PSY 210- Abnormal Psychology
Mercer County Community College
Dr. Heather Jennings

Case Study- (50 Points)

You will select and review **ONE** case study provided in this packet (see below). You will be responsible for reviewing the case and assigning a diagnosis(es). It is common to have more than one diagnosis, list every diagnosis for which the diagnostic criteria are met. You will also be responsible for providing a rationale for the diagnoses, as well as a discussion of rule outs, differential diagnoses. This assignment should be a minimum of 2-3 pages in length (typed, double-spaced, one inch margins).

Summary Overview
The first page must contain a header which includes your client's name, presenting problem and demographic information that is provided in the case summary (*age, sex, race/ethnicity, etc*...), see example below. The diagnosed disorder(s) should be listed directly underneath your demographic information with the principle diagnosis identified and the severity of each disorder noted (e.g., *mild, moderate or severe*). The remaining pages are to be a discussion of how you determined the diagnoses, in the order in which they will be discussed in the body of the paper.

Discussion Section
The discussion section is the section of the paper where you have the opportunity to discuss this case in depth and make an argument for the diagnoses and treatments you assign. It is also the place to identify the psychosocial factors that could influence the symptoms and overall functioning of the client. Present a thorough description of the client's behaviors and how they could be helped through treatment. Please label this section as *Discussion Section* and provide sub-headings for each additional discussion component.
All of the following sections must be included:

- **Assigned Diagnosis**
  Each disorder presented must be supported with evidence from the case summary and the text book. Each diagnosis must be presented and discussed in depth and evidence from the textbook must be included to support your diagnosis. In short, if you assign the diagnosis of Obsessive-Compulsive Disorder (OCD), you must back-up your decision with diagnostic criteria from the textbook. A differential diagnosis should be included (if applicable). Every diagnosis must be justified with information from the textbook. An in-text citation MUST be used and a reference page must be included.

  - A *Differential diagnosis* refers to all of the diagnostic categories that you seriously considered during the diagnostic process. Because the symptoms present in the case study suggest the possibility of several disorders, a thorough discussion of disorders that you excluded is warranted. In other words, you should discuss why you assigned the diagnoses that you did and why you ruled out others.

- **Environmental and Psychosocial Functioning**
  The assessment of environmental and psychosocial functioning must also be included in both the header and discussion sections of the paper. Please refer to TABLE 2.2 "Examples from Z Codes in ICD-10" for this assessment. A discussion of this psychosocial assessment should be presented after the diagnoses.

- **Treatment plan**
  Now that you have assessed your client, now you must help them get better! You must provide a brief outline of how the treatment should take place for you client by developing a treatment plan. Based on your assessment, you must identify one (1) short-term and one (1) long-term goal for the client, recommend a treatment site and treatment modality. Justify your plan with information from the textbook.

Sample Summary Overview

Client: John Smith, 25 year-old Hispanic Male

Presenting Problem:
Client presented with suicidal thoughts and attempt.

Assigned Diagnosis (or Diagnoses):
Major Depressive Disorder-Severe (Principle Diagnosis)
Posttraumatic Stress Disorder-Mild
Generalized Anxiety Disorder-Mild

Environmental and Psychosocial Functioning:
Problems related to social environment
Problems related to employment to unemployment

Treatment Plan:
Short-term goal: Reduce and/or eliminate suicidal ideation; client will contract for safety

Long-term goal: Understand sources for stress and depression; develop effective coping skills to minimize symptoms and enhance psychosocial functioning.

Treatment Site: In-patient hospitalization is required because client is a danger to self.

Treatment Modality: Individual therapy

(PSY 210) Abnormal Psychology
Case Summary Assignment
Grading Rubric
Dr. Jennings

Required Sections:	Earned Points	Possible Points
Summary Overview		**10**
Assigned Diagnosis		**20**
Environmental and Psychosocial Functioning		**10**
Treatment Plan		**10**
Total Points		

An "A" level paper will receive 45-50 points: Student provided the correct diagnosis(es) for each client, including principle and/or differential. Each diagnosis or lack of a diagnosis was clearly justified based on current clinical criteria. Factual evidence was used effectively and correctly cited in APA format both in text and on reference page. Student clearly identifies and insightfully analyzes important features of the symptoms/behaviors demonstrated by "client" to support diagnosis(es). Student develops ideas cogently and organizes them logically. Overall summary and discussion sections were outstanding. Appropriate treatment goals, site and modality were identified. There are few or no errors in mechanics, usage, grammar, or spelling. The content presented is exceptional and presents a very comprehensive clinical picture of the case summary.

A "B" level paper will receive 40-44 Points: The student provided one inaccurate diagnosis, or provided justification for the diagnosis that was not concise or lacked important analysis of symptomatology. Overall summary and discussion section contained minor errors, but provided well-defined clinical picture. Factual evidence was used somewhat effectively and correctly cited in APA format both in text and on reference page. Treatment plan may be somewhat inappropriate to client's needs and/or disorder(s).The paper is grammatically correct, and has more than 4 spelling errors. The student provides personal insight, but less of a thorough analysis of the content. The content presented is very good and presents a comprehensive clinical picture of the case summary.

A "C" level paper will receive 35-39 Points: The student provided 2 or more inaccurate diagnoses and/or provided little justification of diagnoses presented and/or lack of analysis of symptomatology. The overall summary and discussion sections are incomplete or poorly developed. Factual evidence was used ineffectively and/or incorrectly cited in APA format both in text and on reference page. The paper contains multiple grammatical errors and/or more than 4 spelling errors. The content presented is marginal and does not present a comprehensive clinical picture of the case summary and/or required sections not presented.

A "D" level paper will receive 30-34 Points: The student provided 2 or more inaccurate diagnoses or provided little or no justification of diagnoses presented or lack of analysis of symptomatology. The content presented is below average and does not present a comprehensive clinical picture of the case summary and/or required sections not presented. Factual evidence was not presented or did not justify diagnosis and/or incorrectly cited in APA format both in text and on reference page. The writing quality of the assignment was below average.

An "F" level paper will receive 29-0 Points: Student proved no correct diagnosis (es) or provided no justification of diagnoses presented or lack of analysis of symptomatology. The content presented is well below average and no evidence of comprehension of the case summary is demonstrated. Factual evidence was not presented or did not justify diagnosis and/or incorrectly cited in APA format both in text and on reference page. Writing quality is well below average and/or required sections not presented.

Case Summary #1

Robin Henderson is a 30-year-old married Caucasian woman with no children who lives in a middle-class urban area with her husband. Robin was referred to a clinical psychologist by her psychiatrist. The psychiatrist has been treating Robin for more than 18 months with primarily anti-depressant medication. During this time, Robin has been hospitalized at least 10 times (one hospitalization lasted 6 months) for treatment of suicidal ideation (and one near lethal attempt) and numerous instances of suicidal gestures, including at least 10 instances of drinking Clorox bleach and self-inflicting multiple cuts and burns.

Robin was accompanied by her husband to the first meeting with the clinical psychologist. Her husband stated that both he and the patient's family considered Robin "too dangerous" to be outside a hospital setting. Consequently, he and her family were seriously discussing the possibility of long-term inpatient care. However, Robin expressed a strong preference for outpatient treatment, although no therapist had agreed to accept Robin as an outpatient client. The clinical psychologist agreed to accept Robin into therapy, as long as she was committed to working toward behavioral change and stay in treatment for at least 1 year. This agreement also included Robin contracting for safety- agreeing she would not attempt suicide.

Clinical History

Robin was raised as an only child. Both her father (who worked as a salesman) and her mother had a history of alcohol abuse and depression. Robin disclosed in therapy that she had experienced severe physical abuse by her mother throughout childhood. When Robin was 5, her father began sexually abusing her. Although the sexual abuse had been non-violent for the first several years, her father's sexual advances became physically abusive when Robin was about 12 years-old. This abuse continued through Robin's first years of high school.

Beginning at age 14, Robin began having difficulties with alcohol abuse and bulimia nervosa. In fact, Robin met her husband at an A.A (Alcoholics Anonymous) meeting while she was attending college. Robin continued to display binge-drinking behavior at an intermittent frequency and often engaged in restricted food intake with consequent eating binges. Despite these behaviors, Robin was able to function well in work and school settings, until the age of 27.

She had earned her college degree and completed 2 years of medical school. However, during her second year of medical school, a classmate that Robin barely knew committed suicide. Robin reported that when she heard of the suicide, she decided to kill herself as well. Robin displayed very little insight as to why the situation had provoked her inclination to kill herself. Within weeks, Robin dropped out of medical school and became severely depressed and actively suicidal.

A certain chain of events seemed to precede Robin's suicidal behavior. This chain began with an interpersonal encounter, usually with her husband, which caused Robin to feel threatened, criticized or unloved (usually with no clear or objective basis for this perception. These feelings were followed by urges to either self-mutilate or kill herself. Robin's decision to self-mutilate or attempt suicide were often done out of spite- accompanied by the thought, "I'll show you." Robin's self-injurious behaviors appeared to be attention-seeking. Once Robin burned her leg very deeply and filled the area with dirt to convince the doctor that she needed medical attention- she required reconstructive surgery.

Although she had been able to function competently in school and at work, Robin's interpersonal behavior was erratic and unstable; she would quickly and without reason, fluctuate from one extreme to the other. Robin's behavior was very inconsistent- she would behave appropriately at times, well mannered and reasonable and at other times she seemed irrational and enraged, often verbally berating her friends. Afterwards she would become worried that she had permanently alienated them. Robin would frantically do something kind for her friends in an attempt to bring them emotionally closer to her. When friends or family tried to distance themselves from her, Robin would threaten suicide to keep them from leaving her.

During the course of treatment, Robin's husband reported that he could not take her suicidal and erratic behavior any longer. Robin's husband filed for divorce shortly after her treatment began. Robin began binge drinking and taking illegal pain medication. Robin reported suicidal ideation and feeling of worthlessness. Robin displayed signs of improvement during therapy, but this ended in her 14 month of treatment when she committed suicide by consuming an overdose of prescription medication and alcohol.

Case Summary #2

At the time of his admission to the psychiatric hospital, Carl Landau was a 19-year-old single African American male. Carl was a college freshman majoring in philosophy who had withdrawn from school because of his incapacitating symptoms and behaviors. He had an 8-year history of emotional and behavioral problems that had become increasingly severe, including excessive washing and showering; ceremonial rituals for dressing and studying; compulsive placement of any objects he handled; grotesque hissing, coughing, and head tossing while eating; and shuffling and wiping his feet while walking.

These behaviors interfered with every aspect of his daily functioning. Carl had steadily deteriorated over the past 2 years. He had isolated himself from his friends and family, refused meals, and neglected his personal appearance. His hair was very long, as he had refused to have it cut in 5 years. He had never shaved or trimmed his beard. When Carl walked, he shuffled and took small steps on his toes while continually looking back, checking and rechecking. On occasion, he would run in place. Carl had withdrawn his left arm completely from his shirt sleeve, as if it was injured and his shirt was a sling.

Seven weeks prior to his admission to the hospital, Carl's behaviors had become so time-consuming and debilitating that he refused to engage in any personal hygiene for fear that grooming and cleaning would interfere with his studying. Although Carl had previously showered almost continuously, at this time he did not shower at all. He stopped washing his hair, brushing his teeth and changing his clothes. He left his bedroom infrequently, and he had begun defecating on paper towels and urinating in paper cups while in his bedroom, he would store the waste in the corner of his closet. His eating habits degenerated from eating with the family, to eating in the adjacent room, to eating in his room. In the 2 months prior to his admission, Carl had lost 20 pounds and would only eat late at night, when others were asleep. He felt eating was "barbaric" and his eating rituals consisted of hissing noises, coughs and hacks, and severe head tossing. His food intake had been narrowed to peanut butter, or a combination of ice cream, sugar, cocoa and mayonnaise. Carl did not eat several foods (e.g., cola, beef, and butter) because he felt they contained diseases and germs that were poisonous. In addition, he was preoccupied with the placement of objects. Excessive time was spent ensuring that wastebaskets and curtains were in the proper places. These preoccupations had progressed to tilting of wastebaskets and twisting of curtains, which Carl periodically checked throughout the day. These behaviors were associated with distressing thoughts that he could not get out of his mind, unless he engaged in these actions.

Carl reported that some of his rituals while eating were attempts to reduce the probability of being contaminated or poisoned. For example, the loud hissing sounds and coughing before he out the food in his mouth were part of his attempts to exhale all of the air from his system, thereby allowing the food that he swallowed to enter an air-free and sterile environment (his stomach) Carl realized that this was not rational, but was strongly driven by the idea of reducing any chance of contamination. This belief also motivated Carl to stop showering and using the bathroom. Carl feared that he may nick himself while shaving, which would allow contaminants (that might kill him) to enter his body.

The placements of objects in a certain way (waste basket, curtains, shirt sleeve) were all methods to protect him and his family from some future catastrophe such as contracting AIDS. The more Carl tried to dismiss these thoughts or resist engaging in a problem behavior, the more distressing his thoughts became.

Clinical History

Carl was raised in a very caring family consisting of himself, a younger brother, his mother, and his father who was a minister at a local church. Carl was quiet and withdrawn and only had a few friends. Nevertheless, he did very well in school and was functioning reasonably well until the seventh grade, when he became the object of jokes and ridicule by a group of students in his class. Under their constant harassment, Carl began experiencing emotional distress, and many of his problem behaviors emerged. Although he performed very well academically throughout high school, Carl began to deteriorate to the point that he often missed school and went from having few friends to no friends. Increasingly, Carl started withdrawing to his bedroom to engage in problem behaviors described previously. This marked deterioration in Carl's behavior prompted his parents to bring him into treatment.

Case Summary #3

Mr. Ben Simpson is a single, unemployed, 44-year-old Caucasian man brought to the emergency room by the police for striking an elderly woman in his apartment building. His chief complaint is, "That damn bitch. She and the rest of them deserved more than that for what they put me through." The patient has been continuously ill since age 22. During his first year of law school, he gradually became more and more convinced that his classmates were making fun of him. He noticed that they would snort and sneeze whenever he entered the classroom. When a girl he was dating broke off the relationship with him, he believed that she had been "replaced" by a look-alike. He called the police and asked for their help to solve the "kidnapping." His academic performance in school declined dramatically, and he was asked to leave and seek psychiatric care.

Mr. Simpson got a job as an investment counselor at a bank, which he held for 7 months. However, he was receiving an increasing number of distracting "signals" from co-workers, and he became more and more suspicious and withdrawn. It was at this time that he first reported hearing voices. He was eventually fired and soon thereafter was hospitalized for the first time, at age 24. He has not worked since.

Mr. Simpson has been hospitalized 12 times, the longest stay being 8 months. However, in the last 5 years he has been hospitalized only once, for 3 weeks. During the hospitalizations he has received various antipsychotic drugs. Although outpatient medication has been prescribed, he usually stops taking it shortly after leaving the hospital. Aside from twice-yearly lunch meetings with his uncle and his contacts with mental health workers, he is totally isolated socially. He lives on his own and manages his own financial affairs, including a modest inheritance. He reads the *Wall Street Journal* daily. He cooks and cleans for himself.

Mr. Simpson maintains that his apartment is the center of a large communication system that involves all the major television networks, his neighbors, and apparently hundreds of "actors" in his neighborhood. There are secret cameras in his apartment that carefully monitor all his activities. When he is watching television, many of his minor actions (e.g., going to the bathroom) are soon directly commented on by the announcer. Whenever he goes outside, the "actors" have all been warned to keep him under surveillance. Everyone on the street watches him. His neighbors operate two different "machines"; one is responsible for all of his voices, except the "joker." He is not certain who controls this voice, which "visits" him only occasionally and is very funny. The other voices, which he hears many times each day, are generated by this machine, which he sometimes thinks is directly run by the neighbor whom he attacked. For example, when he is going over his investments, these "harassing" voices constantly tell him which stocks to buy. The other machine he calls "the dream machine." This machine puts erotic dreams into his head, usually of "black women."

Mr. Simpson described other unusual experiences. For example, he recently went to a shoe store 30 miles from his house in the hope of buying some shoes that wouldn't be "altered." However, he soon

found out that, like the rest of the shoes he buys, special nails had been put into the bottom of the shoes to annoy him. He was amazed that his decision concerning which shoe store to go to must have been known to his "harassers" before he himself knew it, so that they had time to get the altered shoes made up especially for him. He realizes that great effort and "millions of dollars" are involved in keeping him under surveillance. He sometimes thinks this is all part of a large experiment to discover the secret of his "superior intelligence."

At the interview, Mr. Simpson is well groomed, and his speech is coherent and goal-directed. His affect is, at most, only mildly blunted. He was initially very angry at being brought in by the police. After several weeks of treatment with an antipsychotic drug that failed to control his psychotic symptoms, he was transferred to a long-term care facility with a plan to arrange a structured living situation for him.

Case Summary #4

Hank Allen is a 32 year-old married Caucasian male who was brought to this screening center for psychiatric evaluation following his arrest for the murder and sexual assault or ten women. His wife, Jody, who eventually testified against him, had worked as his partner, luring victims to their deaths.

Wanting to further her husband's fantasy of finding the "perfect lover," Jody had accompanied him to shopping centers or county fairs and talked young girls into climbing into their customized van. Once inside, the victims were confronted by her husband, who held a handgun and bound them with adhesive tape. Most were teenagers, though two of the final victims were adults; the youngest was 13. The oldest victim, age 34, was a bartender who closed up late one night, went out to her car, then rolled down her window to talk to the couple, who had been inside drinking and who now approached her. The Allen's kidnapped her and drove her back to their own residence. While Jody sat inside watching an old movie on television, Hank assaulted his victim in the back of the van, scripting her to play the role of his teenage daughter. When he was through, Jody rejoined him and drove away in the early morning hours, the radio blaring to drown out the sounds of her husband in the back of the van, strangling his victim to death. That evening they celebrated Hank's birthday at a restaurant.

Most of Hank's victims were petite blonds like Jody and Hank's own daughter. All were sexually abused, then shot or strangled to death; several were buried in shallow graves. One, a pregnant 21-year-old hitchhiker (Jody was also pregnant at the time), was raped, strangled, and buried alive in sand.

Hank rated the sexual performance of each of his victims and always made sure that Jody knew she was never number one. Jody tried to redeem herself in the eyes of her difficult husband by submitting to his every demand. Even when she finally separated from him, she was unable to say no. They had been apart for several months when Hank called her, asking that they get together one more time. She agreed, and that day they claimed their ninth and tenth victims.

Clinical History

Hank's violence was a legacy from his father. When he was born, his 19-year-old father was serving a prison sentence for auto theft and passing bad checks. A later conviction earned him a term for second-degree robbery, but he escaped. In an ensuing saga of recapture, escape, recapture, and escape, he killed a police officer and a prison guard, blinding the latter by tossing acid into his face before beating him to death. Often told that he was going to be just like his father when he grew up, Hank was 16 when he learned that his father had been captured and executed in a gas chamber after his mother betrayed his hiding place. Hank later confessed to the police: "Sometimes I [think] about blowing her head off. . . . Sometimes I wanna put a shotgun in her mouth and blow the back of her head off. . . . "

In a forensic psychiatric evaluation, Hank revealed that his mother was the object of his most intense sexual fantasy:

> “I was gonna string her up by her feet, strip her, hang her up by her feet, spin her, take a razor blade, make little cuts, just little ones, watch the blood run out, just drip off her head. Hang her up in the closet, put airplane glue on her, light her up. Tattoo "bitch" on her forehead. . . “

Hank's mother had beaten and mocked her son, a bed wetter until age 13, calling him "pissy pants" in front of guests. One of her husbands punished him mercilessly, forcing him to drink urine and burning a cigar coal into his wrist. When his mother tried to intervene, his stepfather smashed her head into a plaster wall. From that point on, she joined in the active abuse of her children. As far back as he could remember, Hank had nightmares of being smothered by nylon stocking material and being strapped to a chair in a gas chamber as green gas floated into the room.

Hank began to burglarize with an older brother at 7, and at 12 was put on probation. A year later he was sent to the California Youth Authority for committing "lewd and lascivious acts" with a 6-year-old girl. As a teenager he faced charges of armed robbery and auto theft. A habitual truant, he was suspended from high school at 17 with F's in five academic subjects and F's in five categories of "citizenship." That same year he married for the first time.

Often knocked unconscious in fights, he was comatose twice, briefly at 16 and for over a week at 20. A computed tomography brain scan revealed "abnormally enlarged sulci and slightly enlarged ventricles." A neuropsychological battery showed "damage to the right frontal lobe."

Hank married seven times. He beat each of his wives, sometimes badly. Most of the marriages lasted no more than a few months. One wife described him as "dominant" and said "he's got to be in control." Another, who had had clumps of hair yanked from her head, called him "a Jekyll and Hyde." Yet another said he was "vicious." When she told him she wanted out, he took revenge by beating her parents. His first marriage ended when he beat his wife with a hammer. When she left him, she replaced his mother in his central fantasy. They had married 5 days after the birth of a baby daughter and a custody battle ensued. In spite of his lengthy record of assaults, thefts, and parole violations, Hank won.

When he was 23, Hank went on a crime spree that eventually covered five states. Stealing license plates and cars, holding up bars and drugstores, he eluded capture until caught and convicted for the armed robbery of a motel. Sent to prison for 5 years to life, he molested his 6-year-old daughter for the first time during a conjugal visit.

He was 30, and his divorce from his fifth wife had not been finalized when he moved in with Jody. By the time they met, Hank had been arrested on 23 separate occasions. The following summer Hank was fired from his job as a driver. He had been fired often, and it was an event that usually left him sexually impotent.

Shortly before his final arrest, Hank, a gun enthusiast, owned a semiautomatic assault rifle, an automatic pistol, two revolvers, and a derringer. He was working as a bartender. A co-worker described him as a ladies' man and said that women called him at work at all hours. After hanging up, he would rate them. For his crimes, he eventually received multiple death sentences. Five years after his arrest, he now awaits execution.