Casebook for DSM-5®
Diagnosis and Treatment Planning

Elizabeth Ventura
Editor
Casebook for DSM-5®
Elizabeth Ventura, PhD, LPL, NCC, is a counselor educator, qualitative researcher, and trauma specialist. She has been practicing clinically since 2004 and has specific clinical training in both cognitive behavioral therapy and dialectical behavioral therapy. Although her area of expertise focuses on trauma work and the treatment of eating disorders, she has built her clinical practice working with individuals across the life span where she has experience in various mental health conditions. She is a core faculty member in the clinical mental health counseling department at Walden University. Her teaching experience includes such courses as psychopathology and diagnosis, research design and program evaluation, testing and appraisal, advanced counseling techniques, foundations of counseling, counseling trauma survivors, practicum, internship, and supervision.

Dr. Ventura has presented at numerous local, state, and national conferences, including the profession’s flagship professional conferences, the American Counseling Association and the Association for Counselor Education and Supervision. She has published chapters in such texts as Trauma Counseling: Theories and Interventions; The Counselor’s Companion: What Every Beginning Counselor Needs to Know; and the forthcoming Introduction to the Counseling Profession. In addition, she is the president of Associates in Counseling & Wellness, LLC, which provides private therapy and group therapy services to individuals, families, and couples.
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Contributors

Heather Ambrose, PhD, LCMHC, LMFT
Core Faculty, School of Counseling, Walden University, Layton, Utah

Renee Anderson, PhD, LPCC-S
Core Faculty, School of Counseling, Walden University, Butler, Pennsylvania

Brooks Bastian Hanks, PhD, LCPC
Core Faculty, School of Counseling, Walden University, Southeast Idaho

Jayna Bonfini, MA, LPC, NCC
Private Practice, McMurray, Pennsylvania

Christian J. Dean, PhD, LPC, LMFT, NCC
Core Faculty, School of Counseling, Walden University, Baton Rouge, Louisiana

Jeannie Falkner, PhD, LCSW
Core Faculty, Walden University, Oxford, Mississippi

Brandy L. Gilea, PhD, LPCC-S, NCC
Core Faculty, Walden University, Canfield, Ohio

Maranda A. Griffin, PhD, LPC
Core Faculty, Walden University, Orange Park, Florida

Christie Jenkins, PhD, LPCC-S
Core Faculty, School of Counseling, Walden University, Perrysburg, Ohio

Sola Kippers, PhD, LPC-S, LMFT
Clinical Counseling, Capella University, Baton Rouge, Louisiana

© Springer Publishing Company
Rhonda Neswald-Potter, PhD, LPCC, ACS
Clinical Director, Manzanita Counseling Center, University of New Mexico,
Contributing Faculty Member, Walden University, Albuquerque, New Mexico

Stacy Overton, PhD, LPC, LAC
Core Faculty, Walden University, Fort Collins, Colorado

Joshua Parnell, BA
Student, Walden University, Pittsburgh, Pennsylvania

Torey Portrie-Bethke, PhD
NCC, Core Faculty, School of Counseling, Walden University, Northwood, New Hampshire

Amanda Rovnak, PhD, PCC-S, LICDC-CS, LISW-S
Core Faculty Member, School of Counseling, Walden University, Copley, Ohio

Jessica Russo, PhD, LPCC-S, NCC
Core Faculty, School of Counseling, Walden University, Portage Lakes, Ohio

Stephanie L. Stern, MA, LPC, LBS, NCC
Private Practice, McMurray, Pennsylvania

Elizabeth M. Ventura, PhD, LPC, NCC
Core Faculty, School of Counseling, Walden University, McMurray, Pennsylvania

Margaret Zappitello, EdD, LPC, LMFT, LAC, MAC, NCC
Core Faculty, School of Counseling, Walden University, Brighton, Colorado
Preface

The collection of cases presented in this book has been compiled from seasoned clinicians who have experienced complex client symptomology. These cases illustrate real-world examples of actual clients seen in practice. The details of the cases are organized to provide readers with examples of case conceptualization, as well as diagnostic impressions, conclusions, and treatment recommendations. Remembering that each client is different, and the training and skill level of the treating therapist is equally unique, the recommendations provided in the cases serve as examples for students to critically analyze and adapt their own theoretical approach when conceptualizing the cases.

It is certainly true for me that the clients I have encountered have changed my life. The gratefulness and gratitude I feel for having the opportunity to walk with each of them throughout their personal journeys is inexpressible. Through my own work with clients I have learned that authenticity cannot be attempted; rather, it must be interwoven into the fabric of the self. For 50 minutes, we are given the gift to sit across from another human being struggling deeply with aspects of his or her life and are entrusted to help him or her navigate this pain. We are entrusted to know the way, sometimes as a guide, other times as a follower. Regardless of the role we play, we are entrusted to be among the few that see this level of human vulnerability and shame in its most exposed state. We are expected to be prepared for this and to meet it with passion, integrity, and competence.

Practice now for those moments on the horizon.
RECOMMENDATIONS FOR USE

This casebook provides a practical and realistic way for students in such mental health professions as clinical psychology, counseling psychology, counseling, and social work to put the new DSM-5 into practice by presenting actual clinical experiences from practitioners. By exploring detailed clinical vignettes, this text offers trainees the opportunity to explore their own ideas on symptom presentation, diagnosis, and treatment planning with a full range of disorders and conditions covered in the DSM-5. Unlike other casebooks, this book not only provides vignettes, but also explores the rationale behind diagnostic criteria and connects diagnostic criteria in the DSM-5 with symptomology in the case. In addition, each case includes a discussion of treatment interventions that is crucial for students in helping professions. These treatment considerations are inclusive of a wide range of evidence-based approaches as appropriate for each case. Cases are presented across major categories of disorders to help students understand the nature of differential diagnosis. Cases also reflect cultural and social considerations in making diagnostic decisions.

An ideal text to enhance courses in psychopathology and diagnosis, as well as practicum and internship, this casebook will diversify and broaden the classroom experience by enlightening students with compelling clinical cases that have been experienced by practicing professionals.

Elizabeth M. Ventura
Acknowledgments

Thanks are due to the countless individuals who are brave enough to seek counseling and whose stories have inspired this book. These individuals may never fully understand how their stories can help change the lives of others and how their resilience has changed mine. I am grateful every day for having been a part of each of their journeys.

As clinicians, we advocate for self-care and a work–life balance. My husband, Mick, is my balance and truly the best human being I know. Thank you for giving me the time, encouragement, and love to make this happen.

Last, I am overwhelmed by the support of my colleagues and the contributions made by the incredibly talented clinicians who have provided the cases in this book.
Introduction

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association. 2013) is the result of the first significant revision since the publication of DSM-IV in 1994. With advances in research and clinical applications, modifications were needed to accurately frame client symptom presentation and reflect the changes and advances in science and technology, as well as cultural and societal factors. With these changes come a set of standards that practitioners-in-training should familiarize themselves with and learn to accurately apply diagnostic criteria to real-world examples.

As a counselor educator, I have found that the use of diagnostic criteria in the absence of practical case applications is limiting for students. The power of using real-world case presentations to help students conceptualize symptomology helps trainees to integrate knowledge in a way that surpasses traditional rote memory learning strategies.

Counselor educators have an ethical responsibility to act as gatekeepers in training programs. Although professionalism and comportment issues are foundational elements in our profession, competence in the areas of diagnosis and theory-driven interventions have risen to the surface with managed care. Often, in short periods of time, change is expected. Counselors-in-training are charged with implementing theory and technique with intentionality to arrive at the correct diagnosis and treatment plan in order to effectively deliver care. This is certainly a task that requires confidence, competence, and creativity. Research has shown that trainees gain a sense of efficacy
from practicing in supervisory settings with realistic examples and from a constructivist paradigm. The hope is that this book can begin the process for trainees to understand the client complexities that present daily in the counseling office and meet those challenges with a sense of self-assurance that can, in fact, help to promote change.

■ REFERENCES

CASE ONE

Dylan

HISTORY

Dylan attended his first session accompanied by his 42-year-old mother, Brenda, and 22-year-old sister, Carly. As a 15-year-old freshman in Cyber High school, Dylan was incredibly attached to his family and relied on his sister and mom as his primary supports.

A week prior to his initial appointment, Brenda called for a phone consultation to discuss Dylan’s primary symptoms. At the time of the call, Dylan was not eating a majority of foods that were prepared at home. He was struggling to leave the house and seemed affected by preoccupation with thoughts around getting the stomach flu. Dylan was fearful that eating anything that was prepared at home would result in vomiting and prolonged illness. He would routinely inspect utensils at home to ensure cleanliness and oversee his parents and siblings as they participated in preparing meals. With the severity of symptoms increasing over the course of 60 days, Dylan had lost 17 pounds as a result of the eating restrictions. Brenda had notified me that his current psychologist attributed the symptoms to anxiety; however, he was not seeing any alleviation of symptoms despite weekly therapy.

As Dylan entered the office, he slipped his sleeve over his hand to open the door from the lobby to the main office but then quickly recovered and extended his hand to accept the clipboard of paperwork and pencil.
to finish the logistics of the intake appointment. He made very little eye contact throughout the session, and his responses were literal. Questions such as, “Tell me what has been going on” required extensive further clarification because the lack of clarity in the initial question caused intense anxiety. Dylan often looked to his mother and sister throughout the session to assist in answering questions or for clarification; however, he did correct any misinterpretations that they expressed. He was able to discuss his interests in video gaming and design, online role-playing games, and Lego building but expressed that all of these are better when interacting with others online. Although Dylan wants peer interaction and friendships, his past experience has been such that he now avoids the inevitable rejection that comes with attempting social interactions.

At numerous points throughout the intake, Dylan coughed repeatedly as he listened to his mother and sister describe the tumultuous relationship he has with his older brother, Corey, who recently returned home from college. Corey, 19, is described as having little empathy and time for Dylan’s anxiety and, as a result, takes a very harsh approach with Dylan that creates stress and arguments. Dylan sleeps on the bottom bunk, with Corey often climbing over him at odd times of the night, disrupting his routine, as he has no schedule since being home from school. As Dylan discussed a recent argument over “rocking the bed,” his cough became more pronounced and repetitive. Brenda discussed that Dylan has always “rocked” himself to sleep, and although this would not be much of an issue in and of itself, it poses quite an issue being on the bottom of a bunk bed.

The intake progressed to discuss more of the symptoms related to his weight loss. Dylan discussed feeling that the weight loss now was likely unhealthier than any stomach flu he could ever contract. He had no rational reason for fearing vomiting, nor could he describe a situation in which someone died from profuse vomiting. When asked, “What is the worst thing that could happen to you?” he was speechless and yet, strangely enough, a sense of calmness overcame him realizing he did not know the worst case scenario.

Dylan coughed again. And again. And again.

Brenda commented that the coughing occurs daily and reported that it has been “happening forever.” Carly reported that it has not always been coughing; he has had sniffling episodes during which he has sounded sick but was perfectly healthy.
More social history from Dylan’s past reveals that he has struggled with appropriate communication that is relevant to his peer group. He has a difficult time dealing with rule breakers and has always been incredibly literal. When asked, “What would you say if I told you it was raining cats and dogs outside?” He responded, “I would first look outside to see what you were referring to and make sure there were not cats or dogs outside.” Brenda and Carly both agreed that his inability to connect to other kids his age in socially appropriate activities has caused a tremendous amount of isolation in his life.

**DIAGNOSTIC IMPRESSIONS**

Dylan has accepted that his life, as it stands, is not worth living. He fears a life in which he is afraid to eat food prepared by another individual and wants to understand why he allows these “thoughts to take over my mind.” His preoccupation with flu symptoms and vomiting creates a world in which he needs to compensate by attempting to create rules so that it does not happen. These rules are irrational and change according to the needs he may have at the time. For example, Dylan will not eat red meat prepared by his mother in his kitchen at home; however, if his sister agrees to make his dinner and it is red meat, he will eat it. He will eat out at certain restaurants with buffets, but not others. Having these rules in place gives Dylan a sense of control and this, in turn, creates a sense of safety for him that feels comfortable, but only for a moment.

Dylan is still in a place where he wants to appear somewhat socially acceptable. He secretly attempted to open the door with his sleeve; however, he quickly recovered to take the pencil and intake paperwork (although he was thinking of washing his hands the entire time the session was conducted).

His obsessions (thoughts of getting sick, contaminated, or infected) are consuming, and his quality of life has deteriorated. As a result of these obsessive thoughts, he engages in repetitive compulsive behaviors that include checking food temperatures, cleaning utensils, hand washing to the point of raw skin, and checking kitchen cleanliness. Despite his best efforts, he cannot control the urges he feels and rarely gets a break from the obsessive thoughts and compulsions that accompany them.
Motor tics co-occur often in individuals with Obsessive-Compulsive Disorder (OCD). These tics occur nearly every day and have occurred prior to the age of 18. Individuals experiencing these tics find that they are uncontrollable and involuntary. Co-occurrence of these two conditions has been fairly high with more than 60% of individuals with Tic Disorder experiencing symptoms of OCD.

Dylan has experienced distress related to social relationships prior to the manifestation of the OCD symptoms. He makes little eye contact, struggles to understand social cues and nonverbal body language, and has difficulty relating to his peer group despite wanting to have friendships. Dylan fixates easily on issues or behaviors and has a difficult time with inferences or interpreting meaning. Given the symptoms presentation, there should be more diagnostic testing to determine if an Autism Spectrum Disorder is warranted.

■ DIAGNOSTIC CONCLUSIONS

Obsessive-Compulsive Disorder (OCD)
Tic Disorder
Social (Pragmatic) Communication Disorder

■ SUGGESTED THERAPEUTIC INTERVENTIONS

OCD and Tic Disorder are neuropsychiatric disorders that are often treated by behavior modification and/or medication management. In both cases, parental and/or familial support is also indicative of long-term success rates in those diagnosed. According to Lombroso and Scahill (2008), habit reversal training (HRT) “involves helping clients increase awareness of tics prior to their expression, self-monitoring, relaxation training, and competing responses.” Individuals aware of an expression of a tic are encouraged to produce a voluntary competing response instead of the conditioned response. Early indications show that this is a positive behavior modification for those suffering from Tic Disorders.
The treatment of OCD has been well established in the roots of behavioral therapy. Exposing clients to the feared stimuli and blocking the conditioned response ultimately reduces the symptoms and severity of OCD. In children and adolescents, it is imperative that parent training is reinforced so that the child can have continued support at home and/or school. In either case, medication management coupled with behavior modification is generally considered the most comprehensive treatment protocol.

FOR YOUR CONSIDERATION

1. Given what you know about Dylan, what are some ways you can begin to help him understand his own diagnoses? Considering that certain concepts related to his condition may be confusing, be creative in your approach!
2. How might Dylan’s family hinder his progress with his OCD in the home environment? Consider ways to help his family support him and not enable him.

REFERENCE