DIAGNOSING ORGANIC BRAIN SYNDROME
in the
PRIMITIVE EFA; LOW ACTIVITY LEVEL CLIENT

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J.C., an unemployed 35 year old male, was admitted to a standard methadone maintenance schedule as a result of clear physiological addiction to opiates. Initial consultations further revealed a constellation of symptomatology including hyperactivity, apparent memory dysfunction, appetite and sleep disturbance, as well as unusual consumption of stimulants such as coffee and cigarettes. Despite methadone stablization, which should have produced some degree of sedation, the symptoms not only continued but seemed to worsen. The clinical staff reviewed the case shortly into treatment when fairly consistent use of cocaine began to present serious questions as to the efficacy of out-patient treatment. J.C. maintained that the stimulant cocaine actually calmed him, and that he was using it more as a tranquilizer than as a drug of abuse. Despite this unpalatable reasoning, the staff agreed to continue services pending the outcome of a comprehensive psychiatric and psychological assessment.

Historical Abstract:

J.C. and a younger sister were raised by natural parents, both now deceased. The dominant mother clearly encouraged a great deal of succor dependence upon her and assumed the martyr's role of having to care for her emotionally ill husband and son. She had "arranged" for extensive electroconvulsive therapy series for both. Since this occurred some ten years ago, it is thought not to be a factor influencing the present assessment.

Of significance, a medical records search reveals normal development through age 12 and although an active youngster, no indication of hyperkinesis, learning disability or other emotional impairment is noted. He was admitted to an area hospital in his 12th year following a period of unexplained fever spiking, with resulting diagnosis of Fever of Unexplained Origin. Two years later, at age 14, a discharge diagnosis of Rheumatic Heart Disease is noted, and interestingly enough, the clinical symptoms of present concern emerged at about that time. Certainly there is suspicion that J.C. was an undiagnosed Rheumatic Fever patient with resulting sequela involving organic brain syndrom.

Assessment Abstract:

A full assessment was undertaken although for present study purposes, results of the Wechsler Adult Intelligence Scale, Wechsler Memory Scale

Form 1, and Benton Visual Retention Form A, are considered.

Intellective measures reveal: VIQ=101; PIQ=103; FSIQ=102. Further N.L. 80G=12 (E+uc, Fuu, Acu)L.

Digit Span = 4	Block Design = 9	Picture Arrangement = 12
Arithmetic = 7	Similarities = 13	Picture Completion = 9
Information =13	Comprehension = 9	Object Assembly = 11
		Digit Span = 7

The MQ of 69 is clearly inconsistent with expectations, and is accounted for by a primary memory deficit related to attention span and a secondarily clear cut perceptual deficit findings.

Probable diagnosis is Amnestic Organic Brain Syndrome, possible involving bilateral damage to diencephalic and medial temporal areas.

Discussion:

Extroversion, so to speak, is historically characteristic of J.C. and masked true hyperactivity which, during adolescence, became a function of organic factors. Likewise, his apparent scattered and ultimatly nondirected affect and interests have been regarded as a single developmental trait. As such, the cardinal feature responded to by helping professionals has been his hyperactivity, resulting in a single-symptom approach to treatment rather then more global causative strategy.

The difficulty in differentiating E+,F, low activity level behaviors from potential organic involvement is formidable, and such a differential diagnosis may actually be impossible without both sound historical data and other clinical corollaries. Fortunatly, both are available in this case, which permits a degree of interpretive confidence in the Wechsler data. It is, for example, remarkable that J.C. is so intallectively well retained. Vocabulary, Information and Similarities are quite strong, indicating that neither retrograde amnesia nor concretizing of thought processes are major factors. This is especially important. since traditional scatter analysis would maintain that such should not likely be the case in most organic situations. Considering also the rarity of the Fuu configuration even in otherwise non-organic clients, J.C. presents an interesting diagnostic problem.

J.C. responded remarkably well to a chemotherapeutic reigmen of low dose methadone in combination with amphetamine. A structured and goal directed psychotherapeutic approach supplements this effort. Day two of the medication regimen revealed substantial reduction in behavioral activity and behavior which was clearly more purposeful. More structure in thought processes, resulting in counseling accessibility, is also evident.