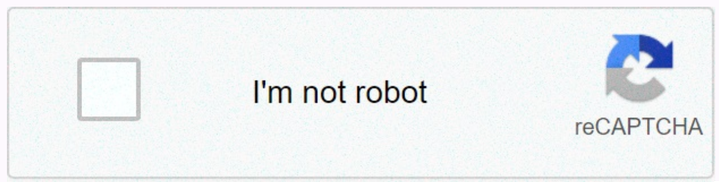

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Case formulation sample

C7 58 Diagnosis and Treatment Planning Dr. David Moore Argosy University-Seattle Page 1 Example of Case Formulation The treatment of dual-disorder CBT of a childhood trauma survivor I. Introduction to the theoretical model This client's assessment and therapy approach falls within the realm of behavioural therapy of counselling theory. In the behavioural side of counselling theory, cognitive behavioural therapy (CBT) 1 has been successfully used to treat anxiety disorders. 2 In this case study, the client has post-traumatic stress disorder [PTSD]; which is one of the most problematic mental health categories in the anxiety disorder cluster. The clinician uses the CBT methodology. A leading CBT theorist, Albert Ellis, has developed an enhanced CBT model called Rational Emotional Behavioural Therapy (CBTT) 3 that matches this client's treatment needs. The client's alcohol and other drug use disorder, distinct but related to her PTSD, is the second part of her double disorder. Rebt is an effective model of behavioural therapy to address the developmental history model of addiction treatment; which is most often treated from an area of psychodynamic therapy of counselling theory. In rebt, as a psychodynamic method [sometimes called psychoanalytics], the client's historical awareness of her progressive illness and her distortions in thought [i.e. problem denial] is addressed by what Ellis calls the ABC of irrational thinking. 4 The therapist helps the client self-assess with a REBT problem; which is called a first step in the Minnesota Chemical Addiction Treatment Model. 5 In the example of a transcript of the third session, used for explanatory purposes, the client takes her daughter to the therapist's office, which creates an adoption of the dynamic mother-daughter. The therapist allows the family dyad to naturally derail between the multiple dysfunctional subjects that have existed in family dependence and multigenerational trauma. In the session, the therapist uses the REBT framing model to show the dyad's inability to resolve decisions here and now due to long-standing irrational beliefs about their relationship. II. Basic Demographic Information Client Name: Laura Client Age: 42 Years Race: Biraciale 1 Sex: Female Marital Status: Single, Divorced Employment: Pedicure, Cosmetology Without Formal Education Reference: Tacoma Indian Center Treatment: Outpatient Clinic, Individual Counseling 1 Native American and European C7 58 Diagnosis and Treatment Planning Dr. David Moore University-Seattle Page 2 The main presentation issues are Ms. Client's efforts to develop a sustained recovery from addiction that includes the level of behavioural health required to parent a 14-year-old elderly relative who is part of the Washington State Early Intervention Program for Absenteeism and Delinquency [i.e. BECCA BECCA BECCA III. Summary of Clients' History 3.A. History of Addiction Laura Cliente was introduced to alcohol use by her family while she was in kindergarten. An anecdotal description told in his family is a joke about when the customer was a baby and could suck his bottle of beer but had trouble drinking his milk bottle. She remembers the continued drinking from the age of five when she was drinking with her grandmother. Her addiction was established in her elementary years and, at the beginning of her junior high school, she used marijuana, alcohol and hallucinogens [LSD).] Before reaching adulthood, dropping out of high school in his final year, his polydrug abuse degenerated into the addition of cocaine [including the highly addictive smoked version called crack] and methamphetamine. As she entered early adulthood, her memory was clouded by the poly-drug nature of her drug abuse, but she had added the highly toxic combined use of heroin and methamphetamine to her addictive behaviour. 3.B. Psychological functioning and history Parallel to the neglect of childhood by the consumption of alcohol provided by her family, she was verbally and physically abused by her parents and grandparents. In the midst of three children, she was the only adopted child. She perceives that this difference has led her parents to treat her worse than her siblings, not to feel accepted by her parents, and even to wonder if her parents wanted her as a child. His mother is an alcoholic. Aside from her very early exposure to alcohol, her mother's alcoholic behaviour created an environment that she describes as a reason for self-medication for her own alcohol consumption in adolescents and adults. At this level, it is able to link genetic and environmental influences on its dependence. She has an inaccurate perception that apart from the use of alcohol and other drugs, she did not really have any behavioural health problems. She also fails to connect her own mother — her daughter's story to her current situation with her daughter. Once her addictions began to include more expensive and addictive neurochemical drugs [methamphetamine, heroin and cocaine], she began to engage in prostitution and theft to finance her lifestyle. She also experienced psychotic symptoms in her adult life. She does not hear the control voices, but she hears and sees negative auditory and visual hallucinations. An explanatory anecdote provided by Ms. Client was an incident about three years ago when she believed that Satan was talking to her by the cheek. At the of this psychotic illusion, she took a scissor and cut a substantial piece of her cheek to eliminate Satan's influence. Currently, she presents with very low self-esteem, high levels of anxiety, and mood swings that have been diagnosed as bipolar disorder. She is now abstinent from the use of alcohol and other drug drugs C7 58 Diagnosis and treatment planning Dr. David Moore Argosy University-Seattle Page 3 continuing care in support groups; but has a lot of trouble dealing with the anger and frustration that she would historically sedate with one or more drugs. By developing services for Laura, health and social organizations help her develop her life skills when she has little or no prior learning. These deficits are further aggravated by insomnia created by dreams similar to the hallucinations mentioned above. Although abstinent from addictive drug use at the moment, it reports the onset of late-night compulsive over-education .A. 3.C. Education Ms. Client reported having good grades before dropping out of Grade 12. It does not point to any history of child education needs in particular. She plans to continue her studies to complete her GED and is considering post-GED business studies. She reports professional interests in cosmetology and pedicure services [apply makeup and be a nail artist]. She had no formal education in either activity. 3.D. Judicial history Ms. Client has been arrested in the past for prostitution and possession of narcotics. In light of his extensive adult lifestyle of admitted criminal behaviour, his time of incarceration seems less than one might expect. She was the victim of a crime with two extensive situations of rape. In the second rape, at the age of 19, she was held captive for three days by a man who repeatedly raped her when he put a gun to her head. In other areas of contact with law enforcement, whether as an offender or as a victim, she does not remember much about her past. She knows that she has had many legal interactions, but does not remember the details. She identifies her drug of choice for 30 years as methamphetamine, which has extensive links to the illegal drug manufacturing and distribution community. He also left her, as she notes, in a continuous fog. Currently, his main legal problems are the role of a parent. Her 14-year-old daughter, Jericah, is involved in the state absenteeism system [BECCA Bill]. Jericah stopped going to school and Laura can't figure out how to successfully intervene on this behavior. Jericah has a history of depression and self-injury [cutting] behavior. The client believes that much of Jericah's emotional pain and behavioural health problems are the result of Laura's drug abuse and parallel parental absence during childhood years. Mr. Jericah. 3.E. Social History In addition to her addiction, she also points out that her overall lifestyle has been influenced by problem gambling during periods of active use of alcohol and other drugs. She reports the assumption that if she played, she could get more money for the drugs. During the last period of abstinence from alcohol and drugs, she did not have any gambling behaviour. In recent years, years, I posted about the case formulation. Although I have presented the abductive theory of the method (ATOM) which is a process of inference of phenomena to the underlying causal mechanisms, this is not the only way to develop a formulation. I've posted about some of the other ways in which formulations can be developed, and today I'll describe a simplified formulation to show how it can work in practice. Remember that when I write about patients, I make sure that the details that can identify the individual are changed - or I describe a composite of several patients. Robert is a 39-year-old independent electrician who suffered a fractured non-dominant hand when he fell off a ladder two years ago. This rupture developed into a complex regional type of pain disorder i that had been slowly resolved with the use of the drug, functional restoration (classified daily use of the hand), and mirror box therapy. Robert showed up for pain management assessment when his progress plateaued, and he became increasingly distressed. He was evaluated in a complete three-part pain assessment in which he was seen by a medical pain management specialist, a functional evaluator and a psychosocial evaluator. He completed a series of pre-assessment questionnaires that were used to report areas for further investigation. The information was made available from the referent (the general practitioner), the case manager (clinical notes from the orthopaedic surgeon and the initial physiotherapy treatment provider) and an initial on-the-job evaluation that provided details of his work requirements. The medical assessment consists of a review of one's medical history, a complete musculoskeletal examination, a general review of systems, current and past medications used for pain management, and a specific pain examination. The objective is to determine whether all appropriate investigations have been completed, whether appropriate medical treatments have been continued and whether the drug regimen is streamlined. Functional assessment consists of a description of a 24-hour day (activity configuration, roles), an approach to activity (e.g., boom and bust, avoidance), a basic functional base (e.g., cardiovascular fitness, lifting tolerance, strength of adhesion) and physical examination (e.g. muscle length/herence, ROM, posture). Psychosocial assessment takes into account attitudes and beliefs; behaviours (including coping strategies, roles) Compensation issues diagnostic and iatrogenic problems Reactions including depression and anxiety Responses from family and friends (and their attitudes and behaviours) and finally, work issues. Robert's medical examination found that he had normal body systems including cardiovascular, respiratory, endocrine and neurological except for light-touch marked allodynia over a glove distribution of his left hand (non-dominant). Sur Sur his left hand was slightly swollen relative to the right, the skin a slightly darker color, the obvious changes in the growth of nails and hair, and cooler to the touch than the right. His scaphoid fracture had united, and there was no displacement or necrosis. He had responded only to gabapentin for pain relief, but had also found mirror box therapy provided him with 45 minutes of pain reduction after 10 minutes passive observation of the reflection of the unchanged hand. He had not responded to a previous infusion of pamidronate, but was taking a low dose of nortriptyline for night sedation and pain relief. Functionally, he had reduced the range of movement on the wrist, and his grip strength on the left was 2 sd below average for the non-dominant hand for males of his age, and compared to his right (dominant hand) which was 1 sd above the dominant hand average for males of his age. He has exhibited significant painful behaviour, cradled his hand and not using it when gesturing or removing clothing, or performing functional tasks such as lifting a box or clinging to the handlebars of the exercycle. He said he avoided using his left hand to eat, wash his hair, button shirts and zip, tie laces and similar activities. He was wearing a tight glove to protect the hand from involuntary light touch or air movement, water, etc. He had stopped working and reported that although he had performed the exercises recommended by his therapists, he avoided using his hand at other times. Psychosocial evaluation revealed that he believed doctors had failed to diagnose a serious nerve condition in his hand, and he thought that when his pain increased, it was because the nerve was badly cracked and it was a sign of further damage to his nerve. He believed that if his pain increased, he would get to the point that he would no longer be able to cope, and the results of not facing him would mean that he would be angry with everyone and lose the plot. Although he found that the pain was resolved, he was very concerned that it was only a temporary change. The majority of his behaviours have been described, but he also identified that he isolating himself, avoiding being with friends and family because my family is choking me with kindness. He had not received a weekly allowance because of the difficulty of obtaining his last tax statements from Internal Income, so he had no income replacement. While his salaries were paid for by the CCA, he had had to obtain transportation funding with the help of his physiotherapist and to pay for his medication. He could not afford to employ another person to cover his work, so his business was gradually running down. With regard to diagnosis or iatrogenic problems, he had received good information from his health care providers, but did not feel confident to ask his specialist what the term was Meant. He felt that he was not educated enough to challenge his expert recommendation that he continue to use his hand normally, and instead he pretended to follow their recommendations during therapy, but did not transfer that into daily life. Emotionally, he felt in tears, irritable, out of control and couldn't be disturbed about his normal activities. Even though his business was closing, he felt that his main goal was recovery rather than work, and he said he felt it wasn't really real. Family and friends had told him to make himself easy, and if his hand hurt, he would have to wait for him to improve before trying to do things like go back to work or use it around the house. His partner was frustrated and spooked by their financial situation, and angry that he had been taking shortcuts to work again.

And finally, his work situation was tenuous. As a self-employed person, he had minimized his income for tax purposes and had delayed the investment of his returns in Inland Revenue. He could not afford to employ another worker to keep the business running, and as a result, he was quickly in progress. He loved his job, and had a number of very enthusiastic entrepreneurs who asked for it. He was a specialized electrician who primarily wired comprehensive environmental control systems for people with disabilities. And tomorrow - let's put it all together! Together!

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