Case Presentation: Client 1
Brandon Waggoner

Liberty University

September 4, 2018

**Case Presentation**

**Demographic Information**

Client is an unmarried 21 year old white male. He is the oldest of two with a younger sister. He reports good relationships with all family members. He currently is in college studying video production and works part time with a video crew doing convocation and other events. He reports excellent health, with no presenting history of medical or mental illness for himself or family members. He was in counseling before in 2016 for a presenting problem of anxiety.

**Presenting Problem**

The client is reports anxiety as the presenting problem. Within the initial assessment client reported on the psycho-social form of disruptions in sleep, decreased motivations, depressed mood, anxiety, unwanted thoughts, stress, racing thoughts, loneliness, shyness, and fears. Risk assessment was minimal with no reported suicidal ideation or actions past or present.

**Observational Data**

Client presents with high levels of cognitive functioning but low levels of positive thoughts toward himself. He is not overweight and is well kept. His communication is quick with racing speech and anxious in his presentation. He is able to sit still but moves around with his hands and other motions.

**History of the Presenting Problem**

He states that the anxiety began in late high school after some bullying by a specific friend in a friend group. Previous counseling was helpful in 2016, however, a breakup from a girlfriend prior to the first session prompted him to seek counseling again. He reported a panic attack with “inability to walk” and needing help from a friend since his physical state was a struggle to breathe and a “paralyzing” feeling. Concern for what others are thinking has developed from the bullying which was subtle, but effective in creating a schema of negative personal identity. He thinks of himself as “worthless” and “ignorant.” He has many people in his support structure, but not many in the core of meaningful relationships.

**DSM-5 Diagnosis**

Diagnosis was Generalized Anxiety Disorder (GAD) 300.02. In initial intake the client met the criteria for this diagnosis in many ways. The client had worry for more days than not for the past 2 years, he found it difficult to control, had difficulty concentrating, had sleep disturbance, was restless, and the anxiety caused life disturbance. This diagnosis was chosen over social anxiety disorder due to the fact that the client worried more on whether he was being evaluated rather than on worry focused on a specific social event. He often would worry about what his roommates thought of him or his co-workers. There were no other secondary diagnoses that came up this far in counseling. Comorbid diagnosis of bipolar or other disorder is not warranted due to a lack of conduct disturbance, substance abuse, or emotional fluctuations.

**Treatment Planning**

 The treatment plan (see attached chart) will focus on two problems and subsequent goals. The first goal will be to reduce the anxiety experience by the client. Cognitive behavioral therapy has been sown to be effective in reducing GAD (see evidence section). Thus, the treatment began with a psychoeducational approach in which the client was taught first relaxation skills in order to calm himself in the event of another panic attack. Insights were then built in order to normalize the emotions felt by the client as well as tie them to past experiences such as the bullying in high school. Changing negative thinking patterns into compassionate thoughts was facilitated by the daily thought record and role playing anxious situations. Throughout this treatment, building social support is critical. Thus, the concentric circle model was used to illustrate the goal of deeper intimate relationships with others as developing a secure base.

**Counselor Name**: Brandon Waggoner **Client Name**: Client #1 **Case #**: 1

**Problem 1.**: Anxiety

**Goal 1.:** Reduction of anxiety score on the Level 2 assessment

**Objective 1.:** Relaxation skills acquisition

**Intervention 1.:** Deep breathing

**Intervention 2.:** Guided imagery

**Objective 2.:** Build insight into the client’s story and experiences

**Intervention 1.:** Identification of core hurts or fears

**Intervention 2.:** Narrative therapy

**Goal 2.:** Increase in compassionate thoughts

**Objective 1.:** Have the client become aware of his thoughts

**Intervention 1.:** Psychoeducation on how thoughts impact emotions

**Intervention 2.:** Psychoeducation and role playing in identifying cognitive distortions

**Objective 2.:** Incorporate the daily thought record (DTR) into the clients skill set

**Intervention 1.:** Psychoeducation and practice of the DTR

**Intervention 2.:** Self-awareness and mindfulness techniques

**Problem 2.**: Lack of social support

**Goal 1.:** Reduce Isolation

**Objective 1.:** One or more individuals in the core of the concentric circles

**Intervention 1.:** Identify what makes a friend close according to the client

**Intervention 2.:** Develop the skills of building intimacy

**Goal 2.:** Increase positive social experiences

**Objective 1.:** Develop experiences to counter the negative schemas

**Intervention 1.:** Role play social situations

**Intervention 2.:** Exposure therapy with social interactions

**Ethics**

 There are several ethics considerations in working this treatment with this client based on the ACA 2014 Ethics Code. First, there should be consideration with the limitations of the counselor. The code of ethics states that counselors should not counsel beyond their level of expertise (American Counseling Association, 2014). In counseling this client with high levels of anxiety, there could be need for medication or more intense psychological evaluation. The presence of trauma would also be a possibility for referral of treatment. Additionally, confidentiality as well as proper evaluation and assessment should be considerations as well.

**Multi-cultural**

 There are not many cultural considerations with this client. Since the client is the same race and age of the counselor, there are many similarities in cultural experiences. Even though the client comes from a religious background, there should be some cautions in projecting beliefs and values upon the client. A complete assessment on assumptions and expectations of the client on views should be thorough in order to grasp and political or cultural undertones. The culture from the family of origin could breed this anxiety as a natural spiritual “struggle.” Thus, understanding any nuances would be beneficial.

**Research/Evidence based treatments**

 Cognitive behavior therapy (CBT) will be used at the center of the treatment plan. Kaczkurkin and Foa (2015) detail how this therapy can be effective in overcoming anxiety. Exposure therapy is often used in conjunction with CBT which makes it difficult to determine the merits of CBT on its own (Olthuis et al., 2016). Relaxation methods are used with effective results, however there should be caution with overuse due to a high dropout rate with those techniques (Norton, 2012). Impact of social support on anxiety reduction has been shown to be a critical element for treatment as well (Dour et al., 2014). All of this is dependent on the client’s self-awareness and understanding of the thought that come from his core hurt or fear, which is rejection. By countering the fear of rejection, progress can be made in eliminating the source for the anxiety (Schneider, Arch, & Wolitzky-Taylor, 2015).

**Assessment/Testing Procedure**

Assessment began with a psycho/social/spiritual intake form used at the counseling center. The Level 1 DSM-V Cross Cutting Measure instrument was used to gain an overall assessment of functioning. Anxiety was specifically evaluated with the Level 2 Anxiety Symptom Measure (Narrow et al., 2013). This Level 2 measure will be used for constant evaluation of improvement in the anxiety symptoms. The amount of people in his support structure was evaluated through the concentric circles model, in which he had only one person in his core which was a roommate.

Session

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Goal** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Identification of compassionate thoughts in DTR** | - | - | no | yes | no | yes | - | - | - | - |
| **Level 2 Anxiety** | 67 | - | - | 56 | - | - | - | - | - | - |
| **Number of friends in CC** | 1 | 1 | 1 | 2 | 2 | 2 | - | - | - | - |

**Referral or Adjunct Services Section**

Potential referrals for this client include church groups and other support groups such as the Freedom groups at Thomas Road Baptist Church. Medication can be considered if the anxiety scores increase or if suicidal ideation becomes present. Working with my supervisor as well as other experts will be critical going forward. No counselor should work in isolation.

References

American Counseling Association. (2014). ACA code of ethics. Retrieved from <http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf>

Dour, H. J., Wiley, J. F., Roy‐Byrne, P., Stein, M. B., Sullivan, G., Sherbourne, C. D., ... & Craske, M. G. (2014). Perceived social support mediates anxiety and depressive symptom changes following primary care intervention. *Depression and anxiety*, *31*(5), 436-442. https://doi.org/10.1002/da.22216

Kaczkurkin, A. N., & Foa, E. B. (2015). Cognitive-behavioral therapy for anxiety disorders: an update on the empirical evidence. *Dialogues in clinical neuroscience*, *17*(3), 337. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4610618/>

Narrow, W. E., Clarke, D. E., Kuramoto, S. J., Kraemer, H. C., Kupfer, D. J., Greiner, L., & Regier, D. A. (2013). DSM-5 field trials in the United States and Canada, Part III: development and reliability testing of a cross-cutting symptom assessment for DSM-5. *American Journal of Psychiatry*, *170*(1), 71-82. <https://doi.org/10.1176/appi.ajp.2012.12071000>

Norton, P. J. (2012). A Randomized Clinical Trial of Transdiagnostic CBT for Anxiety Disorder by Comparison to Relaxation Training. *Behavior Therapy*, *43*(3), 506–517. http://doi.org/10.1016/j.beth.2010.08.011

Olthuis, J. V., Watt, M. C., Bailey, K., Hayden, J. A., & Stewart, S. H. (2016). Therapist‐supported Internet cognitive behavioural therapy for anxiety disorders in adults. *Cochrane Database of Systematic Reviews*, (3). <https://www.researchgate.net/publication/282661610>

Schneider, R. L., Arch, J. J., & Wolitzky-Taylor, K. B. (2015). The state of personalized treatment for anxiety disorders: a systematic review of treatment moderators. *Clinical Psychology Review*, *38*, 39-54.