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CNS 771 DG SU 2016
Final Exam Part One
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Bio-psychosocial Assessment

Identifying Information

Daniel Jiang is a 55 year old Chinese American male, who is exhibiting symptoms consistent with depression and expressing feelings of “worthlessness” and “not being himself.” He is married and has two grown children who live out of state.

Present Psychiatric Illness / Symptoms

Client reports changes in his physical functioning. He is experiencing chronic fatigue and says that it is difficult to get out of bed in the morning. He is experiencing a complete lack of motivation for his work, and is concerned it is affecting the quality of his work. He exhibits avoidance of others, retreating to his bedroom or watching television. His wife Elaine has noticed the change and expresses concern about his lack of interest in shared activities.

Client has lost appetite and has lost ten pounds without dieting. He recently had a severe episode that seemed to him to be a heart attack. He reported rapid breathing, sweating and palpitations of the heart. After calling 911, and being seen by a doctor, an EKG showed no evidence of heart concerns. It was suggested by his physician that he seek counseling.

During our first session, Daniel appeared to be anxious and sad. His mood was obviously depressed. He made no eye contact and stared at the floor for the entirety of the session. He reports feeling, “not himself” and a sense of “worthlessness.” He also expresses that, “He doesn’t think he can go on living this way.” He has been feeling this way for 6 months consistently.

Past History of Treatment

Client has never been in counseling before.

Mental Health Medications

No known health medications being administered.

Medical Concerns

A recent, examination and EKG showed no evidence of heart problems. There is family history of heart issues. His father died of a heart attack at age 65. There is also family history of cancer. The client’s mother died of cancer when he was 25 years old.

Client’s last physical was three years ago.

Current Medications

There are no known medications currently being taken.

Dependency / Addiction History

There is no known history of dependency or addiction issues.

Family History of Psychiatric / Addiction Illness

There is no history of psychiatric or addiction illness.

Spirituality

The client reports that spirituality is important to him, but has experienced disappointment recently, as he says that, “God has not answered his prayers for help.” This constitutes an incongruence between his beliefs about God/prayer, and his expectations / experience.

Personal History

It is the 30th anniversary year of his mother’s death resulting from cancer. He lost his mother in his mid-twenties. He lost his father to a heart attack at age 65. He began working at a company when he was 25 years old, and has been at the same company until the present.

Education

Daniel’s education history is unknown. He began working at the company he currently works for at age 25, the same year his mother died. The client’s financial stability suggests that he has completed high school with a diploma and has graduated college with a four year degree.

Work History

The client has worked for the same company for 30 years. He started at this company the year that his mother died of cancer.

Marital / Relationships

The client is married to Elaine and has two grown children who live out of state but who visit frequently. He also has a sister who lives in North Carolina, is married and who has adolescent age children. He reports seeing her family twice a year.

The client reports having a few friends but that he has not had energy to spend time with them. He reports that they call occasionally to check in with the client.

Legal History

There is no known legal history or known pending litigation.

Mental Status

Client appears very depressed, anxious and sad. He does not make eye contact. The lack of eye contact may be due to his Chinese American heritage and or a sense of shame for needing to pursue counseling as it represents a "loss of face or social status" (Ming, 2011, p. 20) He is experiencing a complete lack of motivation / interest in his work and with regard to social engagement. His wife notes that he is no longer interested in mutually enjoyed, shared activities. He has not been attending church, spending time with good friends and has been feeling "worthless" as well as "not being himself" for the past 6 months. The client has exhibited suicidal ideation by expressing these feelings and by saying, "I don't think I can go on living this way."

Summary Impression

Daniel J. is a 55 year old, self referred married male seeking treatment for a major depressive episode. He has expressed anxiety about his health, feelings of worthlessness, feeling not like himself, a complete lack of motivation and has socially isolated himself. It has been 30 years since he lost his mother to cancer. He has been working at the same company for 30 years. These two realities may be feeding the client's anxiety and thoughts of death, as well as his angst about a lack of purpose.

Short Term Goals

1. Develop and implement a safety plan in the event his thoughts of death escalate into active suicidality
2. Encourage client to make and keep regular doctor's appointments every three months to assuage anxiety about medical concerns and monitor nutrition
3. Use bracketing to fully understand the client's world

Long Term Goals

1. Pay close attention to client' s non-verbal behavior and draw attention to it
2. Use paradoxical intention to help the client explore his distressing symptoms and feelings of worthlessness, concern about his health, fatigue and lack of motivation Use guided fantasy to increase death awareness and the awareness of what is important and meaningful
3. Use dream analysis and explore "unconscious conflicts between psychic entities and search for manifestations of the client's issues around the four ultimate concerns" (Murdock, 2013, p. 193).
4. Use de-reflection in order to "direct the client's attention out to the world, and to avoid focusing too intently on internal processes" (Murdock, 2013, p. 193).

Case Conceptualization

The client's name is Daniel Jiang. He was born in 1961 and is 55 years old. Daniel is Chinese American. He is married to Elaine, and has two adult children who live out of state but who visit frequently. They are financially stable, suggestive of a middle to upper socio economic status. Client avoids eye contact. This may be a cultural demonstration of respect and or related to a sense of shame, loss of face or loss of status (Ming, 2011, p. 20). The client is experiencing conflict and exhibiting anxiety with regard to four existential themes of "death, freedom, isolation and meaning" (Murdock, 2013, p. 184). The client has several important strengths. They are (1) loyalty to family and workplace (3) perseverance, (4) his anxiety about his health and behaviors that (calling 911) suggest a will to live and (5) the belief that suicide is shameful (*see suicide risk assessment*). The client's own potential negative perception of counseling process may prove to be a liability to his progress. He is also experiencing a complete lack of motivation and social isolation which may also prove detrimental. The client does have a strong network of support in his wife, his family, his church and some close friends. The client exhibits more than five of the requisite symptoms for diagnosis of MDD. Those symptoms are (1) depressed mood most of the day, (2) markedly diminished interest, (3) significant weight loss when not dieting, (4) hypersomnia, (5) chronic fatigue, (6) psychomotor retardation, (7) feelings of worthlessness, (8) diminished ability to think / concentrate, (9) and suicidal ideation. The suicidal ideation does not appear to be recurrent as there is no prior history known at this time. The client has no specific or active plan to end his life. His symptoms are "seriously distressing, very intense and markedly interfere with social and occupational functioning" (APA, 2013 p. 188).

Treatment Plan

Problem Statement:

The client is exhibiting symptoms consistent with a severe, single episode of major depressive disorder (MDD - F32.2).

Goal Statement and Expected Date of Achievement:

Short Term Goals

1. Develop and implement a safety plan to de-escalate suicidal ideation and in the event his thoughts of death escalate into active suicidality during our first session.
2. Encourage client to make and keep regular doctor's appointments once every three months to assuage anxiety about medical concerns and monitor nutrition. Client to make and keep first appointment before our next session.
3. Use bracketing to fully understand the client's world for the first three sessions

Long Term Goals

1. Pay close attention to client' s non-verbal behavior and draw attention to it
2. Use paradoxical intention to help the client explore his distressing symptoms and feelings of worthlessness, concern about his health, fatigue and lack of motivation Use guided fantasy to increase death awareness and the awareness of what is important and meaningful
3. Use dream analysis and explore "unconscious conflicts between psychic entities and search for manifestations of the client's issues around the four ultimate concerns" (Murdock, 2013, p. 193).
4. Use de-reflection in order to "direct the client's attention out to the world, and to avoid focusing too intently on internal processes" (Murdock, 2013, p. 193).

Treatment Modality: Existential Therapy

Client to receive Existential Therapy and related techniques for 12 weekly sessions. A clear contract will be established. Progress will be evaluated at six weeks and at 12 weeks.

1. Bracketing
2. Attention to Non-Verbal Behavior
3. Paradoxical Intention
4. Guided Fantasy
5. Dream Analysis
6. De-reflection

Rationale:

Existential Therapy seems to be the best modality for treating this particular client. First, the client is experiencing conflict and exhibiting symptoms constant with the four existential themes put forth by Yalom (1980). They are death, freedom, isolation and

meaning (Murdock, 2013, p. 184). Second, as stated by Murdock (2013), “Existential therapy is seen viable for use across cultures” (Murdock, 2013, p. 197).

Clinical Impression or Diagnosis:

It is my clinical impression that the client is presenting with symptoms of a single episode of Severe Major Depressive Disorder (F 32.2).

The client exhibits more than five of the requisite symptoms for diagnosis of MDD. Those symptoms are (1) depressed mood most of the day, (2) markedly diminished interest, (3) significant weight loss when not dieting, (4) hypersomnia, (5) chronic fatigue, (6) psychomotor retardation, (7) feelings of worthlessness, (8) diminished ability to think / concentrate, (9) and suicidal ideation. The suicidal ideation does not appear to be recurrent as there is no prior history known at this time. The client has no specific or active plan to end his life. His symptoms are “seriously distressing, very intense and markedly interfere with social and occupational functioning” (APA, 2013 p. 188).

Names and Credentials:

Jeremy M. George, B.A., Graduate School Student at Wake Forest University, Intern at Life Care Counseling and Coaching

Suicide Risk Assessment

Script of Suicide Risk Assessment:

Daniel: "I feel worthless, and I don't feel like I can go on living this way."

Counselor: "You feel worthless, and you feel that if something doesn't change then you would rather be dead."

Daniel: "Yes."

Counselor: "Have you ever thought of ending your life?"

Daniel: "Yes."

Counselor: "How often have you been having these thoughts?"

Daniel: "For the past month."

Counselor: "When did you last have these thoughts?"

Daniel: "This morning before I came here."

Counselor: "How long do the thoughts last?"

Daniel: "Not long, but they have been occurring more frequently."

Counselor: "When you have these thoughts, how distressed are you on a scale of 1 to 10? (1 = not intense at all; 10 = extremely intense)

Daniel: "8"

Counselor: "Have you thought about how you might try and end your life?"

Daniel: "Not really. I suppose I would just use whatever I could find."

Counselor: "Have you thought about when you might?"

Daniel: "No."

Counselor: "Do you own any weapons?"

Daniel: "Yes, I own a hand gun."

Counselor: "Where do you keep it?"

Daniel: "In my safe."

Counselor: "Who has access to that safe, and how do they gain access."

Daniel: “My wife and I both have keys and know the code.”

Counselor: “Are you taking any medications or medicines currently?”

Daniel: “No.”

Counselor: “Are there any in your home?”

Daniel: “No. We prefer to use natural medicine.”

Counselor: “Have you ever used alcohol or any kind of narcotics?”

Daniel: “No, never.”

Counselor: “Do you know of any family member who has ever had psychological or emotional difficulties in the past?”

Daniel: “No.”

Counselor: “Do you have someone you can talk to about these thoughts and feelings you have been having?”

Daniel: “I think I could talk to Elaine, but I am afraid to worry her. I have some friends but I haven’t been around them for a long time now.”

Counselor: “You mentioned earlier that you haven’t been to church in a while either. Is there someone at church you could talk to?”

Daniel: “I guess I could talk to the pastor, but that would be very embarassing.”

Counselor: “If you had to, you could talk to your wife, your friends and your pastor.”

Daniel: “Yes. I guess so. My wife is always bothering me to get up and do something, and my friends call every now and then. I just don’t have the motivation to get out of bed and do anything most days.”

Counselor: “How long has that been going on?

Daniel: “Six months.”

Counselor: “Is there anything that could happen that would increase your desire to end your life?”

Daniel: “Yes, if nothing changes.”

Counselor: “What has kept you safe thus far? What are your reasons to live?”

Daniel: “I don’t want to hurt my family. It would be very shameful for my family if I were to end my life.”

Counselor: “What would your reasons be to end your life?”

Daniel: “I just feel worthless, like my life doesn’t matter. I have no motivation to do anything. Something needs to change. I am not myself.”

Counselor: “Daniel, if it is ok with you, I would like to develop a safety plan with you, just in case your thoughts and feelings become overwhelming. Would that be ok with you?”

Daniel: “Yes, I think I need that.”

Counselor: “You have already identified some very important reasons for living. What are some things that make you feel calm and, or comforted.”

Daniel: “I like gardening with my wife Elaine in the evenings. I like spending time with my friends and family at meals together. I also enjoy classical music.”

Counselor: “Daniel, there are several things that you have done that make me believe you don’t really want to die. First, you called 911when you thought you were having a heart attack. Second, you have been feeling anxious about your health. Those aren’t the behaviors of someone who wants to die.”

Daniel: “No, I don’t want to die, but I also don’t want to keep living feeling the way that I do now. I want to feel better and to matter.”

Counselor: “How likely on a scale of 1 to 10 is it that in the next 72 hours, you would try and harm yourself in order to end your life?” (1 = Not likely at all; and 10 = Very likely)

Daniel: “1-2.”

Counselor: “There are some things I want to ask you to do if you are willing to do them. First I want you to talk to Elaine about these thoughts and feelings before we leave here today. I want you to commit to talking to your closest friend and your pastor about these thoughts and feelings as well before our next session. I would also like you to promise not to harm yourself in any way before our next session. Would you be willing to make these commitments as we work to help you feel better?”

Daniel: “Yes.”

Counselor: “Additionally, I want to give you a list of phone numbers for local health and mental health providers that are in close proximity to your home or work in the event of an emergency. I will also give you the phone number of the National Suicide Prevention Hotline in case your thoughts escalate. Would that be alright with you?”

Daniel: “Yes.”

Counselor: "One more really important thing Daniel. If your compulsion to harm yourself becomes strong, do Elaine and I, or any one of your support team have your permission to admit you to the nearest emergency center?"

Daniel: "Yes."

The SLAP Model

Specificity - The client has no specific or active plan for suicide.

Lethality - The client does not have access to medications, and has not identified a specific plan for ending his life. He does own a gun, which is highly lethal and would be of concern should his suicidality escalate.

Availability - The client's handgun is locked in his safe. Only he and his wife Elaine have keys and know the codes to the safe. I suggest having Elaine change the code, and hold on to both keys for the time being.

Proximity of Social Support - The client has been isolated from his social networks. He has his wife, some close friends who call to check in on him from time to time, and he belongs to a church. He has not attended church for the past 6 months.

Safety Plan

1. Elaine to change the code to the safe, and hold on to both keys for the time being.
2. Client has identified a list of things that make him feel calm or comforted (Fictitious)
   - Gardening with his wife Elaine
   - Seeing his children
   - Spending time with friends and extended family
   - Listening to classical music
3. Client has identified his reasons for living:
   - His wife and family
   - He believes suicide is shameful
   - He doesn't want to die (Note: He doesn't want his life to be as he is currently experiencing it)
4. Client has identified people to whom he can speak about his thoughts and feelings
   - Elaine, his wife
   - His close friends
   - His pastor
5. Client has been given the phone number of the National Suicide Prevention Hotline (1-800-273-8255) and will be carrying his cell phone with him at all times.
6. Client and his wife have also been informed of local health and mental health care providers that are in close proximity to his place of work, and to his home in the event of an emergency. Client agrees to be admitted to an emergency center if his impulse to self harm becomes escalated.
7. Client has made a commitment not to harm himself to the counselor, and to his wife at the end of our initial session. He has promised to speak to his closest friend and to his pastor in the next week before our next session.

Assessment of Risk Level

Risk Level: MODERATE

There are six important reasons that Daniel Jiang is a moderate risk for suicide. The first is that suicidal ideation is present, but no specific plan has been considered. Second, the client exhibits symptoms of listlessness, tiredness, depression and neuro-vegetative signs. Third, the client is not making use of his support system. With the exception of Elaine, his closest friends are unaware of his depression. Fourth, the client's beliefs about suicide are a deterrent to suicide or self harm. Fifth, he is willing to entertain other options to suicide. Sixth, and finally, he has agreed to a safety plan which includes being admitted to an emergency center if his impulse to self harm becomes strong.

Next Steps

The following paragraph is a brief description of the "next steps" of treatment that I would recommend. First, I would develop and implement a safety plan immediately in the event the client's thoughts of death escalate into active suicidality as described above. Second, I would have the client's wife monitor him on a daily basis. I would inform the client's wife about warning signs for which to watch, and equip her with the information needed to get help in the event of an emergency. Third, I would check in with the client and his wife on a weekly basis to evaluate progress and the effectiveness of the safety plan, making adjustments as needed. Fourth, I would administer existential therapy and related techniques in order to address the client's anxiety about death, freedom, isolation and meaning.

References

Ming Liu, William; Iwamoto, Derek Kenji; Chae, Mark H. (2011). Culturally Responsive Counseling with Asian American Men. Retrieved from http://www.eblib.com

Murdock, Nancy L. (2013). Theories of Counseling and Psychotherapy: A Case Approach. Pearson Education Inc. Upper Saddle River, NJ. ISBN-13: 978-0-13-265978-9