

Case conceptualization for depression and anxiety



**ASSIGN
BUSTER**

Include the following information regarding the client you will use for the Case Conceptualization assignments. (Information below may be submitted in bulleted format. Include at least 2 sentences for each component. If no information is available for a section please insert “ no information available or does not apply”)

1. History and Background Information

a. Identifying Information (age, height, weight, gender, gender expression, gender identity, SES, geography, married, divorced, cohabitating, single, etc.)

- 23 years old
- 5'6", 130 lbs
- Female (cisgender), heterosexual
- Lower middle-class
- Single, never married; cohabitating with her boyfriend for 7 years
- 2 children, ages 4 (female) and 6 (male)
 - The father of both of her children is her long-term boyfriend

b. Presentation/Behavioral Observations (i. e., appearance, mood, affect, speech, thoughts)

- The client was dressed appropriately for the session, wearing jeans and a button up blouse with athletic shoes

- She was well groomed, mentioning how she just had her hair and nails done earlier that day, for a party she was attending in the evening

- The client seemed upbeat and excited and overall had a positive demeanor at first observation.

c. Presenting Problem(s)

- Client at first did not appear to have any problems, she did not seem to have anything specific she wanted to talk about

- She was reluctant to share anything that might come across as negative, and required much probing and several questions before opening up about why she scheduled the visit.

d. History of the Presenting Problem(s)

- Client reports feelings of sadness and low mood, lasting at times for periods longer than two weeks over the course of the last year.

- She discussed feelings of worthlessness, accompanied by low energy levels and, at times, a noticeable difference in sleep and eating patterns.

- Client admits to feeling anxious when plans do not go her way, or when there is a last minute change in existing plans.

e. Psychosocial History (only include the history of things that are applicable)

- Family History

- Client discusses not having a relevant father figure for most of her childhood, and even going into adulthood; the times that she has seen her father were not under pleasant circumstances, such as a funeral or other type of catastrophic event.
- Her father never had a good reason or excuse for being absent, he told her once when she was fifteen that she was better off without him.
- Client was primarily raised by her single mother, who showed signs of anxiety and depression as far back as the client can remember.
- Her mother also continuously made excuses for the father not being present, which the client admitted made her feelings seem devalued.

- **Developmental and Social History**
 - Client reported that her mother was “ high strung” and was an authoritarian with her from a young age, especially when it came to her grades in school.
 - Her first sexual encounter was with her current boyfriend that she is dating and living with for the last seven years; from the time she was sixteen years old.
 - She reports not having many close or meaningful friendships due to moving and changing schools on nearly an annual basis.
 - The client describes her current circle of friends as “ people to have fun with and that’s it.”

- **Abuse/Trauma History**
 - The main aspects of abuse that the client reported from stemming from her relationship with her mother.

- She reported things such as name calling, breaking and throwing of objects, physical aggression such as yelling and shoving, and various forms of emotional manipulation such as name calling and gas lighting.
- The client reports that she never felt “ good enough” for her mother, and as a result was always fearful of criticism.
- Educational/Academic History
 - She reports that she has always been a good student, describing her grades as “ A’s and B’s most of the time.”
 - The client graduated from High School, but has not yet attended college despite aspirations to do so.
 - She reports that financial and time restraints are the main reasons for not attending college.
- Employment History
 - The client worked as a waitress throughout High School, and has worked her way up into a management position at a local restaurant.
 - This position is not her “ dream job” but she feels stuck due to her lack of education or experience in other areas.
 - She expressed a desire to find a job that she feels is “ more meaningful.”
- Medical History
 - Aside from her two pregnancies, the client has no significant medical history.
- Psychiatric History

- Client describes mental health as being a “taboo” topic in the household when she was growing up, therefore she had no formal Psychiatric history to report.
- She mentioned that her mother and some of her friends “made fun” of her when she confessed to them that she was seeking treatment.
- The client is initially hesitant to share her reasons for seeking treatment.

- Substance Abuse/Dependence History
 - She admits to using alcohol and drugs such as marijuana, cocaine, and ecstasy strictly on a recreational basis “and never around the kids.”
 - The client is adamant that this only takes place on weekends, and that she has never “needed” to seek treatment for substance abuse.
 - She confirmed that her usage does not affect her daily responsibilities, nor does she believe it affects her daily life.
 - The client described her drug and alcohol use as her way of “unwinding” after a long week or difficult day.

- Medication History
 - No reported history of prescribed medications.

- Legal History
 - No reported history of any legal issues.

- Military History
 - No reported history of Military involvement.

- Religious/Spiritual History

- The client self-identifies as being raised Catholic, but does not practice formal religion on a regular basis.
- She discussed having doubts about a higher power even existing, but goes back and forth on the concept in general.
- The client expressed disappointment in religion from an early age, when the Catholic Church she attended in the past “shunned” her after having children out of wedlock.

Case Conceptualization Three

The client discussed in this Case Study has been in treatment with the author on and off since August of 2018. First, the structure of Acceptance and Commitment Therapy (also referred to as Acceptance and Commitment Training, or “ACT”) will be presented, incorporated with the theory in which it relates to the client. Finally, the proposed treatment plan will be provided.

Theoretical Structure

Important Concepts

The history of Acceptance and Commitment Therapy cannot be discussed without mentioning Psychiatrist and Professor Steven Hayes, as well as Doctor Russ Harris. As Sharf described, “Hayes and colleagues believe that many psychological problems develop as people use ineffective methods to deal with their emotions, such as avoiding certain experiences.” (Sharf 2016, p. 622-623). Russ Harris is a more recent contributor to this theory, having written several books on the topic, in ways that the general public can easily understand.

There are many similarities between Acceptance and Commitment Therapy, and Cognitive Behavior Therapy. For example, both types of therapy focus on finding ways to help the client change the way they see and think about things. As Joel Guarna pointed out, “ ACT is an innovative form of behavioral and cognitive therapy that has built upon both the strengths and the weaknesses of traditional cognitive-behavioral therapy.” (Guarna 2018). They are both goal oriented, and considered short term. However, despite their similarities, many believe that ACT is one of the more modern theories that can be easily explained to clients.

Acceptance and Commitment Therapy focuses mainly on the concept of increasing a person’s level of mindfulness. As McWilliams stated about her client’s experience, “ her psychotherapy had given her a sense of knowledge and self mastery.” (McWilliams 2004, p. 218). This is also achieved through, as Sharf describes, “ an underlying behavioral theory of language and cognition called Relational Frame Theory (or RFT).” (Sharf 2016, p. 624). It is also achieved in conjunction with a series of six processes, which are listed as Acceptance, Diffusion, Being Present, Self as Context, Values, and Committed Action.

Relational Frame Theory

Acceptance and Commitment Therapy would not be complete without incorporating Relational Frame Theory. The primary focus of RFT is for a client to understand the relationship between the language they choose to use, and the way that language manifests itself into their behavior. For example, if a client wakes up in the morning verbally complaining about how

tired they are and what a rough day it will be, they will navigate throughout their day with that mindset.

In a way it is similar to the concept of a Self Fulfilling Prophecy, only instead of beliefs, RFT focuses on the client's choice of words. As Sharf explained, "once language is well developed, associations that individuals make become quick and difficult to control." (Sharf 2016, p. 624). For example, a client might associate hiking with an ex boyfriend, therefore whenever they hear language related to hiking, they are triggered to involuntarily feel and think about the ex boyfriend. Similarly, in Cognitive Behavior Theory, this would be described as the client's Automatic Thoughts.

Acceptance

The opposite of avoidance is acceptance. In terms of ACT, to accept means that the client learns how embrace things such as their thoughts, past history, harmful language, and actions. In a way, the client has to obtain the skills needed in order to let things marinate in their mind. This should also be done without clients judging themselves, or engaging in negative self talk. For example, clients with anxiety especially will need to gather the willpower to embrace their feelings of anxiety, without necessarily having to figure out what is causing it, or judging themselves in the process.

Diffusion

The second of the six processes is cognitive diffusion. In other words, it is the ability to change the negative or irrelevant thoughts that lead to undesirable behavior. For example, a client who is overweight, continuously thinks of

themselves as disgusting; they would not try to stop themselves from having the thought that their disgusting. Instead, they would think to themselves that yes they are having that thought and that it is okay to have that thought.

Clients could also remind themselves how frequently they have this thought, and that in the past it has not served them well. They could also assign the thought a color, shape, or turn it into an object in order to better visualize it. For example, when clients start to think of themselves as being disgusting, that thought could take the shape of a red ball. They could then visualize themselves popping the red ball and seeing that as a metaphor for stopping the thought from moving into a negative or self destructive direction

Being Present

The third of the six processes is the practiced art of being present. This process coincides with the popular practice of mindfulness. Clients are encouraged to soak everything in, down to the last minute detail. For example, when a client leaves for work in the morning, they should slow down and take the time to observe things such as the wind blowing outside, the sound of leaves rustling or neighbor's cars starting; if they drink coffee, they should take slow sips to really appreciate the flavors, and overall contemplate how they are feeling about all of these observations.

Self as Context

The fourth of the six processes is another mindfulness practice, referred to in ACT as Self as Context. This means that the client should become

increasingly self-aware of how they are thinking, feeling, and talking about themselves. For example, clients should learn to use more “ I” statements, rather than saying things such as “ they” or “ them.” Using “ I” more often in their vocabulary allows clients to be more accountable for themselves and their subsequent behavior after having their thoughts or feelings.

Values

The fifth of the six processes is identifying the client’s values. Acceptance, diffusion, being, present, and seeing oneself are all needed in order to discover what the client’s values are. As Sharf pointed out, “ when people identify values, they are able to contact sources of meaning through a variety of actions.” (Sharf, p. 629). Once their values are identified, the client can practice being more mindful with the things they are choosing to spend their time and energy on.

Helping a client discover their values can be a difficult task that requires a lot of attention to details. The counselor starts by asking the client to describe meaningful moments, as well as things they like. For example, by the client describing that they like to travel and that they wish they could do it more often, they are really saying that they value adventure and new experiences.

Committed Action

The sixth process is one that has the most resemblance to traditional cognitive behavioral therapy, which is committed action. CBT and ACT both incorporate goal setting during therapy. In this process, the counselor helps

the client to set goals for themselves, then uses various behavioral techniques in order to help them reach those goals.

Integration of Theory

My client's main struggle is anxiety, which often leads to other issues such as depression or difficulty managing her anger. "Often chronic in nature, anxiety disorders are associated with severe impairments across interpersonal and occupational domains." (Antony, M. M., & Stein, M. B. 2009, p. 4). She expressed concerns that her anxiety and inability to control it have drastically affected her relationships with her mother, boyfriend, and children. She did not see it as being a real issue until her oldest child described her to another parent as someone who is "always freaking out."

During the first or second session, it is important to establish the client's main concern or concerns, and decide on the best approach to take. "Assessing specific behaviors rather than broader characteristics or traits is the hallmark of behavioral assessment." (Sharf 2016, p. 299). She was asked to describe specific scenarios in which she felt she could have handled herself differently or constructively. She needed to explain the process in which her anxiety levels begins to quickly rise, and the stages that she goes through when presented with a scenario that makes her anxious.

For example, when her boyfriend tells her that he will pick the kids up from school, and then later in the day finds out he has to work late and is no longer able to pick them up, my client's initial reaction is to feel anxious. She explained that this initial feeling is not one that she can control, and that from there is where it begins to escalate. She goes from feeling anxious due

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to the scenario being one that she cannot control, to feeling angry with her boyfriend for “ never following through with plans.” She gets so upset that she decides to leave work early without telling anyone, and begins to repeatedly call her boyfriend while he is at work to yell at him for the change in plans.

When she finally goes to pick the kids up from school, her pessimistic mood is still in place, and she begins to snap at her children for what others might consider miniscule things. For example, she yells at her daughter for not brushing her hair, and at her son for not wearing a jacket. The children will later tell her that they felt as if she overreacted, and that they did not understand why she became so angry. Their moods quickly changed from being excited to see their mother as she often works afternoons, to wishing their father had picked them up instead.

During our session she begins by telling me that she does not think she has a problem with anxiety, that she is simple misunderstood by everyone else. The role as her counselor is to help her realize the consequences of her behaviors. Questions should be asked such as “ what did your boss/supervisor say when she found out that you left work unannounced?” or “ how did your boyfriend react to you calling him repeatedly to yell at him while he was still at work?” and “ did you notice any changes in your children’s mood after you criticized and yelled at them?”

The counselor’s goal should be to help her see herself as others see her, and how different that might be from the way she wants others to see her. Since she initially said in the first session that she didn’t even know why she was

there, it was clear that it would be a conversation that had to be carefully eased into. “ It is essential that the clinician conduct diagnostic and therapeutic interviews in a manner that acknowledges the patient’s worse fears and that provides an environment of sensitivity, safety, and trust.” (Antony, M. M., & Stein, M. B. 2009, p. 71).

Changes That Need to be Made

My client would benefit from a minimum of 20 more sessions with a counselor. Goal setting would be a relevant tool for her, such as aiming to slow down her initial reactions and only react after she has thought things through for a certain amount of time. Another goal would be for her to go back to school so that she can find a career that she is passionate about. Lastly, since she mentioned that she wanted to be a better mother, together we would also create a step by step plan for how she will reach these goals.

She would also benefit from Self Monitoring exercises, where she documents her thought process and consequences of her behaviors. For example, the next time she is upset with her boyfriend, she should allocate a minimum of 30 minutes to reflecting on how she feels and why she is feeling that way, before calling him. Lastly, she should find a way to relax, either through deep breathing exercises or meditation, before going to pick her kids up in an unpleasant mood.

In addition, Behavior Modification is crucial in her success. She should learn to reframe her automatic thoughts, such as everyone being against her, into realizing that she has a lot of people in her lift who care about her. Another thought she could reframe is the idea that her boyfriend ‘ never follows

through with anything,' and instead see it as him having a demanding job, which doesn't allow him a lot of flexibility.

Treatment Plan

General Presenting Concerns: depression, anxiety, and anger management

Behavioral Definitions:

1. The client underestimates the way her anxiety influences the quality of her life.
2. She sees her long term boyfriend as a nuisance instead of a life partner, often becoming easily angered with him.
3. Her detached attachment style towards her children and boyfriend results in feelings of isolation and meaninglessness.
4. She pretends that everything is fine on the exterior appearance to others, but on the inside she is experiencing a wide range of what are often unfavorable emotions that she does not know how to handle in a healthy way.

Long-Term Goals:

1. Reach the point where she can admit the fact that her anxiety has a negative impact on her quality of life.
2. Come to terms with the fact that the way her current relationship is functioning is unhealthy.
3. Realize that there are constructive ways to handle conflicts with people.

4. Learn constructive ways to resolve conflicts with others while remaining calm.
5. Find a job or hobby that she is passionate about, or one where she feels like she is making a difference in the world.
6. Reframe her negative automatic thoughts, particularly those that surround her sense of self-worth and feelings of worthlessness.

Short-Term Goals:

1. Continue weekly therapy sessions with a counselor who will be able to understand her needs, and have the patience to teach her healthy coping skills.
2. Work with a counselor on ways in which she can reduce her anxiety, symptoms of depression and anger outbursts.
3. Start a journal in which she writes every day, focusing on the negative outcomes that resulted from an angry or anxious outburst.
4. Learn to reframe her negative thoughts into positive ones.
5. Make time for self-care so that she does not feel burnout from the responsibilities of adulthood and motherhood.

Therapeutic Interventions:

1. Help the client cope with her depression, anxiety, and anger management through methods such as goal setting, self monitoring, and behavior modification.
2. Establish specific goals, with outlined steps, to help her reach the increased quality of life that she desires.
3. Focus on attempting to repair the client's relationship with her boyfriend, even encourage him to join her in at least 5-10 sessions.

4. Guide the client into learning about what a healthy relationship looks like, so that she can mold her future relationships in that way.
5. Help the client learn how to accept accountability for her actions and decisions with positive and negative reinforcement, and reframing her negative automatic thoughts.
6. Use the concept of teamwork to help the client realize that she still has work to do on her own, especially after the sessions end.

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