Caroline's disease

Psychology

Case Study Case Study The client is a 51-year old married Caucasian woman d Caroline who lives in a large metropolitan in, North America with her husband. She has no children of her own, and she spends most of her free time with her extended family. She is seeking treatment because her family physician referred her for psychological treatment. This is because she was taking drugs for her anxiety disorder to which she has never received psychotherapy. Her main symptom is a fear that she will harm other people indirectly by her presence. She has, therefore, made it her duty to protect the world from herself. According to her, everyone she encounters is potentially in danger especially her friends, family members, and children. These thoughts have caused Caroline and her family immense stress, and that is why she seeks psychotherapy. From these symptoms, it is clear that Caroline has obsessive compulsive disorder (OCD). Individuals with this anxiety disorder have unwanted thoughts that become obsessions which prompt them to want to do something compulsively. This patient has obsessive and compulsive characteristics typical to an individual suffering from OCD. This is because she has intrusive unwanted thoughts that have taken over her life, and became an obsession (Jones, 2000). When she wants to get rid of the thoughts, she has to engage in compulsive activities such as flicking her fingers and closing her hands into fists. She also prays a number of times and uses repetitive phrases such as " just goodness" when she feels she cannot contain her negative effects on people. Some of her other repetitive behaviors include raising her eyebrows and continuously blinking her eyes. At around the age of ten years, Caroline witnessed the hospitalization of her mother who had fallen severely while pregnant. It must be during or after this experience that her " bad thoughts" began from which

she believes she can spread " bad energy" and harm people close to her. She might have blamed herself for her mother's fall and her hospitalization and as a result, developed ways to deal with the fault. In addition, her best friend, another person close to her died and this also affected her because the best friend is that one person closest to her more that everybody else. At present, she is most scared of bringing harm to those people close to her such as her friends, children, husband, and other family members. Therefore, she developed ways to protect them from her thus developing the anxiety disorder. Individuals with OCD are usually trapped between severe worries their lack of the capability to control them thus look for other coping strategies (Jones, 2000). Caroline experiences unwanted thoughts of harming people close to her and those she encounters. This associates with cognitive model, which provides a description of what cause OCD. The frequency and duration of her obsessions and compulsions meet the diagnostic criteria for OCD. The cognitive model postulates that individuals have dysfunctional beliefs and evaluations that cause obsessions and compulsions. From Caroline's situation, one can conclude that the strength of her compulsive responses. Cognitive behavioral therapy is a way of treating Caroline's OCD. Carrying out an assessment using this method would first require confirming the diagnosis during the first sessions. Then there is identifying how the OCD started which will guide in formulating a plan to help her treatment process. The treatment involves 15-20 sessions of 50 minutes each depending on her response. The sessions are more frequent at first, and as time passes, I decrease the frequency. Each one of these therapy sessions has their agenda. Step 1 involves sessions 1-4, where we identify minor dysfunctional automatic thoughts looking at past events. Then we look at how these

events affect her moods through role playing scenarios. All the while, I make sure to keep daily records and note the dysfunctional thoughts to confirm that she has OCD. On the fourth session, I explain to her about her condition and the ensuing treatment process. The second step (sessions 5) involves identifying the connection among the thoughts in the cognitive behavioral therapy model. This is when I teach her about the model and the three components of behavior, thought, and emotion. In step 3, (sessions 6-8), I teach her to act like a scientist and evaluate the ability of defeating her thoughts. Thoughts and conclusions about events are noted as tentative. Step four in these sessions involves substituting more reasonable interpretations to her thoughts as we develop and record rational responses to which she needs to believe. The final step (sessions 8-12) is highly critical as it involves identifying and changing her dysfunctional belief that she is not aware. These are the beliefs that caused her OCD and to modify them to more reasonable ones is significant to her recovery. At this point, Caroline can identify the difference between her unrealistic thoughts and normal thoughts thus beginning her healing process. To ensure complete recovery, I will carry out booster sessions after the end of a successful treatment to monitor her progress. In the end, Carolyn will no longer be afraid of bringing harm to others as she now understands that it is not her fault whenever unpleasant things happen to other people (Jones, 2000). References Jones, K. (2000). Theoretical approaches to obsessive compulsive disorder. Cambridge: Cambridge University Press.