

Diagnostic and treatment formulation of emily



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Introduction

Emily is a 41-year old Caucasian female who has come to the clinic seeking help for her feelings of depression. Emily is a substitute school teacher and has had trouble finding work in her district. She has been on unemployment since May of 2010, and reports increasing feelings of depression since this time. She cannot pay her bills, nor can she afford the major dental work she needs - she is frustrated. Described below is a diagnostic assessment and treatment plan following Emily's visit to the clinic.

Assessment

Emily is depressed and angry. She reports having few friends, and those closest to her are in Michigan where she was born. Emily is the oldest of two sisters, both of whom endured physical and emotional abuse at the hands of their alcoholic mother. Their father was quiet and passive in the face of such abuse - " he never got involved and kept to himself." Emily admits that she gets bored easily, and that she has pursued many careers over the last several years. Nonetheless, she has been receiving unemployment since 2010, and her precarious financial situation is a major factor in her current distress. In session, Emily displays anxious tendencies, picking at her fingernails constantly. These behaviors become more aggressive when more sensitive subjects are broached. Her past trauma manifests in her current behaviors, both consciously and subconsciously.

Emily reports a history of abuse. Her mother constantly made her feel worthless, " that she was not good enough to do anything". Emily reports that she is now unable to move forward in her life, and that she feels as

though she sabotages anything good that happens to her. She attributes this stagnation and self-defeat to her past with her mother, who Emily feels “ did not allow her to feel good about herself” and “ did everything in her power to make her life difficult.” Emily has taken steps to address her mother’s abuse – she has attended Alcoholics Anonymous for the past year to try and deal with her mother’s alcoholism. Emily has shown initiative and resolve to address her own mental health concerns as well – she recovered on her own from her battle with bulimia, and currently attends Debtors Anonymous to help ease the stress of her financial situation. Nonetheless, the effects of her past and her mother’s abuse are evident – Emily in session meanders from topic to topic but focuses mainly on her mother, injecting her statements with palpable anger and resentment. Central and fundamental to the problems Emily experiences today is her past with her mother. It has affected her current, adult relationships. She has learned to be invisible, perhaps to minimize the possibility of or reasons for attack upon her to occur, but then consistently seeks out narcissistic, alcoholic men who treat her poorly.

Final Diagnosis

Emily symptoms most clearly match those associated with a diagnosis of major depressive disorder (MDD). According to the DSM-5, there are 9 primary symptoms of major depressive disorder, and the client must display at least 5 of them. These symptoms must occur within the same 2-week period, and the client must have experienced these symptoms for at least 2-weeks. Emily clearly meets 5 of the 9 criteria. Emily experiences a depressed mood – she specifically reports increasing depression since her

unemployment began in 2010. Emily exhibit diminished interest or pleasure in her daily activities – she is frequently bored, has had many careers in the past several years, and she has not pursued an intimate relationship in 10 years. Emily displays psychomotor agitation – she is restless and agitated, and such behaviors increase when discussing sensitive topics such as those related to her past trauma. Emily has feelings of worthless and guilt – she reports that she cannot move forward in her life, and that she sabotages anything good that happens to her. Emily displays diminished concentration – she has engaged in many careers over the last several years, and still reports being easily bored.

Emily's experience is recurrent and chronic, beginning in at least 2010. It is difficult to determine the severity of Emily's distress – while the effects of her depression on her social and occupational functioning are not minimal, eliminating the possibility of a ' mild' specifier, whether or not the impairment of her functioning in these domains results in a moderate or severe specifier is at the discretion of the clinician. Emily's distress warrants a specifier of anxious distress. During the majority of days of her depressed episodes, which this clinician argues are all days since 2010, Emily has had the feeling that she might ' lose control of herself', evidenced by her statement that she feels as though she has to " destroy [the men she dates] before [they] destroy me", and, Emily has felt ' keyed up and tense', as evidenced by her self-professed feelings of anger and resentment, and the vitriol with which she expresses these emotions. The presence of these two symptoms constitute a designation of mild anxious distress. Emily does not display any psychotic features, nor does her distress appear to be in any

type of remission. Thus, the formal, final diagnosis for Emily given the provided information is 296.32 (F33.1/33.2); Major Depressive Disorder, Recurrent With Mild Anxious Distress, Moderate/Severe. The following V and Z codes add further dimension to her diagnosis;

Theoretical models

The mode of treatment I would provide for clients like Emily is informed by different theories that exist in the domain of psychology, namely behavioral, cognitive and psychodynamic. There is much overlap between these theories, indeed, cognitive theory traces its roots to psychodynamic theory. Moreover, the current best practice is to combine both cognitive and behavioral theories in to an approach known as cognitive-behavioral therapy. My approach would be to investigate the conscious and unconscious forces that shape Emily's perspective on the world, with a specific emphasis placed on her childhood experience of trauma with her mother. I would then expose the conscious and unconscious forces discovered in such an investigation to cognitive-behavioral therapy so as to address specific thoughts and behaviors that either perpetuate or exacerbate her feelings of depression. This syncretic model is my approach to therapy and indeed all things - to be zealous about or to adhere uncompromisingly to a model or a set of beliefs is far too rigid an approach to life and all its messy ambiguity. Rather, taking what works from each theory with the express purpose of molding a treatment that works best for the individual client is the salient concern.

Treatment plan

Therapeutic relationship

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Emily exhibits a strong attachment towards her therapist. She recognizes that therapy is helping her and shows her gratitude for this help through many gifts and praise for her therapist. This is a good foundation for a fruitful client-therapist relationship, though it is one the therapist should perhaps monitor such that the client does not project undue or inappropriate feelings on to them. Moreover, Emily has shown initiative and indeed success at addressing mental health issues in her life, overcoming bulimia and attending AA meetings, indicating a receptiveness to therapy and the resolve to follow it through. Emily's experience with and enthusiasm for the therapeutic process bode well for her in terms of her overcoming her current depressed feelings.

Short term goals

- Emily will undergo a full physical examination, complete blood count and general chemistry screening, a thyroid function test, and a test of urine toxicology – REFER TO PRIMARY CARE PROVIDER
- Emily will expand her social and support network
 - o Emily will take her roommate out to dinner at least 2 times a month
 - o Emily will engage in one additional extracurricular or recreational activity
- Emily will seek other avenues of income

Middle stage goals

- Emily will be able to identify and be able to explain personalized causes of depression

- o Emily will develop vocabulary to describe depression
- o Emily will be able to identify the cues for and symptoms of her depression
- o Emily will be able to identify areas of vulnerability that underlie her depression
- o Emily will be able to identify triggers of her depression
- o Emily will be able to identify problematic coping mechanism developed to address her feelings of depression

Long term goals

- Emily will report depressed mood less than once a week
- Emily will be able to reduce her overall level, frequency, and intensity of anger and resentment so that her daily functioning is not impaired

Interventions

The treatment regime I would propose for Emily is one composed of two interventions: psychosocial interventions in the form of CBT and pharmacological intervention in the form of antidepressant medication.

Cognitive-behavioral therapy focuses on the interaction of the individual's thoughts, emotions, and behaviors (Rude & Bates, 2005). The goals of this technique include teaching clients how to identify their dysfunctional thoughts and beliefs, and how these dysfunctional thought processes affect their feelings of depression (Vidair & Gunlicks-Stoessel, 2009). Those suffering from depression have negative internal thought patterns and

recursive negative feedback loops regarding about themselves and the world around them (McBride, Atkinson, Quilty, & Bagby, 2006). “ The theoretical rationale of using cognitive-behavioral therapy rests on how individuals cognitively structure their view of the world and how their unique patterns of thinking influence their affect and behavior” (Hamamci, 2006).

CBT is that modality which will help accomplish the stated middle stage goals, and, along with her medication regimen, lead to the eventual realization of the stated long term goals. Emily will need to rally her strength and resolve to being the process and accomplish the stated short term goals.

Medication will be prescribed by a qualified practitioner, whatever modality of medication that practitioner deems appropriate for Emily. The likely first medication prescribed will be a form of new-generation antidepressants, like an SSRI (selective serotonin reuptake inhibitors).

The literature indicates that for mild or moderate forms of uncomplicated depression, individual psychotherapy alone is sufficient enough to mitigate client’s distress. However, as has been noted, Emily’s distress straddles the border between moderate and severe distress, and her depression is most certainly complicated by her past trauma. Thus, a combination of psychotherapy and psychopharmacology is warranted in this instance.

Law and Ethics

As with any healthcare provider, an MFT must operate within their Scope of Practice and Scope of Competence. The legal bounds of what the MFT can and cannot do are, in CAMFT’s words, the “ breadth of functions [MFTs] may

lawfully perform". While indeed a total and complete treatment of major depression utilizes a dual approach of psychopharmacology and psychosocial interventions, it is beyond the scope of an MFT, for instance, to prescribe the medication a client might need. This falls within the purview of a medically trained doctor. An MFT can encourage the client to take medication already prescribed, or refer the client to a trained professional, but it is within the best interest of the client for clinician to stay within the scope of his or her practice.

Ethically, the MFT must operate within their Scope of Competence. As the CAMFT describes, competence is "based on the individual MFT, what s/he is able to provide; it is determined by one's education, training, and experience". While a master's in MFT serves as a baseline legal requirement to begin a practice, the actual skill set and training of a clinician is ongoing, continuing after the clinician receives their master's. Competence is then defined by the training, education and experience of an individual MFT. In the context of depression, if I am an MFT who has kept up to date on developments in the field regarding cutting edge research and treatment for the disorder, then it is within my scope of competence to attempt to treat the client. If I know I have not however kept up to date on cutting edge developments, then treatment of a client with depression may lie outside my scope of competence, and it may behoove me to refer the client.

Conclusion

Given the provided data, the most appropriate diagnosis for Emily is Major Depressive Disorder, Recurrent With Mild Anxious Distress, Moderate/Severe

(296. 32 [F33. 1/33. 2]). Emily entered the clinic reporting feelings of depression following an extended period of unemployment, but even an initial assessment of Emily reveals a complex and fraught family history of abuse and mental illness which necessarily inform her current feelings. It would be unreasonable to assume that Emily's past traumas have no bearing on who she is and what she experiences today. Thus, the treatment plan for Emily's distress includes addressing the underlying causes of her depression (likely her past trauma) using a psychodynamic investigation, alongside addressing the current manifestations of her distress using cognitive-behavioral therapy. These psychosocial interventions will be performed alongside psychopharmacological interventions.