Case Reflection:

Adam's Case Study

Kevin Hull

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Westfield State University

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Abstract

The purpose of this report is to reflect upon a case that involved an individual that started treatment as a resistant individual, however opened up after building a strong relationship with the clinician. At the start of the report you will read a brief assessment of Adam including a clinical formulation and diagnosis. Then you will read the section about the interventions that were implemented and the individual's achievement throughout treatment. Lastly, you will read about the first five objectives for the class and how the clinician has mastered them through his work with this specific case and other cases that he served.

Keywords: Post-Traumatic Stress Disorder, Major Depressive Disorder, Empathy, Transference

ASSESSMENT OF ADAM

Basics

Adam is a sixteen-year-old (almost seventeen) Caucasian male. Adam currently resides in Chicopee with his mother (45), father (47), his younger sister (5), younger brother (13), and his older half-sister (20). Adam is currently enrolled as a junior at Chicopee Comprehensive High School and is single. Adam is seen at River Valley Counseling Center through the School-Based Program in an out-patient capacity. Services are voluntary and completed while in school. Adam has been in services since the start of September 2016 and sessions are comprised of Adam and the clinician.

Reason for Referral and Current Involvement

Around the time his brother died (technically this individual is Adam's half-brother however he does not identify him as his half-brother), Adam reported self-harming behaviors, such as cutting. He stated that in September 2015, he had suicidal ideations and he held a knife to his neck but did not act any further. Adam's mother stated that he had told people he was hearing voices telling him to kill himself or others. School requested assessment at the close of last school year due to "issues" regarding auditory hallucinations telling him to kill, but it was also related to depression and anxiety over unresolved loss and trauma.

Adam's History

Adam constantly reports verbal and emotional abuse from his father, yet he has never expressed physical or sexual abuse. Adam also stated that he feels his father has been emotionally neglectful in the past, such as not being a positive role model or father figure and also not being reliable or dependable. Adam reports witnessing his father doing and dealing drugs in his presence, yet this has not happened in years. This places a lot of pressure on Adam because he

feels that it is his duty to be a father figure to his younger siblings because he is the oldest male sibling in the family.

Adam reported that the sudden death of his brother in 2013 is an extremely traumatic event for him. He stated that his brother died of an overdose of drugs and alcohol and he was present in the house during the finding of the body the next morning. Adam feels a great deal of guilt over not "being there" or doing something to otherwise change the situation with his brother.

Prior to his current treatment at River Valley Counseling Center, Adam has no past treatment of mental health issues. However, Adam reports that he believes his depression started around the age of nine. In addition, Adam reported that he was seen at Baystate Hospital a few years ago for a panic attack.

Adam's Family History

Adam reported that he was born and raised locally and that due to marital discord his mother had wanted to move the family to North Carolina in 2013. However this did not happen because his older sister wanted to be able to finish high school and had a boyfriend here. Adam's father is reportedly in and out of medical facilities due to obesity and Adam "resents" him as a father. Prior to his death, Adam's brother struggled with substance abuse and mental health issues and was reportedly in and out of the home and Adam's life because of these issues.

In addition, Adam and his mother reported family history of mental illness and substance abuse on both paternal and maternal sides, specifically depression and bipolar disorder. There is also a significant family history of diabetes. Adam's mother also stated that his maternal uncle was murdered at age forty-two and maternal aunt died due to complications with asthma. Furthermore she stated that while at inpatient psychiatric units, Adam's brother made threats to

strangle other patients and also threatened to harm himself, and on one occasion did harm himself.

Clinician Formulation

Adam is a sixteen-year-old male who lives with both of his parents and his three siblings, two that are younger and one that is an older half-sister. Adam also had an older half-brother that died due to an overdose of heroin and alcohol in 2013. Prior to the death, Adams half-brother was in and out of hospitalization for mental health and substance related reasons. In addition, Adam has expressed emotional abuse from his father and has stated that he is "not a person he can rely on" and believes that his father "caused" his half-brother's death. These beliefs and feelings have created feeling of "resentment" towards his father that is often displayed by angry outbursts. On a more positive note, Adam is currently a junior at Chicopee Comprehensive high school and reports doing well in school. Adam participates within school activities and is well-liked by many teachers and students.

Adam was referred to River Valley Counseling at the end of last school year due to concern about auditory hallucinations of his brother telling him to kill himself and others. Prior to these hallucinations Adam practiced self-harming behaviors shortly following the death of his brother, but reports that these behaviors no longer occur. In addition, Adam reported a single incident where he experienced suicidal ideation, however did not carry out his plan. Adam has never received prior mental health treatment.

In spite of everything Adam has experienced, he currently is able to function well both in and out of school. Adam reports feelings of prolonged sadness and helplessness beginning at the age of nine. Adam often withdraws from society in times of sadness and reports that he "wants to remain in the middle of the pack (in school) so he does not get attention." In addition to the withdrawing behaviors, Adam also avoids situations and places that remind him of his brother.

He fears that any memory of his brother will spark a negative flashback causing him to blackout. Adam also reports vivid nightmares about his brother that cause him to wake up in the middle of the night screaming. Adam reports that he struggles to confide in people, no matter the gender, sex, or age of the individual.

Adam is highly intelligent and very motivated to change but tends to withdraw in times of sadness. Adam would benefit from a safe space to explore his thoughts around grief and loss, and some trauma and coping skills for recurrences of these symptoms. In addition, Adam could benefit from Cognitive-Behavioral Therapy and exploring his thoughts, feelings, and behaviors.

Adam has been clinically diagnosed with Posttraumatic Stress Disorder (PTSD) due to his behavior of intrusive thoughts, avoidance, and hyperarousal. In addition, to PTSD the social worker is comfortable in diagnosing Adam with major depressive disorder due to his behaviors of withdrawal, hopelessness, and extreme guilt (American Psychiatric Association).

**This assessment is based off the initial sessions with Adam.

Treatment Plan- these goals and objectives were created mutually by the clinician and Adam.

Goal #1: Explore and resolve grief and loss issues
- Objective #1: The client will increase his understanding of grief and loss by 50%
  - Intervention #1: The client will identify steps towards managing grief.
  - Intervention #2: The clinician and client will develop a short-term action plan for dealing with grief and loss.
- Objective #2: The client will talk through brother's death and personal feelings around the death during individual therapy twice a month.
  - Intervention #1: The client will initiate discussion about brother's death once a month and talk about feelings around the death.

Goal #2: Symptoms of depression will be significantly reduced and will no longer interfere with the client's functioning.
- Objective #1: "I really want to figure out all my family stuff." Client will identify at least 3 situations where he will "put himself first."
  - Intervention #1: The client will learn to take care of self before others, at appropriate times.
- Objective #2: The client will use less negative self talk by 50%.
  - Intervention #1: The social worker will provide client with ways to challenge his negative self talk. (i.e. what is my evidence that I will fail at this task?)

Objective #3: The client will utilize coping skills discussed in individual therapy 75% of the time.
Intervention #1: The client will focus on building supports who he is willing to talk about his "feelings" with.
Intervention #2: The client will find an activity that he enjoys doing, such as wrestling, to relieve stress and build relationships.

Goal #3: The client will increase and practice ability to manage anger.
Objective #1: The client will verbalize his emotions around anger to his mother and aunt once a month.
Intervention #1: The client will identify feelings and emotions he feels when angry while in therapy.
Objective #2: The client will learn what triggers his anger and frustration and will state his triggers to the clinician twice a month.
Intervention #1: The client will identify situations that make him angry and/or frustrated.
Objective #3: The client will increase his low frustration tolerance by 50%.
Intervention #1: The client will learn three ways to communicate verbally when angry.
Intervention #2: The client will learn two positive anger management skills.

**Adam's treatment goals are set to be completed by September 26th, 2017 one year from the creation of the initial treatment plan.

REFLECTION

Interventions and Achievement of Therapeutic Goals

Within the intake session with Adam and his mother, I discussed with them the possibly of medication and if they would be open to talking to the prescriber. Even though Adam and his mother were open to medication, they both wanted to attempt to resolve the presenting problems without medication. I respected their decision and seven months later medication is still not part of the treatment. Within the NASW Code of Ethics it states, "Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals" (National Association of Social Workers, 1999).

When working with Adam, the main focus of my interventions were based around Cognitive-behavioral approaches. The most prevalent interventions that have been used throughout treatment with Adam stem from Cognitive Behavioral Therapy (CBT). CBT at its most basic form is based around how individuals think, how an individual feels, how an

individual acts, and how each of these three ideas interact together. Simply, an individual's thoughts establish how an individual feels and behaves. The overall goal of CBT is to change patterns of thinking and behaving of the individual, which in turn will change the way the individual feels (McLeod, 2015). Assisting Adam with developing awareness of his thoughts and schemas may lead to Adam understanding his depressive and anxious feelings.

Adam has a lot of distorted cognitions that I believe lead him to have feelings of irritability, hopelessness, and excessive guilt. Multiple times Adam has stated to the social worker that even though society states that children are supposed to respect their fathers, I do not have to do that because he does not show me respect or love. Adam's beliefs and perception of his father is that no matter what his father does, it is abusive and forceful. In addition, Adam only notices the negative things that happen to him and not notice the positive things. Lastly, Adam has irrational beliefs and thoughts that he could have done something to change his brother's death. Adam believes that his brother's death was his fault because the day before the death, Adam got into a fight at school and Adam's brother had a discussion with him about not getting into fights because it ruins lives.

Due to Adam's automatic thoughts and schemas that derived through this life experiences I used interventions such as; identifying and challenging negative thoughts (e.g. negative self-talk and self-blame); identifying and connecting Adam with enjoyable activities such as hobbies, social activities and exercise; and keeping track of feelings, thoughts and behaviors to become aware of symptoms. Even though these interventions are broad and unspecific they have allowed me to create more focused interventions such as thought stopping techniques, mindfulness, and questioning. On multiple occasions Adam reports using different coping techniques that we discussed within treatment, such as deep breathing or thought stopping. Even when they are not

effective I praise Adam and his attempt in trying the technique. I feel that every time I show praise towards Adam he gains confidence within treatment and our therapeutic relationship becomes stronger.

In addition to the Cognitive-behavioral approach and CBT interventions, I have also attempted to incorporate Ecological approach throughout Narrative Therapy. Through Narrative Therapy I am able to build a relationship with Adam and provide him with constant validation. Also, I was able to meet Adam where he was at and assist Adam in realizing that all systems within his life affect his mood and behavior. In addition, Narrative Therapy allows me the space and structure to incorporate normalization techniques within treatment. I constantly normalize Adam's feelings and explain to Adam that he is not defined by the problem, but instead the problem exists as a separate entity.

Adam has made great progress within treatment and reports a significant decrease in depression, anxiety, and anger. Adam reported to me that he no longer wants to withdraw when upset and states that he has become much more social in and out of school. Adam has obtained and begun to practice multiple mindfulness techniques that decrease his symptoms of depression, anxiety, and anger. Adam's progress towards his treatment goals is remarkable and I believe that his progress will continue to occur.

Course Objections

"Demonstrate understanding of the individuality of adult experience and a respect for the adaptive growth potential in all people."

As a sixteen-year-old adolescent, Adam is transferring into young adulthood and is beginning to demand independence. However, he is struggling to gain this independence because he believes that it is his duty to protect his siblings from his father and be a father figure for his younger siblings. When I began working with Adam I felt that it would be a great idea to get him

involved with an after school activity and after discussing it with his mother she agreed. However when I brought up the idea to Adam in the fall, Adam made it clear to me that he was not ready to take that step of leaving his siblings home alone after school with his father, which I completely respected. “People live and move within a stream of time, and their situation at any given moment is a product of who they have been and what they have learned throughout that stream of time” (Moursund, and Erskine, 2004, Pg. 34). Fortunately, in the winter Adam stated to me that he wanted to join the wrestling team and he was very excited to wrestle throughout the winter. However, about a month into the wrestling season Adam decided to quit due to not being home with his younger siblings after school. Even though it was unfortunate thay Adam could not continue an activity that he enjoyed due to the fact that he believes he has to protect his siblings, the month that he did participate in wrestling showed his potential for growth. Within treatment Adam and I explored his feelings of not being able to continue an activity due to his fears and Adam expressed that, “my family needs me more than I need sports, but I am sad that I had to leave my teammates.” Through these conversations, I constantly validated Adam’s feelings around anger and sadness. In addition, I constantly praised him for being involved for as long as he was and for how far he has come since the fall.

“Apply a critical and self-reflective understanding of how the theoretical orientations of clinical social workers inform their responses to client communications and interactions.”

As a clinician, I use a combination of theoretical orientations when working on a case, such as Cognitive-Behavioral approach, Ecological perspective, Strengths perspective, and Psychoanalytic perspective. In the first chapter of the Moursund and Erskine text it stated, “Psychotherapy does not happen in a vacuum…Any approach to psychotherapy inevitably overlaps to some extent with other approaches that are being used and have been used in the past” (Moursund & Erskine, 2004, pg. 1). Having a wide range of knowledge enables me to

communicate and interact with Adam with a high level of competence. After getting to know the individual and building a rapport with that individual, the clinician can begin work from a perspective or perspectives that will have a strong impact. For instance, most of the work that I do with Adam is through a Cognitive-behavioral and Ecological lens (as stated above). Through research and supervision I have gained an appropriate level of understanding of how to select appropriate interventions and evidence-based treatment. However, I understand that all individuals are different, and one intervention that may be beneficial for one person may not be beneficial to another. For example, Adam enjoys Thought Stopping interventions and mindfulness techniques, yet other individuals that I work with dislike those interventions and techniques. As a clinical social worker it is crucial to have a wide range of understanding around theoretical orientations and how they intertwine, because all individuals that you serve are different and individualization of interventions is important for change.

"Utilize a framework for clinical assessments which can be used to individualize clients and their situations, including relational concepts such as transference and countertransference."

When I was first assigned Adam, I was told that, "he needs a good male role model" and I began to question what his experiences with other males within his life have been. Then during the intake session, Adam and his mother discussed a lot about his father, his father's friends, and uncles all in negative ways. After completing the intake I went back to the office and began to think about a way to tackle this case, and I began to think that Adam is going to struggle to engage within the session due to the fact that I am a male and his lack of trust with males within his life.

> The dynamic unconscious becomes transformed primarily through analysis of resistance — that is, the investigation of the patient's expectations and fears in the transference that if his or her central affective states and developmental longings

> are exposed to the analyst, they will meet with the same traumatogenic, faulty responsiveness that they received from the original caregivers (Stolorow, 1992, pg. 29).

And as I predicted, Adam was very resistant and reluctant to discuss his feelings within the initial sessions within treatment, however remained motivated for change and engaged through sessions. Adam would often state that "I do not like to talk about my feelings" and "No one understands what I am going through." When Adam first made this statement I did not disagree with his statement. In fact, I answered, "you are right I do not know what you are going through so could you please help me understand." I understood how his experiences with other males and/or people of "power" may have influenced Adam's behavior and concerns within treatment. I attempted to empower Adam and give him a voice of his own by having him discuss and explore his fears and distrust, of me and others, within treatment. I believe that through this intervention Adam began to trust our therapeutic relationship.

"Demonstrate an appreciation of the ways in which social and economic justice are fundamental to the practice of clinical social work and how a commitment to meeting individual needs is an essential component of this goal."

Throughout my time at River Valley I began to appreciate the ways in which social and economic justice set a foundation for clinical practice. When Adam began wrestling he reported that his parents did not have the money to buy the shoes or head gear, and he could not officially wrestle in the matches (only practice) until he could afford the equipment. This absolutely broke my heart that Adam could not fully participate due to a lack of financial stability at home and I believed that it was my duty to "protect" him. Due to my feeling of needing to protect, I took it upon myself to talk to the school and the wrestling coach to inquire about obtaining free equipment. Unfortunately, both the school and the coach told me that it was not possible to only

provide one student with free equipment; however Adam was very appreciative that I attempted. After this situation occurred I questioned why I was so protective over Adam and I believe that "the impulse to protect stems from the therapist's sensitivity to the nuances of the client's feelings" (Moursund, and Erskine, 2004, Pg. 101).

"Apply professional social work values and ethics as a core aspect of clinical practice in prevention, assessment, treatment, practice evaluation and advocacy."

When I began working with Adam, I constantly questioned why he was resistant and withdrawn within sessions. I began to believe that nothing was getting completed within treatment and thought that perhaps I was not competent enough to provide Adam with the proper services that he need. However, after talking to my supervisor multiple times about this case I came to realize "…it is possible that there are benefits of withdrawing into a sad state after a major loss…" (Brandell, pg. 476). After realizing that Adam was withdrawing as a defense mechanism, I began to understand the importance of normalizing his behaviors. Within the text by Moursund and Erskine it stated that, "The involved therapist normalizes her client's responses. Clients need reassurance that their behavior is not crazy, not shameful or disgusting" (pg. 120). Often times individuals feels like they are the only person dealing with grief, depression, anxiety, etc and early on, Adam would often state that he did not deserve to be happy. However, I would attempt to normalize his feelings by expressing that others have similar experiences and stated that every human being has the right to be happy and the right to have worth.

When I first began working with Adam I understood the importance of the therapeutic relationship and I understood the idea of empathy. However, I struggled to understand how to incorporate empathy into my work with Adam because I did not comprehend how I was supposed to understand what Adam was going through when I had never experienced the same

things myself. I believed that in order to fully empathize with someone I had to completely understand their situation and their struggles. However, I came to realize that no matter the individual's background I can find connections and empathize with that individual because everyone has human emotions and feelings, such as sadness, joy, grief, etc. After coming to this realization and I was able to empathize with Adam the therapeutic relationship began to thrive. In social work there is nothing more vital than the importance of human relationships and being able to build a strong relationship around integrity and honesty. Being able to apply integrity and responsibility to your clinical practice encourages aspects of prevention, assessment, treatment, practice evaluation and advocacy within treatment with individuals that you are helping, such as myself with Adam.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Brandell,J.R. (Ed.) *Theory and Practice in Clinical Social Work (2nd Ed).* Thousand Oaks, Ca: Sage Publications

McLeod, Saul (2015). Cognitive Behavioral Therapy. Retrieved from http://www.simplypsychology.org/cognitive-therapy.html

Moursund, J. P. and Erskine, R. G. (2004). Integrative psychotherapy: The art and science of relationship. Pacific Grove, Ca: Thompson/Brooks Cole. ISBN 0=534-51355-7

National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers*. Washington, DC. NASW Press.

Stolorow, R. D, Atwood, G. E., Brandschaft, B (1992). Three Realms of the unconscious and their therapeutic transformation. *Psychoanalytic Review*, 79, 25-30.