally noted as problems, which may contribute to her depressive condition.

- II Positive factors of the patient** (include resources pertinent to treatment and health promotion, e.g. maturity of personality, abilities, talents and copying skills, social supports and resources, and personal and spiritual aspirations)

Patient completed high-school education and had supervisory office experience. She has no previous history of mental illness nor of alcohol or drug misuse. She feels identified with her cultural roots and at the same time appears motivated to do well in the host society. She currently holds a job and her employer is quite supportive. She has a friend who provides transportation. She is articulate and motivated to get better.

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- III Expectations on restoration and promotion of health** (include specific expectations on types and outcome of treatment and aspirations on health status and quality of life for the foreseeable future)

Clinician and patient agree that the present depressive condition is treatable with both medication and psychotherapy. They further agree that attention to her situation of isolation, problematic legal position and marital conflict is likely to both ameliorate her depression and improve her quality of life. They also agree that her anaemia and hypothyroidism are treatable with medication. Health promotion strategies may also include attention to nutritional habits, as well as affirmation of her cultural identity and of her competencies, talents and social supports.

APPENDIX 3 TREATMENT PLAN

Name: Ms Y Record no: V001 Date (d/m/y): 19 March 2001

Age: 28 Gender: M F Marital status: Married Occupation: Domestic worker

Clinicians involved: Psychiatrist and, prospectively, a primary care physician and a social worker

Setting: Out-patient clinic

Instructions

Under 'Clinical problems' list as targets for care key clinical disorders, disabilities and contextual problems presented in the multi-axial diagnostic formulation, as well as problems noted in the idiographic formulation. After the problem name, consider listing its key descriptors. Keep the list as simple and short as possible. Consolidate into one encompassing term all problems that share the same intervention.

'Interventions' should list diagnostic studies as well as treatment and health promotion activities pertinent to each clinical problem. Be as specific as possible in identifying the type of treatment, doses and schedules, amounts and time frames, as well as the clinicians responsible.

The space for 'Observations' may be used in a flexible way as needed. It might include target dates for problem resolution, dates of scheduled reassessments, and notes that a problem has been resolved or has become inactive.

Clinical problems	Interventions	Observations
1. Depression (sadness, insomnia, weight loss)	a. Start SSRI antidepressant, adjusting dose according to response and side-effects b. Psychotherapy with Spanish-speaking female therapist, engaging husband as therapy progresses, and considering health promotion strategies focused on strengthening patient's positive factors	Evaluate in 2 weeks Assess in 8 weeks
2. Sociocultural problems (marital, gender and cultural conflicts)	a. Prepare cultural formulation to clarify cultural identity and relations to illness and care b. Refer to social services for immigration, isolation and other social problems	Assess in 8 weeks
3. Iron-deficiency anaemia	a. Prescription of ferrous sulphate 325 mg three times daily b. Refer to primary care service	Follow-up on primary care referral
4. Hypothyroidism	a. Levothyroxine 0.025 mg per day b. Refer to primary care service	Follow-up on primary care referral