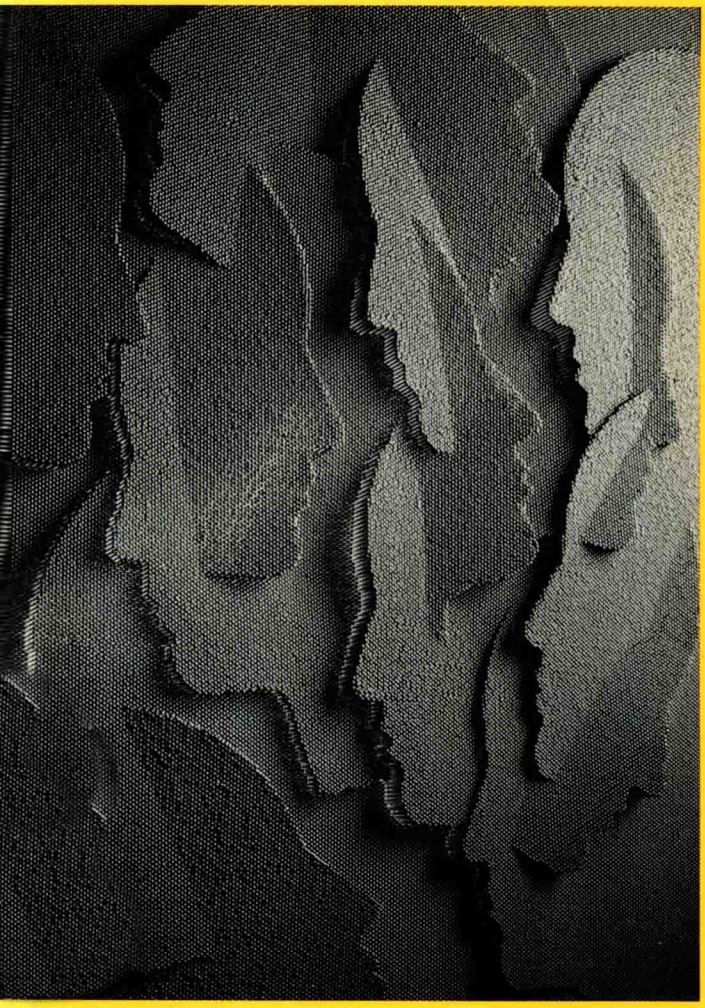
CASEBOOK IN ABNORMAL PSYCHOLOGY



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Casebook in Abnormal Psychology

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To my wife, Lisa

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INTRODUCTION

The *Casebook in Abnormal Psychology* consists of a selection of eleven different psychiatric case histories representing several major areas of abnormal psychology including, Anxiety Disorders, Mood Disorders, Psychotic Disorders, and Childhood Disorders. The diagnoses follow the conventions of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised* (American Psychiatric Association, 1987), commonly abbreviated as simply *DSM-III-R*. Any exceptions are noted at the end of each case.

Each case is presented with a particular treatment. The treatments represent basic approaches to abnormal psychology: Psychodynamic, Cognitive-Behavioral, Sociocultural, Neuroscience, and Eclectic. The *Casebook in Abnormal Psychology* is meant to be used as a supplement for any textbook in abnormal psychology such as *Abnormal Psychology: Current Perspectives,* Fifth Edition, by Richard R. Bootzin and Joan Ross Acocella. Consequently, the therapy descriptions presented are only general descriptions of the processes involved in psychotherapy. For a more detailed discussion of the theoretical foundations and therapeutic techniques of any particular approach to therapy, readers should refer to their texts, practitioners' guides, or therapy handbooks.

The cases in this book are based on actual material provided by practicing psychiatrists and psychologists. The presenting symptoms described in this casebook were actually observed, and the therapeutic techniques utilized in treatment were actually administered. However, because of the need to maintain confidentiality, details such as names, gender, occupations, and places that may identify particular individuals have been changed. In many cases, symptoms and treatments from different people have been combined into one case. Any resemblance to real persons is purely coincidental.

CASE ORGANIZATION

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 describe them.

The **presenting complaint** refers to the various symptoms and circumstances that prompted the person to seek psychiatric help. Most often this information is collected at the first therapy session, which usually involves an initial interview. In some instances, family members are relied upon as primary information sources because the individual is unable to provide an adequate account of his or her symptoms. An example of this might be a woman suffering from Alzheimer's disease or a child with Separation Anxiety Disorder.

The **personal history** section provides background information that the therapist may find helpful in diagnosing and treating the person. Unlike a person's presenting complaint, the person's personal history is actively solicited by the therapist. As a result, these histories vary greatly from case to case, depending on what the particular therapist may find useful. For example, traditional psychodynamic therapists often devote a great deal of time in therapy to obtaining a detailed account of the person's childhood in the hopes of uncovering the unconscious conflicts that may afflict the person. Since, according to this view, a person's symptoms are merely superficial manifestations of underlying unconscious traumas, knowing the precise nature of these symptoms is important only because it can provide clues to the latent problems. More important are the various clues that may shed light on the person's unconscious (e.g., dreams, fears, etc.) In contrast, most behavior therapists are concerned primarily with the objective history of the disorder: the form of the symptoms, when and under what circumstances the symptoms first appeared, and so forth. For these therapists, a knowledge of the person's dreams or childhood memories is irrelevant and therefore unimportant. A particularly interesting comparison can be found in the case histories of Generalized Anxiety Disorder and Dysthymic Disorder.

The differences between various theoretical approaches becomes most evident when one examines the way in which therapists formulate their treatment plans and implement them. The next section, **conceptualization and treatment,** focuses on these processes. The case conceptualization refers to how the therapist organizes the case and makes sense of the person's symptoms. The therapist draws together different information from the person's complaints and history and then pieces them together to form a coherent picture of the disorder. The therapist uses these facts to determine an official diagnosis. To help clarify these diagnoses, a definition of the relevant *DSM-III-R* disorder also appears in this section.

The treatment section documents the exact methods used to implement the treatment plan. Specific therapy techniques are described in as much

detail as possible. In most of the cases, segments of actual dialogues between the therapist and the person seeking treatment are included. The aim of this section is to give the reader a concrete and vivid impression of what actually occurs in the therapy session.

Readers must keep in mind that the therapy approach presented with each case is not the only treatment available; virtually every disorder may be treated by a variety of different therapeutic programs. By presenting a particular treatment with each disorder, it is *not* intended to imply that the form of treatment presented is the most effective—or even the most common—treatment for that particular disorder. (However, in no case is a therapy inappropriate for its diagnosis.) Instead, the aim of providing specific treatments along with each case is to expose readers to the specific techniques commonly practiced by psychiatric professionals of different theoretical orientations. By describing specific therapeutic techniques, it is hoped that readers will gain a clearer concept of how different theoretical approaches are employed in the course of therapy.

The case **prognosis** refers to the therapist's prediction of how the person will function after therapy. In some cases, the person is expected to be more or less cured of his or her disorder. In other cases, the person is predicted to relapse. In the more chronic cases, the person is not expected to show a significant improvement in the foreseeable future and will in all likelihood continue to deteriorate. These prognoses are based on both the individual's response to therapy and on the typical response most people with this disorder show. Keep in mind, however, that therapists will tend to present cases that have been treated successfully, and consequently the prognoses for these case histories may be more optimistic than population norms would suggest.

Finally the **discussion** section describes any aspect of the case history that was atypical or otherwise noteworthy. This section mentions if a person was given any unusual treatment techniques or if therapy was performed in an unusual way. Other therapy techniques that are commonly used to treat the disorder are pointed out. This section also reviews the therapist's personal approach to the case. It discusses how the therapist's own conceptualization of the person's problem determined the information they sought in the person's history and the particular treatments they employed.

THE PURPOSES OF THIS CASEBOOK

There are three main purposes of this casebook. The first is to provide readers with a detailed and vivid account of the symptoms that characterize various disorders. For example, many descriptions of psychiatric disorders

employ general terms such as describing an anxious man as being "paralyzed by irrational fears." Although this description is accurate, it does not provide the same impression as noting that this man "worries about finding the 'perfect' suit to such an extent that he has not bought any clothes at all in over two years." Similarly, this casebook aims to provide a concrete view of how therapy is conducted. Using the same example, saying that the anxious man was "given a task-oriented homework assignment" is not as informative as providing actual dialogue in which the therapist gives the person direct instructions to go to a nearby clothing store. In short, the primary goal of this casebook is not to describe what different disorders and therapies are; it is to describe what these disorders and therapies are *like*.

It has been said that the psychotherapy a person receives is not determined so much by his or her symptoms as by the theoretical orientation of his or her therapist. The second purpose of this casebook is to highlight the differences in how various therapies are conducted. Many of these differences are obvious. Some therapies last for weeks, others are life-long. Some focus on immediate concerns, some focus on past issues, and some attempt to treat both. In addition to these overt differences, various therapies contain more subtle discrepancies that may nevertheless affect a person's therapy in important ways. For example, some therapists refer to the people they treat as *clients;* others refer to them as *patients.* The difference between these two terms involves certain subtle yet clear implications for the person's role in the therapeutic process, specifically the client/patient's status *vis-a-vis* the therapist. As another example, some therapists insist that the person seeking therapy define the goals of treatment; other therapists maintain their own agenda. This distinction will have a great impact on the client/patient's status in therapy and, consequently, on the course of therapy and its duration. Many people are to some extent or another ignorant of the options available in therapy. By outlining the differences between various therapeutic approaches, it is hoped that this casebook will provide a clear picture of these options. Of course, this is of particular pragmatic value should the reader, or someone he or she knows, decide to seek psychiatric help.

Although this casebook discusses different treatment approaches as though they were clearly distinct, these differences tend in reality to be blurred. That is, practicing psychiatric professionals rarely ally themselves solely with one theoretical orientation; to varying degrees most therapists employ a more or less eclectic approach. This trend has been increasingly prevelant over the past decade. Evidence of this spreading eclecticism can be seen throughout this casebook—from psychodynamic therapists who employ medications and situation manipulations to behavior therapists who interest themselves in the client/patient's subjective thoughts and feelings. Although an argument can be made for calling every form of therapy in this

casebook "eclectic," for clarity's sake the cases presented here are labelled with the theoretical approach that forms the primary basis of each particular treatment.

The third purpose of this casebook is to illustrate the limitations of the psychiatric professional in everyday practice. For example, therapy that aims at achieving a dynamic insight is limited to those people who are intellectually capable of this accomplishment. Therapy for young or more seriously disturbed people would require some fundamental alterations. As another example, behavior therapists find themselves at a loss with people who conceptualize their problems in nonspecific terms. When the person says, "I want to be fulfilled" or "I want to be happier," the behavior therapist must first translate these rather vague goals into more concrete terms before therapy can proceed. Of course, all forms of psychotherapy will be limited in their ability to treat disorders involving psychosis or severe organic impairment. Most therapists would agree that pharmacotherapy (in some cases combined with supportive therapy for the person's family), is the only realistic approach for these disorders.

As a final note, it is hoped that this small, select sample of case studies will provide students with information on psychopathology and psychotherapy that is beyond the scope of their texts. More generally, it is hoped that readers will find this casebook stimulating and thought-provoking.

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CASE 1

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 hospital internship after he graduated from medical school. His internship was a high-pressure position that involved a great many demands and responsibilities. The schedule—involving thirty-six-hour on-call periods, daily rounds, and constant emergencies—was arduous and exhausting. Gradually he began to notice that he and the other interns were making a number of small errors and oversights in the care they provided their patients. He found himself ruminating about these lapses, and he began to hesitate in making decisions and taking action for fear of making some

catastrophic mistake. His anxieties about making a mistake 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 of his program, who threatened to report him to the head of the program. As the year wore on Terry's performance continued to decline, and by the end of the year he was threatened with dismissal from the 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 was a physician) and some luck, he was accepted into a program in Washington, D.C. This internship was indeed less demanding than the first, and he felt that perhaps he could manage it. After a few months, though, Terry again felt overwhelmed by his recurrent anxieties about making a terrible mistake. 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 National Institutes of Health. 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; it 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, instead of working. 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."

Terry's incapacitating anxieties have interfered not only with his career, but also with his relationships with his family and his girlfriend. As one indication of this, he has avoided visiting his parents for the last three years. He states that his parents' (particularly his father's) poor opinion 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 potentially 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 (especially in his back and neck), and an almost constant feeling of fatigue. He also admits to feeling worthless, and he describes himself as having low self-esteem and little motivation. Occasionally he also experiences brief periods of panic in which he suffers from shortness of breath, a wildly racing heartbeat, perfuse 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 initially emerged during his first internship and have gradually intensified over the past few years.

Terry began psychodynamic therapy soon after he lost his job with the FDA and stopped working. He reports that this therapy was very complex and involving. In particular, he says that his therapeutic experience gave him two important insights into the underlying causes of his paralyzing anxieties and his 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 of his weaknesses. Although Terry felt that these insights were valid, they did not seem to precipitate any significant change in his behavior, and they were becoming less useful to him. In his words, "the effect of these (insights) was wearing off." A friend suggested that Terry might benefit from a more direct form of psychotherapy and referred him to a cognitive-behavior therapist.

❑ PERSONAL HISTORY

Terry grew up in a small town in Ohio. His father is a general practitioner in town and is on the staff of the county hospital. Terry's mother is a teacher. She quit her job when his older sister was born. After his younger sister was diagnosed as mentally retarded, however, she returned to school to acquire special training in teaching handicapped children. She now teaches learning-disabled children as part of the county special education program. Terry's parents, particularly his father, always had high aspirations for him and were quite demanding.

Terry's older sister still lives with her parents and attends a small, little-known law school near home. Terry describes her as "not too bright." He states that his father is frustrated at being stuck in a small town and criticizes his daughter for not getting into a more prestigious law school. His younger sister is moderately mentally retarded. She too lives at home, and she works at a sheltered workshop run by the county special education program.

Terry always had the impression that he was looked on as the "success"

of the family. He had always gotten excellent grades in school; in fact he won full scholarships that supported both his undergraduate education and his training in medical school, both at highly prestigious universities. He had always considered himself to be a very good student. He enjoyed studying, even in the difficult 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 internship 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, and he appears to be much more competent and able than he describes. 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, no matter how trivial, perfectly. 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-III-R* criteria for Generalized Anxiety Disorder. People with this disorder suffer from pervasive feelings of dread or worry that involve at least two or more major life circumstances (one's career, one's relationship with a spouse, the health of one's children, etc.). The focus of these anxieties is much more broad and unspecified than is the case with other anxiety disorders such as Panic Disorder or Simple Phobia. Furthermore, these feelings of anxiety are not solely associated with any other Axis I diagnosis. Thus, for example, although someone with Generalized Anxiety Disorder may 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 motor tension, autonomic hyperactivity, and defensive vigilance.

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. In order to establish a better working relationship with Terry, she attempted to make him feel comfortable with her, and she carefully explained her approach. Since cognitive-behavioral therapy requires much more direct, active participation than many clients suppose (particularly those with a history of psychodynamic treatment), it is important that the client be 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 in order 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 behavior or attitude. Concrete plans that address some specific feared situation, such as "I want to send my resume to 50 prospective employers," are more effective than more general aims, such as "I want to work." Like most clients, though, Terry's initial goals were quite vague and unfocused. He stated that he wanted to start working, to get along with his parents better, and to "be not 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 especially 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 his or her initially vague goals into more specific and workable terms.

Therapy began with a discussion of 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 several 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 slight. Over time, clients are expected to integrate these isolated issues and apply 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. Terry's girlfriend was making plans for the two of them to take a vacation to Boston to visit her sister. As part of the preparation for this trip, she had asked him to buy some new clothes, including "at least one decent suit." He had thought about buying a suit on several previous occasions, but every time the prospect of having to pick one out overwhelmed him. 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. In order 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. It also had to be practical—appropriate for every possible occasion, from sightseeing to going to the symphony. The threat of making a mistake and buying "the wrong suit" made him so anxious that he could not bring himself even to 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 would be easy for Terry, and gradually 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 actually are unable to, or that you'd rather avoid the whole thing?