

PSY 210- Abnormal Psychology  
Professor Jennings  
Case Study Assignment  
20 points

NEW Due date: April 10<sup>th</sup>

You will select and review ONE case study provided in this packet. You will be responsible for reviewing the case and assigning multi-axial diagnoses. You will also be responsible for providing a rationale for the diagnoses, as well as a discussion of rule outs, differential diagnoses, and prognosis. This assignment should be 2-3 pages in length (typed, double-spaced, one inch margins). Please review the complete hand out included in the course syllabus for additional instructions.

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 put 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

At the time of his admission to a private psychiatric hospital, Sonny Ford was a 24-year-old single Latino male who lived with his adoptive parents. Sonny had been referred for hospital admission by his outpatient psychotherapist. Over the past 2 years, Sonny had struggled with symptoms such as concentration difficulties, anxiety, and obsessional thinking. More significantly, within the year prior to his admission, Sonny began to experience paranoid and delusional thoughts that had become quite persistent. These difficulties began after Sonny smoked marijuana. While experiencing the effects of marijuana, Sonny believed that his mind had gone “numb.” From that time on, Sonny believed that the marijuana had permanently “warped” his brain. He became increasingly distressed and frustrated over his inability to get others to agree that marijuana had this effect on him. More recently, Sonny had developed concerns that the police and FBI were “out to get him.” In addition, he had begun to feel that certain television shows had special importance to him and important information was embedded in these programs directed specifically at him. Sonny believed that these messages coming to him through the television were sent to remind him that he was at risk for some sort of plot by the authorities. Sonny also heard voices in his head. Although he could not make out what they were saying, Sonny perceived the voices as “angry” and “critical.”

Over the past few months, Sonny’s symptoms had worsened to the point that they were interfering substantially with his attendance at work as a state office janitor. Because of these factors and the lack of improvement in outpatient counseling, Sonny was referred to this inpatient hospital.

At the intake evaluation for his inpatient admission, Sonny’s emotions were restricted. Although appearing tense and anxious, Sonny’s face was mostly immobile for the duration of the interview. He engaged in very little eye contact with the interviewer and his body movements were agitated and restless, as evidenced by rocking movements of his legs and body. His speech was hesitant and deliberate, and he often answered the interviewer’s questions with brief and empty replies. For example, when the interviewer asked “what difficulties are you having that you would like help for?” Sonny replied, “I think it was the marijuana.”

### Clinical History

Sonny was adopted at birth, and no records were available about medical or psychiatric history of his family origin. Sonny was raised in a household of four: in addition to his parents, he had a sister 4 years older who had also been adopted. He could recall very few memories from his early childhood. However, Sonny said that throughout his life he had always been a loner who, to this day, never had any friends. Sonny’s parents, who were present at the time of his admission to the

hospital, confirmed that Sonny had always been frustrated by social interactions and added that their son had always been hypertensive to real or perceived criticism during his school years. Sonny was very attached to his father and, for many years, experienced considerable distress and loneliness when he was separated from the family's home or his father for extended periods. Whereas Sonny described his father as "a very accepting person" he claimed that his mother was "excessively critical and not accepting of me as a person." Sonny also claimed that his mother was an alcoholic, a statement that was not supported by either of his parents.

When Sonny was 16, he realized that he was homosexual. Although his father had been accepting Sonny reported that his mother had been very unaccepting of his homosexuality and often referred to him with pejorative labels, such as "fag." While Sonny accepted his sexual orientation, he said that being gay had caused him many troubles one of which was loneliness. Many of Sonny's persistent and obsessive thoughts focused on the possibility of contracting the HIV virus from having unprotected sex on one occasion. Sonny's fears of having HIV had not been quieted by the fact that the person with whom he had sex with was HIV negative or by the fact that all of his recent HIV tests were also negative.

Despite lifelong difficulties with social adjustment, Sonny had been able to meet most of the demands and responsibilities of adolescence. Following his graduation from high school (with a C+ average), sonny decided to attend a local college to take introductory courses. This decision was strongly influenced by his apprehension of moving out of his parent's house to attend school away from his immediate community. However, it was during his freshman year that Sonny had smoked the marijuana that he believed permanently damaged his brain. Following the incident, Sonny dropped out of college due to the worsening of behaviors. Sonny enrolled at a second college for only one semester before dropping out again, because of his inability to cope with sitting in crowded classrooms and completing assignments and tests on time.

Sonny has held his current position as a janitor for the last 18 months, in part because this position allows him to work alone and does not require extensive social interaction.