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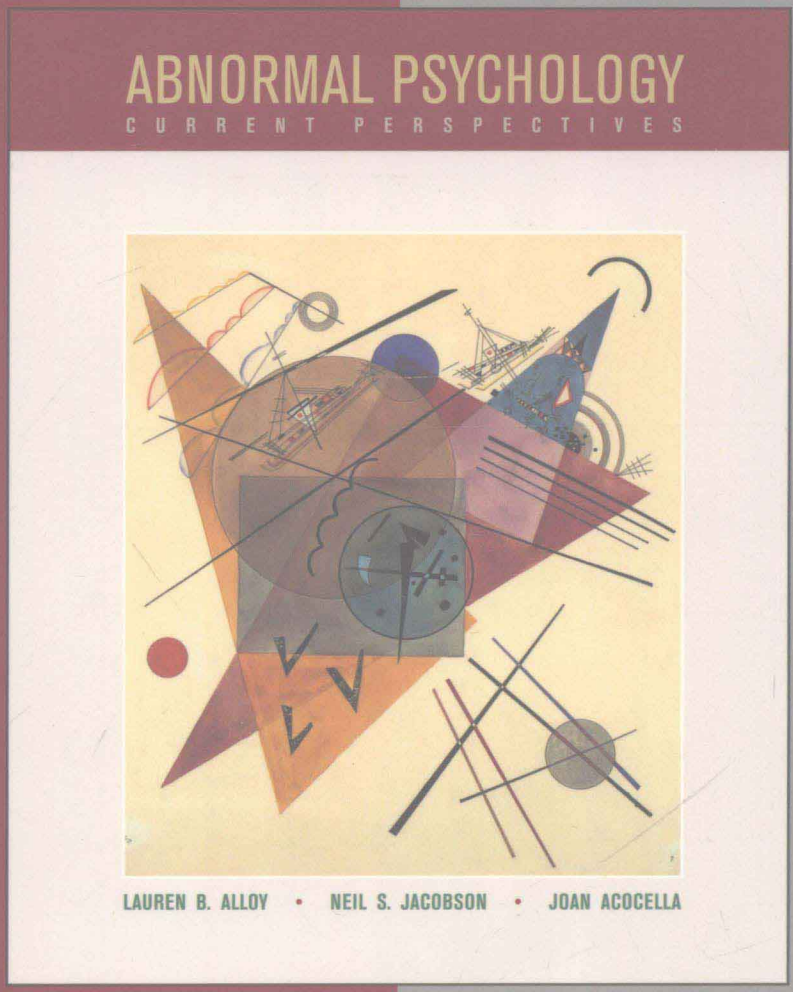

Fourth Edition
Prepared by John Vitkus

Casebook in *Abnormal Psychology*

Fourth Edition

John Vitkus
Case Western Reserve University
Medical College of Ohio

Boston Burr Ridge, IL Dubuque, IA Madison, WI
New York San Francisco St. Louis
Bangkok Bogotá Caracas Lisbon London Madrid Mexico City
Milan New Delhi Seoul Singapore Sydney Taipei Toronto

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To my parents, Myles and Joyce,
who made this book possible.
To my wife, Lisa,
who made this book worthwhile.
And to my children, Allison and Ian,
who made this book necessary.

PREFACE

Casebook in Abnormal Psychology, Fourth Edition consists of 14 case histories based on material supplied by psychiatric professionals. The presenting symptoms were actually observed, and the therapeutic techniques were actually administered. To maintain confidentiality, information that could identify individuals has been changed. Any resemblance to real persons is coincidental.

The 14 cases survey a variety of psychiatric diagnoses which follow the conventions of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, often abbreviated as *DSM-IV*.

Cases are presented within particular treatment approaches. **Please note:** By presenting a particular treatment with each disorder, I am *not* implying that the treatment presented is the most effective—or even the most common—treatment for that disorder.

Each case is organized into five sections: presenting complaint, personal history, conceptualization and treatment, prognosis, and discussion. These categories reflect, in a general way, how psychiatric professionals organize their cases and communicate among themselves.

This book was written with three primary goals. The first is to provide readers with a detailed and vivid account of the symptoms that characterize various disorders. The second is to highlight the differences in various therapeutic approaches. The third is to illustrate the limitations of psychiatric intervention in everyday practice.

This edition updates earlier editions with current research and treatment strategies. Most notable among these are the introduction of two new medications: sildenafil (Viagra) for male erectile disorder, and donepizil (Aricept) for Alzheimer's disease. Less dramatic but just as significant has been the introduction of many new, so-called atypical antipsychotic medications for schizophrenia. Finally, the field has been changed dramatically by the implementation of cost containment strategies known collectively as managed. The reader should keep in mind that the majority of these cases occurred before managed care was widely implemented, and many of the treatments described would be seen as quite luxurious by today's more spartan standards.

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VA Medical Center
Brecksville, OH

Ellie Bragar, Psy.D.
private practice
New York, NY

Howard A. Crystal, M.D.
Einstein College of Medicine
Yeshiva University
Bronx, NY

Zira DeFries, M.D.
private practice
New York, NY

John Fogelman, M.D.
St. Luke's/Roosevelt Hospital
New York, NY

David Geldmacher, M.D.
Fairhill Center for Aging
University Hospitals
Cleveland, OH

Kevin MacColl, M.A.
Beth Israel Medical Center
New York, NY

Harriet N. Mischel, Ph.D.
private practice
New York, NY

Steve Rasmussen, M.D.
Butler Hospital,
Brown University
Providence, RI

Sharon Silver-Regent, Ph.D.
private practice
New York, NY

David Spiegel, M.D.
Stanford University
Medical Center
Stanford, CA

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Barnard College
New York, NY

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Columbia/Presbyterian
Medical Center,
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CASEBOOK IN ABNORMAL PSYCHOLOGY

CONTENTS

GENERALIZED ANXIETY DISORDER
Cognitive-Behavioral Therapy

PRESENTING COMPLAINT

Terry is a 31-year-old man living in Washington, D.C. At his initial interview, he was dressed in clean but rather shabby "college clothes" (a T-shirt, jeans, and an old, worn warm-up jacket). Terry's manner and posture revealed that he was very apprehensive about therapy; his eyes nervously scanned the interview room, he held himself stiffly rigid and stayed by the door, and his speech was barely audible and marked by hesitations and waverings. After some brief introductions, Terry and the therapist each took a seat. The therapist began the session, asking, "What is it that brings you here today?"

Terry's reply was very rapid and forced. He stated that his problems began during his residency after graduating from medical school. Being an internal medicine resident involved constant pressure and responsibilities. The schedule, involving 36-hour on-call periods, daily 6:00 a.m. rounds, and constant emergencies, was grueling and exhausting. Gradually he began to notice that he and his fellow residents were making a number of small errors and oversights in the care they provided their patients. Although none was even remotely life-threatening, still he found himself ruminating about these lapses. He began to hesitate in making decisions and taking action for fear of making some catastrophic mistake. His anxieties steadily worsened until he began calling in sick and avoiding particularly stressful situations at the hospital. As a result he was not completing many of the assignments given to him by the chief resident, who threatened to report him to the program director. As time wore on, Terry's performance continued to decline, and by the end of the year he was threatened with dismissal from his program. He resigned at the end of the year.

Before his resignation he began making plans to be transferred to a less demanding program. With some help from his father (who is a

physician) and some luck, he was accepted into a hospital in Washington, D.C. His second-year residency was indeed less demanding than the first, and he felt that perhaps he could manage it. After a few months, though, Terry again felt an overwhelming dread of making some terrible mistake, and he had to quit the second program after six months. He then began to work in a less stressful position as a research fellow for the Food and Drug Administration (FDA). Even in this relatively relaxed atmosphere, Terry found that he still had great difficulty carrying out his duties. He found that he could not handle any negative feelings at work, and he again began missing work to avoid trouble. Terry's contract with the FDA expired after six months and was not renewed. At this time even the prospect of having to apply for another position produced terrible anxieties, and Terry decided to live off a trust fund set up by his grandfather. For the last two years he has been supported by this trust fund and, in part at least, by his girlfriend, with whom he lives and who, according to Terry, pays "more than her share."

Besides crippling his career, Terry's incapacitating anxieties have interfered with his relationships with his family and his girlfriend. For one thing, he has avoided visiting his parents for the last three years. He states that his parents' (particularly his father's) poor opinions of him make going home "out of the question." He also confesses that he avoids discussing any potentially controversial subject with his girlfriend for fear that he may cause an irreconcilable rift. As Terry puts it, "I stay away from anything touchy because I don't want to say something wrong and blow it [the relationship]. Then what'll I do?" Even routine tasks, such as washing his clothes, shopping for groceries, and writing letters to friends are impossible to accomplish for fear that some small step may be bungled or overlooked. Terry freely acknowledges that his fears are exaggerated and irrational. He admits (after some persuasion) that he is an intelligent, capable young man. Nevertheless, he feels utterly unable to overcome his anxieties, and he takes great pains to avoid situations that may bring them on.

Along with these dysfunctional cognitions, Terry reports a number of somatic symptoms. He is very tense; he always feels nervous

or "keyed up" and is easily distracted and irritated by minor problems. He complains of frequent throbbing headaches, annoying body aches and pains in his back and neck, and an almost constant feeling of fatigue. He also admits to feeling low self-esteem, describing himself as "worthless" and "lazy." On occasion he experiences brief periods of panic in which he suffers from a shortness of breath, a wildly racing heartbeat, profuse sweating, and mild dizziness. These feelings of panic tend to come on when some feared situation (e.g., having to make a decision or having to confront his girlfriend) cannot be avoided. He states that these symptoms first emerged during his first residency and have gradually intensified over the past few years.

Terry began dynamic psychotherapy soon after he lost his job with the FDA. He reports that this therapy was very complex and involved, which he found impressive in many ways. In particular, he says that his therapeutic experience gave him two important insights into the underlying causes of his paralyzing anxieties and low self-esteem: (1) his parents' expectations of him were too high and he always felt a great pressure to be perfect in their eyes, and (2) the teasing he received from his peers as a child has made him self-conscious about his weaknesses. Although Terry felt that these insights were valid, they did not seem to precipitate any significant change in his behavior. A friend suggested that Terry might benefit from a more direct form of psychotherapy and referred him to a cognitive-behavioral therapist.

PERSONAL HISTORY

Terry grew up in a small town in central Ohio. His father is a general practitioner in town and is on the staff of the county hospital. Terry's mother was an elementary school teacher until she quit her job when his older sister was born. After his younger sister was diagnosed as moderately mentally retarded, however, his mother took night courses at Ohio State University to receive training in teaching disabled children. She is now employed in the county's special education program.

Terry says that his older sister is a disappointment to their parents. After getting average grades at a small local college and working for several years as a paralegal, she now attends a small, little-known law school. Terry describes her as "not too bright." His father criticizes her for not getting into a more prestigious law school. Part of his father's anger, Terry speculates, stems from frustration at being stuck in a routine medical position in a small town. His younger lives at home and works at a sheltered workshop for mentally retarded adults run by the county special education program. According to Terry, his mother's training in special education has enabled his parents to cope fairly well with the burdens of supporting a disabled child.

According to Terry, his father early on "wrote off" his sisters (and, to a certain extent, his own stagnant career) and focused on Terry to be the "success" of the family. And Terry worked hard to fulfill this expectation. He had always earned excellent grades in school; in fact, he won full scholarships at prestigious universities that supported his undergraduate education and his training in medical school. He had always considered himself to be a good student and enjoyed studying, even in the difficult, competitive atmosphere of medical school. He described his academic achievement as something he did for himself--for his own education and improvement. In contrast, during his residencies he felt that he was toiling endlessly on what he considered to be "someone else's scum work." For the first time he began to fear his own fallibility and to avoid anxiety-provoking situations.

CONCEPTUALIZATION AND TREATMENT

Terry is a very intelligent and articulate young man who appears to be much more competent and capable than he presents himself to be. He shows no evidence of a psychotic disorder. He seems willing, even pressured, to discuss his problems, and he seems highly motivated toward reducing them. The therapist thought it reasonable, then, to take Terry's complaints at face value.

Terry's primary problem involves his excessive and unwarranted apprehension about his own fallibility and his need to perform every activity perfectly, no matter how trivial. This overriding fear has crippled his occupational and social functioning as well as his ability to perform—or even to attempt—a variety of routine, everyday tasks. This anxiety is also manifested by a number of physiological symptoms, including constant vigilance, distractibility, and irritability; pervasive muscle tension; and autonomic hyperactivity, as expressed by his occasional feelings of panic. Although he complains of periods of feeling depressed and worthless, his worries and anxieties are clearly not limited to these periods. Thus, it seems that his anxiety is his primary problem and not merely a response to his mild depression.

Terry's symptoms clearly fit the *DSM-IV* criteria for generalized anxiety disorder. People with this disorder suffer from pervasive, long-standing, and uncontrollable feelings of dread or worry that involve a number of major life activities (career, marriage, parenting, etc.). The focus of these anxieties is much broader than is the case with more circumscribed anxiety disorders such as panic disorder or simple phobia, and they are not solely associated with any other Axis I diagnosis. Thus, for example, although someone with generalized anxiety disorder might also experience a major depressive episode, his or her anxieties are not solely about being depressed. In addition, people with generalized anxiety disorder display somatic signs of their apprehension, including muscle tension, autonomic hyperactivity, fatigue, and irritability. Terry clearly fits this picture.

Terry's therapy can be organized as a process involving four general steps. The therapist's initial aim was to establish rapport with her client. To establish a better working relationship with Terry, she attempted to make him feel comfortable with her. This is no easy task with someone as tense and anxious as Terry. The first step was to explain her approach. Because cognitive-behavioral therapy requires much more direct, active participation than initially supposed by many clients (particularly those like Terry who have a history of psychodynamic treatment), it is important that the client be made fully aware of what to expect. The therapist also gave Terry encouragement that his

disorder was treatable with cognitive-behavioral therapy. It is important to establish this basis of hope to foster the client's expectations for change.

The second step was to have Terry form goals for his therapy. Ideally these goals would involve some specific behaviors or attitudes. It is more effective to formulate concrete plans that address some specific feared situation, such as "I want to send my résumé to 50 prospective employers," than more general aims such as "I want to work." Like most clients with generalized anxiety disorder, though, Terry at first proposed goals that were quite vague and unfocused. He wanted to start working, to get along with his parents better, and to "not be so apprehensive about things." At first these general goals are adequate; the important point is to have the client formulate *some* goals. Overly general ones can always be specified and put into behavioral contexts as therapy progresses.

Third, relaxation training is suggested for clients who show a great deal of physical tension and seem amenable to this treatment. Therapists have developed relaxation techniques that specifically address a client's dysfunctional cognitions, muscular tension, and autonomic hyperactivity. When he began therapy, Terry showed a variety of physical manifestations of tension. Having been trained in medicine, he was attuned to the somatic aspects of healing and was very willing to try relaxation techniques that involved physiological elements.

The fourth step in therapy was a review by Terry and the therapist of the issues and goals Terry had targeted. By going over his initial complaints and plans, both the therapist and the client are assured that they understand each other fully. In addition, this review allows the client, with the aid of the therapist, to put vague initial goals into more specific and workable terms.

Therapy began by first discussing the specific issues that were of immediate concern to Terry. These topics were not necessarily a central part of Terry's goals, nor were they necessarily closely related. For example, Terry's first few sessions of therapy focused on a variety of distinct problems, including, among other things, his inability to buy a suit, his anxiety concerning needed dental work, and his dread of an

upcoming visit to his parents. These loosely related issues were dealt with on a problem-by-problem basis, a process the therapist referred to as "putting out fires." This troubleshooting approach is employed for several reasons. First, cognitive-behavioral therapy is most effective if therapeutic issues are specified and well defined; individual psychological "fires" are particularly suited to this. Second, the client's enthusiasm for therapy and belief in the effectiveness of treatment is likely to be increased by initial success experiences, especially in immediate problem areas. Third, although these issues do not appear to be closely related, for the most part they share a common foundation: they are indications of Terry's tendency to avoid situations that carry a possibility of failure, however inconsequential. Over time, clients are expected to integrate these isolated issues and generalize their therapeutic gains to other areas of their lives.

The first topic Terry wanted to discuss was his inability to buy himself a suit. It had been years since Terry had shopped for clothes; he contented himself with wearing worn jeans and T-shirts. Several months ago, Terry's girlfriend made plans for the two of them to take a vacation to Boston to visit her sister. As a part of the preparation for this trip, she asked him to buy some new clothes, including "at least one decent suit." He thought about buying a suit on several occasions, but every time he was overwhelmed by the prospect of having to pick one out. He would begin shaking and sweating even as he approached a clothing store. Terry explained that he hated shopping for clothes, especially suits, because he was convinced that he would not be able to pick out the right suit. Not only would he waste his money, but everyone else would see his failure. To be at all acceptable, the suit had to be just the right color, just the right material, just the right cut, just the right price, and so on. It also had to be practical—appropriate for every possible occasion, from a sightseeing tour to a funeral. The prospect of buying the "wrong" suit made him so anxious that he could not bring himself to even enter a clothing store.

The therapist began by having Terry clarify exactly what he was and was not capable of. She then gave him clear assignments that she judged he would be able to accomplish successfully. These assignments