PRESENTATION CASE CONCEPUALIZATION ASSIGNMENT

VIDEO JULY 10, 2024

SUZY VAILE

TIME STAMP: 9:30-19:00

Confidentiality-Jimbo

Demographic Information: Includes Jim, 56, Male, husband and father, retired commercial truck driver.

Presenting Problem: Patient presents with acute stress symptoms (anxiety, sleep disruption, feeling overwhelmed, nightmares, stress, blame/shame, lack of control) resulting from both a life-altering hospitalization with COVID, as well as a car fire that significantly injured both Jimbo and his brother. He feels responsible for his brother and has recurrent nightmares about the fire. They have decreased as we have met- the scoring on his PHQ-9 has decreased significantly in the last 6 monthly/bi-weekly sessions.

Behavioral Impressions: Patient presents with a positive affect and is aware of time, place, and situation. He is neatly dressed and accompanied by his wife.

Relevant Historical Information: Includes the following how long problem(s) persisted, family of origin information, precipitating circumstances:

History of the Presenting Problem: 7 months.

Biopsychosocial History:

Family of origin: mother and father, two brothers, one sister. One brother is deceased. Father is recently deceased. Patient maintains that his father was mentally and physically abusive to the

whole family, and as the oldest child, he felt responsible for protecting them. He has shared specific examples and how it still impacts him today.

Current family system: Married, two children that are married and not living at home, but one does live on the same property.

Previous counseling experience: None – he was a referral from the cancer center where he was receiving chemotherapy and radiation therapy for cancer treatment.

Psychiatric history of self and family- none

Social relationship history-small inner circle, mainly family

Academic/Work history- commercial truck driver who travelled extensively

Medical/Developmental history- COVID 19, hospitalization, intubated and ventilated, coma, cancer treatment, traumatic fire

Addiction Screening: Negative for substance use.

Risk Assessment: No suicidal ideation (SI), no history of SI, no current SI

Diagnosis: Acute Stress Disorder F43.0, unspecified F43.20, and Adjustment Disorder, unspecified F43.20

Primary: Directly experienced a traumatic event, witnessing the event as it occurred to others

Secondary: Recurrent distressing memories of the event, nightmares, dissociative reactions, sleep disturbances, nightmares

Adjustment Disorder: the criteria for acute stress have extended beyond 30 days but is does not meet criteria for PTSD. Patient is also experiencing mood swings, depression, and guilt, which does meet criteria for adjustment disorder.

Client Impressions:

Strengths-patient is open to feedback and is transparent in his feelings

Barriers to growth- lack of progress, feeling depressed over symptoms, not feeling heard or validated by his wife.

Defense mechanisms- justification for choices

Coping skills- mindfulness exercises, square breathing, using "I feel" messages, clarifying questions.

What is client trying to accomplish? Relief from acute stress symptoms, improved communication and connection with his wife

Case Conceptualization Summary:

Jimbo's current acute stress symptoms (including anxiety, depression, sleep disruptions, nightmares, and guilt) make sense in light of his recent traumatic accident that critically burned Jimbo and his brother. Given his lack of support from family, (father recently deceased, mother deceased) and current developmental stage (intimacy concerns), these factors appear to have contributed to Jimbo's feelings of guilt and depression. He has felt stuck for a long period of time, and following his chemotherapy and radiation treatment, was referred to me for acute stress symptoms. He recognizes that he is the change factor and is willing to work toward his goals to alleviate his symptoms.

Theoretical Orientation and Research/Evidence-based treatment:

I employ an eclectic, person-centered approach using reflections, open-ended questions, and scaling questions. As such, I correlate the counseling journey with a tour guide and a tourist. As an eclectic, person-centered counselor, I see myself as a tour guide, discovering the needs and wants of the client and then helping them design a route to arrive at their destination, whatever that looks like for them at the time; allowing for pit stops, detours, and re-routing, while offering tools for them to use along their journey. My personal counseling style utilizes a combination Person-Centered Therapy and Gestalt Therapy.

Treatment Planning

Short Term Goals: Increase quality of sleep, utilize coping skills, increase communication

Long Term Goals: Alleviate as many of the acute stress symptoms as possible; root cause is lack of communication, craving connection

Interventions: Mindfulness Exercises to alleviate stress Box Breathing for stress reduction and increase sleep quality Talk therapy to learn coping strategies, bring presenting issues to the here and now, empty chair technique, “I feel” exercises.

References

Beutler, L. E. (2000). *Eclectic psychotherapy*. American Psychological Association.

Brunell, L. F. (1978). A multimodal treatment model for a mental hospital: Designing specific treatments for specific problems. *Professional Psychology*, 9(4), 570.

Highlen, P. S., & Hill, C. E. (1984). Factors affecting client change in individual counseling: Current status and theoretical speculations. *Handbook of counseling psychology*, 334-396.

Ethical Issues: I discussed any ethical concerns with the client; we reviewed confidentiality and its limitations, and client reviewed and signed Professional Disclosure Statement, so Informed Consent requirements were met. No questions from client.

Multi-cultural Factors: I ask inviting questions and create a safe space for client to talk about his culture and any perspectives that he wants to share with me. I ask considerate and thoughtful questions as they arise and are pertinent to patient care.

Assessment: I completed a PHQ-9 assessment for the patient at our first appointment and subsequently in treatment to assess his acute stress symptoms and to help measure his progress. His numbers have decreased significantly, and his symptoms have improved (fewer nightmares, less sleep disruptions, decreased guilt, and intrusive thoughts) as we have progressed in our sessions. I complete an assessment throughout therapy to help assess our progress or need for another style of intervention, based on the patient's needs and level of comfort.

Referral/Access- Because I have built rapport with the patient, and he does not feel comfortable sharing his story with other therapists, I will not be referring him for further treatment unless he becomes a harm to himself or others.

Prognosis- Patient is eager to improve the quality of his life and longs to enjoy his "golden years" with his wife. Prognosis is very good that he will continue to improve; we have already decreased sessions from weekly to once a month with continued success.

Treatment Plan Goal Chart

Dx/Problem	Long Term Goal(s)	Short Term Goal(s)	Evidence Based Interventions
Acute Stress (F43.0)	Alleviate all symptoms and reduce medication	Increase sleep quality, reduce nightmares, decrease anxiety and depression	Mindfulness exercises, square square breathing, Empty Chair technique, scaling questions, talk therapy using here and now and "I feel" statements