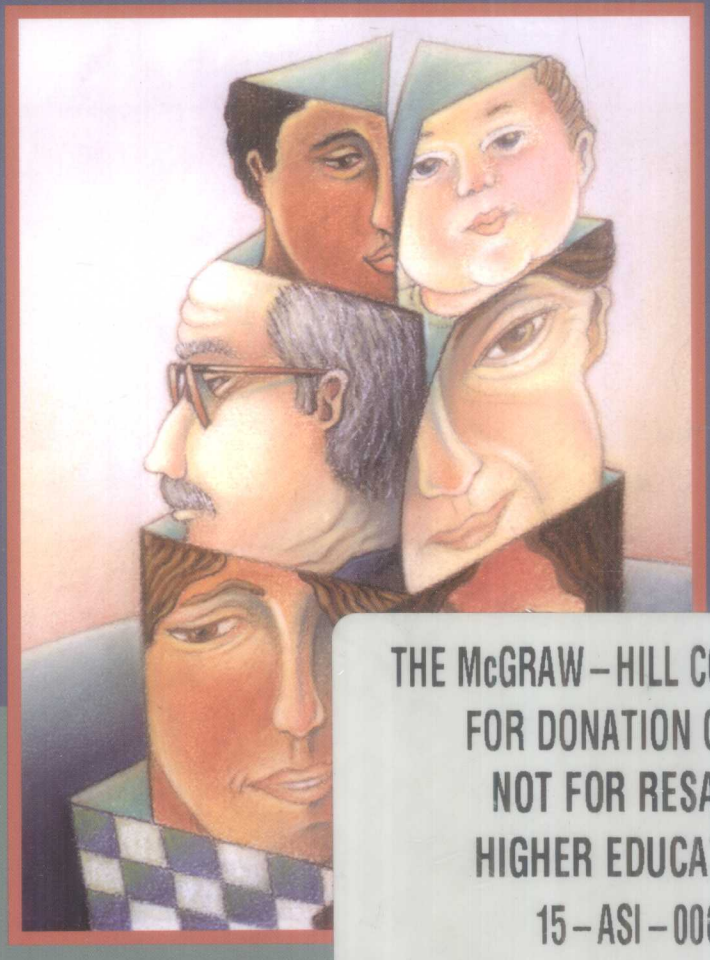
THE McGRAW-HILL CASEBOOK FOR ABNORMAL PSYCHOLOGY

FIFTH EDITION



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JOHN VITKUS

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CASEBOOK IN ABNORMAL PSYCHOLOGY

Fifth Edition

John Vitkus
Cleveland Clinic Foundation

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Casebook in Abnormal Psychology, Fifth Edition

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PREFACE

Casebook in Abnormal Psychology, Fifth Edition consists of 21 case histories based on my professional experience and additional material supplied by mental health 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 21 cases survey a variety of psychiatric diagnoses that follow the conventions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, often abbreviated as *DSM-IV-TR*. Each case is divided into four sections: Presenting Complaint, Personal Background, Conceptualization and Treatment, and Prognosis. These sections discuss, respectively, (1) the circumstances that brought the person to therapy at that time; (2) developmental, family, or other influences that may have contributed to the current problem; (3) the therapist's understanding of the case and plan of treatment; and finally (4) an estimation of the likely outcome of the therapy. In a general way, this organization reflects how mental health professionals approach their cases and communicate with each other.

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 "correct" approach for that problem. It may not be the most effective—or even the most common—treatment offered for that disorder. However, it was an actual treatment provided by an actual therapist to patients with similar symptoms.

This book was written with four 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 just how these therapeutic approaches are

actually put into practice in the course of treating specific psychiatric symptoms. The fourth is to acquaint the reader with the benefits and limitations of professional intervention in everyday practice.

This edition differs from previous editions in three primary ways. First, it updates and expands upon earlier editions by incorporating the terminology of *DSM-IV-TR* and by the addition of new cases. Also, the reader should be aware that over the past 15 years the treatment of mental problems has been changed dramatically by the implementation of cost containment strategies known collectively as managed care. Some of these cases occurred before managed care was widely implemented, and as a result some of the treatments described would be seen as quite luxurious by today's more spartan standards. Finally and most noticeably, for the sake of improved readability the cases in this edition were simplified to focus specifically on the therapeutic process and less on background research. Readers are of course encouraged to probe the topics presented in this book in greater depth by consulting their textbooks, consulting with faculty and clinical staff, and through the Internet.

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VA Medical Center, Brecksville, OH

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

Dana Brendza, Psy.D.
Cleveland Clinic Foundation, Cleveland, OH

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

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

Jennifer Egert, B.A.
Association for the Help of Retarded Children, New York, NY

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

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Cleveland Clinic Foundation, Cleveland, OH

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Fairhill Center for Aging, University Hospitals, Cleveland, OH

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Michael McKee, Ph.D.
Cleveland Clinic Foundation, Cleveland, OH

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private practice, New York, NY

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Stanford Sleep Medicine and Neurosciences Institute, Stanford, CA

Pat Pantone, Ph.D.
St. Luke's/Roosevelt Hospital Center, 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 University Medical Center,
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CONTENTS

WORRIED SICK

PRESENTING COMPLAINT

Terry is a 31-year-old man living in Washington, D.C. At his first therapy session (often called the "initial interview" or "psychiatric/psychological evaluation"), he was dressed in clean but rather shabby "college clothes" (a t-shirt, jeans, and an old pullover jacket). Terry's manner and posture revealed that he was very apprehensive about therapy; his eyes nervously scanned the interview room, and he held himself stiffly rigid while talking, his speech was barely audible and marked by hesitations and a wavering tone. After some brief introductions, Terry and the therapist each took a seat. The therapist began the session by asking, "What brings you here today?"

Terry's reply was very rapid and forced. He stated that his problems began during his medial residency after graduating from medical school. "Oh, you're a doctor, then?" interjected the therapist. Terry seemed distracted—even thrown off—by her question. She realized that he felt pressured to describe his problems, and she decided to back off and let him tell his story without interrupting. Terry soon regained his train of thought and returned to his narrative. 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 he knew these were fairly common and relatively minor, still he found himself ruminating about his lapses. He began to hesitate in making decisions 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 physican father and with 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 stop working and instead live off a trust fund set up by his grandfather. For the last two years he has been supported by this trust fund and his girlfriend. With open self-criticism, Terry acknowledges that she pays "more than her share."

Besides crippling his career, Terry's incapacitating anxieties have interfered with his relationships. For one thing, he has avoided visiting his parents for the last three years. He states that his parents' poor opinions of him (particularly his father's) 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.

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After some gentle prodding, he admits that he is an intelligent young man who should be successful. Nevertheless, he feels utterly unable to overcome his anxieties, and he takes great pains to avoid situations that may bring them on. His problems have left him feeling utterly worthless.

Along with these self-critical anxieties, 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 pains in his back and neck, and an almost constant feeling of fatigue. On occasion he experiences brief periods of acute anxiety in which he suffers from a shortness of breath, a wildly racing heartbeat, profuse sweating, and mild dizziness. These panicky feelings 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 traditional psychodynamic 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: first, his parents' expectations of him were too high and he always felt a great pressure to be perfect in their eyes, and, second, 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 bring about 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 mentally retarded, however, his mother took night courses at Ohio State University to receive training in teaching special needs children. She is now employed in the county's MR/DD (mental retardation/developmentally delayed) 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 sister lives at home and works at a sheltered workshop for mentally retarded adults. According to Terry, his mother's training has enabled her to cope fairly well with the burdens of supporting a disabled child. He describes his father as coping with her retardation by focusing on his career and spending as much time away from home as possible.

According to Terry, his father wrote off his sisters early on 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 a full scholarship at Northwestern University for his undergraduate education and a partial scholarship for his training at Harvard Medical School. He had always considered himself to be a good student. He enjoyed studying, even in the difficult, competitive atmosphere of medical school. He never experienced significant failure until his residencies, where 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. Sometimes people's initial complaints don't really describe their underlying disorder, either because they distort their descriptions or are unaware of their real problems. But Terry seems to have a good awareness of his situation and to truly want help, and so the therapist thought it reasonable to accept his complaints at face value.

Terry's primary problem involves an excessive and unwarranted apprehension about his own fallibility, perhaps motivated by his irrational 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 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 panicky feelings. He also complains of feeling depressed and worthless.

Terry's symptoms clearly fit the *DSM-IV-TR* criteria for generalized anxiety disorder, usually abbreviated GAD. 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. A diagnosis of GAD requires that the anxiety is not just the result of some other Axis I diagnosis. In Terry's case, he feels depressed as well as anxious, but his anxiety is pervasive and not solely about being depressed. In addition, people with GAD 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 first 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. She started by explaining her treatment 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 particular feared situation, such as "I want to send my résumé to 50 prospective employers," than more general aims such as "I want to get back to work." Like most clients with GAD, 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 anxious about things." At first these general goals are adequate; they were better defined as therapy progressed. In the beginning it is more important point is to have the client formulate *some* goals and engage in therapy. Overly general ones can always be put into more specific behavioral contexts later on.

Third, relaxation training is suggested for clients who show a great deal of physical tension. 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 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. For example, Terry's first few sessions of therapy focused on a variety of distinct problems, including 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 problem areas that are of immediate interest to the client. Third, although these issues do not appear to be closely related, for the most part they share a common foundation: they are all 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 went shopping 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 one. 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 started off with small steps that Terry thought he could do easily; gradually these steps became more and more complicated and difficult. The following segment of a therapy session illustrates this process:

Terry: You see, I just can't go through with it [buying a suit].
Therapist: Do you mean you are unable to, or that you'd rather avoid the whole thing?
Terry: What do you mean?
Therapist: Well, if I held a gun to your head, would you be able to go to the clothing store?
Terry: Well, yeah, I suppose so.
Therapist: So you are physically able to walk into a clothing store, right?
Terry: Yeah, I guess I am.
Therapist: OK. I want you to go to at least two clothing stores on your way home today. All right?
Terry: The mall's too far away. I couldn't possibly make it to day.

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