Diagnostic Case Study:

Mr. Jones

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Presenting Problem
At his initial intake at Life Christian Counseling Network (LCCN) clinic, Mr. Jones\(^1\) stated that he just recently recognized that he suffers from Bipolar I Disorder. He has good insight into his difficulty with medication compliance and is seeking psychotherapy to develop alternate coping mechanisms. He said that he believes he will be able to manage the symptoms with enough support and with a medication protocol that allows him more emotional range. He has come into treatment with the support of his significant other, and stated that he is committed to doing whatever it takes to eliminate the self-destructive cycle. He wants to “stop the sadness” of deep depression and the out-of-control behavior of mania so he can attempt to resume his career as a pianist and composer.

Brief Diagnostic Summary
Mr. Jones is a male Caucasian, 40 years of age. He is charming, insightful, well groomed, of average height and weight. During the interview, he maintained good eye contact with appropriate affect. He appeared to be of above average intelligence He was engaged in the interview process and appeared relaxed and confident during the interview. Mr. Jones was oriented times three and demonstrated good short term memory but had difficulty with long term memory. He is sophisticated and has traveled the world extensively. He is a classically trained pianist and composer. He is currently unemployed but in his last job he was underemployed as a carpenter. He lives alone but has a stable relationship with his significant other, a mental health professional. He reports he has one close friend and is also close to his friend’s family.

Mr. Jones reports that he had little if any emotional connection to his emotionally distant parents. He remembers one “terrible argument” with his father that precipitated his leaving home as a teenager. He denies having any living relatives. He stated that he was a “child prodigy” who could play advanced piano music at age 3. He was a voracious reader and had “read everything by age 12”. Mr. Jones stated that he was the “center of the universe” at age 15. Mr. Jones stated that the onset of his first manic episode occurred at age 15 when he “woke up in a mental hospital” and that he has been in and out of hospitals for the “last twenty years” without any ability to maintain mood stability, employment stability, or relational constancy.

He attended college at a music conservatory but left during his junior year due to a manic episode. He reported a suicide attempt during that time “after swallowing 73 Extra Strength Tylenol on a full stomach.” His girlfriend at the time, “the only one who had ever loved me” broke off the relationship because “I was too much work. I was too much work for everybody.”

Mr. Jones was unable to give a detailed history. He reported that he has had short periods of high functioning, of stable employment and financial stability interrupted by episodes of debilitating mania where he has depleted his financial resources and been combative with employers, and then cycled into periods of severe depression. He reported within the last 12 months, he has suffered from a hypomanic episode (1) that developed into a manic episode (2), a major depressive episode (3), and a second hypomanic (4) episode. A partial remission of less than one month was achieved through medication compliance between the depressive state (3) and most recent hypomanic state (4).

\(^1\) Mr. Jones is a hypothetical character and therefore, no attempt has been made to alter or disguise his identifying demographic material or history.
During the first hypomanic episode (1), he was brought by the police to the hospital in a delusional state for 72-hour observation. He had been restrained from attempting to “fly off” of the roof of a four story building. He was released with a diagnosis of schizophrenia. He was returned to the hospital within two days by the police in a state of full blown mania after he disrupted a symphony orchestra performance. During this manic episode, he spent his entire savings of $12,000. He exhibited heightened powers of observation, perception, mental processing and math skills. He exhibited grandiosity, poor judgment, racing thoughts, pressured speech, incoherence, severe agitation, and an inability to sleep. He was reported by the attending psychiatrist as being expansive, intrusive, inappropriate, and euphoric. He was prescribed and began a course of Lithium treatment. At the competency hearing for involuntary commitment with indeterminate release, he demonstrated lack of insight into his behavior but denied any history of depressive episodes, and persuaded the judge to release him.

Within a week, he was voluntarily admitted to the hospital in a state of severe depression. He was disoriented, unaware of his surroundings, was observed wandering in and out of traffic, was despondent, exhibited psychomotor retardation, anhedonia, and reported that he was overwhelmed with sadness and weeping. He was hopeless, disheveled, poorly groomed, and listless. He wept that he couldn’t “make the sadness go away.” Upon his physical exam at admission heavy bruising on his torso was observed that he couldn’t account for.

During his 30 day stay at the hospital, Mr. Jones made significant progress. However, he abruptly left the hospital before completing treatment when he was transferred from his attending psychiatrist to a new physician in a different hospital. Upon leaving he discontinued all psychotropic medications and quickly entered into a hypomanic state. After being located on the rooftop site of his previous flying attempt, Mr. Jones recognized that he could not manage the symptoms without further treatment and he agreed to enter therapy and resume medication. He was referred by his former psychiatrist to this counseling center for psychotherapy and for medication management.

Mr. Jones is reluctant to use many of the mood stabilizing drugs. He states he needs his “highs”. However, he does recognize that his manic states are destructive to his functioning and to relationships. He desires intimacy, stability, and constancy, and he is willing at this point to stay in therapy as well as use medication that is closely monitored to avoid a depressed affect or mania. He does not currently have suicidal ideation but admitted that within the last six months he has had severe suicidal ideation.

Cardinal Diagnostic Features

Bipolar I Disorder is definitively characterized by one or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes (APA, Diagnostic & Statistical Manual, IV; Text Revision, [DSM-IV-TR], 2000). Mania is defined as a distinct period lasting at least a week (or less if hospitalization is required) where there is “a persistently elevated, expansive, or irritable mood” (DSM-IV-TR, p. 357) (Criterion A).

To meet criteria for Bipolar I Disorder, three additional symptoms from Criterion B must be present. These include inflated self esteem or grandiosity, decreased need for sleep, pressured speech, flight of ideas or racing thoughts, distractibility, an upswing in goal directed activity or agitation, and excessive involvement in high risk behaviors. Criterion C is an exclusion criteria: the criteria for a Mixed Episode must not be met. The disturbance in mood must be sufficient to interrupt occupational or relational functioning, require hospitalization, or have psychotic features (Criterion D). Finally, Criterion E is an additional exclusion criteria: the symptoms
cannot be attributable to a substance or general medical condition, including anti-depressant treatment (DSM-IV-TR).

**Differential Diagnosis**

Mr. Jones met criteria A through E for Bipolar Disorder I. Mr. Jones had no underlying medical conditions thus ruling out Mood disorder due to General Medical Condition. He tested negatively for any substances. He indicated in his first hospitalization that in the past he has used moderate amounts of wine as a way to relax but does not have a history of substance abuse, thus ruling out Substance Induced Mood Disorder. He did not meet criteria for Attention Deficit/Hyperactivity Disorder. Bereavement and Adjustment Disorder were ruled out. Finally, he did not present with prominent irritability thus Manic Episodes with Irritable Mood was ruled out.

There was concern about the possibility of a co-morbid personality disorder. Mr. Jones reported chronic feelings of emptiness and core abandonment issues, inability to tolerate loss of relationship and identity disturbance, self-blaming and self-accusation at loss of relationship which can be features of Borderline Personality Disorder. He did not meet the criteria for Borderline Personality Disorder or for Personality Disorder NOS. It was determined that the exhibited features were part of the manifestation of manic episodes.

Mr. Jones experienced partial remission during his extended hospital stay but the mood disorder returned upon cessation of medications. Within the previous 12 months, Mr. Jones has experience at least four episodes of a mood disturbance thus Mr. Jones meets criteria for the specifier, Rapid Cycling.

**DSM Multi-axial Diagnosis**

<table>
<thead>
<tr>
<th>Axis I</th>
<th>296.40 Bipolar I Disorder, Most Recent Episode Hypomanic, In Partial Remission, Without Interepisode Recovery, with Rapid Cycling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis II</td>
<td>799.9 Diagnosis Deferred on Axis II</td>
</tr>
<tr>
<td>Axis III</td>
<td>None</td>
</tr>
<tr>
<td>Axis IV</td>
<td>Unemployment Economic problems</td>
</tr>
<tr>
<td>Axis V</td>
<td>GAF 35 (Current) Highest in last year 65</td>
</tr>
<tr>
<td>Axis VI(^2)</td>
<td>Existential concerns but no religious affiliation</td>
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</tbody>
</table>

**Interaction of Psychopathology and Spirituality**

Mr. Jones denies any religious training or affiliation. He has not indicated any spiritual practices or spiritual resources. However, he does have existential concerns with the purposelessness of his illness, the suffering he has endured and caused to loved ones. He cannot find any meaning in why he had such prodigious gifts that were wasted the last 20 years of his life.

During manic episodes, he endured auditory hallucinations which he still wonders about. He questions whether it was possible that he had actually connected with a force in the universe at that time. He feels somewhat bitter toward a God who would have endowed him with so much promise and ability that could not be realized. He is also angry that this same God would

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\(^2\) Axis VI is used at the LCCN clinic to assess spiritual strengths or resources
not spare his family from so much pain. He is not open to discussing this further at this time because he isn’t interested in a “God that is either not very powerful or not very good”.

It is the opinion of this writer that a strong therapeutic alliance with a caring compassionate Christian counselor could help Mr. Jones form a deep attachment with someone who can incarnate God’s loving presence. It is hoped that this attachment could increase his ability to internalize the sense of being loved and acceptance and provide a segue into experiencing the love of God.

Treatment Approach

Treatment will consist of psycho-education to aid in regulating Mr. Jones’s circadian rhythms, building social support and increasing insight about medication management and self-awareness. Treatment will be a multi-modal approach including Cognitive Behavioral Therapy (CBT), interpersonal and social rhythm therapy (IPSRT), and psychodynamic therapy. Individual therapy will be targeted toward building insight and increasing personal responsibility. Group therapy will be used to increase social skills, and increase support. Adjunctive therapies (such as anger management classes) are geared toward improving coping skills.

Immediate goals.

1. Medication compliance
2. Regulate circadian rhythm by reestablishing regular routine (regular bedtime and time of arising, morning routine) and establish regular daily cardiovascular exercise (Frank, 2007)
3. Identify and increase social support including spiritual resources if applicable
4. Compliance with therapeutic plan regarding frequency and modality of therapy, whether individual, family, and/or group
5. Attend a National Alliance of the Mentally Ill (NAMI) psycho-education meeting for people living with Bi-Polar Disease and their families and/or significant others
6. Monitor suicidality

Short term objectives.

1. Diminish manic mood and return to previous level of most effective functioning
2. Psycho-education about necessity of medication compliance, the need to learn effective coping strategies for stressful life events, and the need to minimize disruptions in social rhythms (Frank, 2007, p. 465)
3. Reduce psycho-social stressors
4. Psycho-education to self-monitor his mood cycles and to identify his triggers for depression and mania (Yarhouse, Butman, McRay, 2003, p. 162)
5. Explore early childhood and construct spiritual and family genogram to identify sources of irrational beliefs
6. Target negative self talk, irrational attitudes and beliefs, and guilt over real or imagined wrongs and shame (Yarhouse, Butman, McRay p. 159)
7. Teach relaxation skills to improve anxiety and mood management
8. Improve communication skills to improve relationships and reduce stress
9. Complete anger management training to gain additional coping skills and symptom reduction
10. Join a Weekly NAMI support group to provide additional social support and resources
11. Monitor suicidality to reduce risk of self-harm

Long-term goals.

1. Develop the ability to accept the diagnosis of Bipolar I, and cope with negative feelings generated by living with a chronic disease
2. Medication compliance
3. Monitor mood cycles
4. Utilize effective coping strategies for stressful life events; minimize disruptions in social rhythms (Frank, 2007, p. 465)
5. Increase social support system (Frank, 2007)
6. Develop healthy cognitive beliefs about self, others, and the world, in order to reduce depressive symptoms.
7. Develop realistic expectations about schedule, goals, and accomplishments.
8. Elimination of suicidal risk.
9. Internalize skills
10. “Achieve an optimal level of wellness” (National Alliance for the Mentally Ill [NAMI], 2009)

Length of treatment.

Due to the chronic nature of Bipolar I Disorder and the difficulties surrounding long term medication compliance and management, it is recommended that Mr. Jones remain in therapy for as long as he is receiving medication. It is recommended that he continue with weekly therapy until his immediate therapeutic goals have been met. At that point, it is likely that biweekly sessions will be sufficient to help him achieve his short-term objectives. At that point, it is recommended that he continue in a minimum of once monthly sessions to maintain stability.

Treatment goals can change over the course of the illness. It is recommended that the treatment plan and goals be reviewed regularly with Mr. Jones and that they be amended collaboratively.

Prognosis for recovery.

Mr. Jones is highly motivated to learn to manage his disease and has stated that he will comply long term with an acceptable medication regime. He is in a stable relationship with a professional female who is very knowledgeable of Bipolar Disorder, who is extremely supportive of his treatment goals, and who is a willing participant and co-therapist in IPSRT. She is also willing to attend a NAMI support group for family members of persons diagnosed with Bipolar I Disorder. As long as Mr. Jones is willing to comply with treatment recommendations, it is expected that he has a favorable prognosis for achieving a very functional level of living.
References


Chris,

Your skills as a clinician shine in your write up. I liked the Axis VI that you invented, although I recall that you have shown this to me before, it stands out here. My feedback is for you to write consistently in the past tense throughout, make statements about details that you cannot verify as “he reported that he is an accomplished musician” instead of “he is an accomplished musician”; and give rationale for all of your treatment goals. Excellent work, readable with a nice flow and very detailed and well referenced.

20/20

TOTAL: 20 points

(1.5 points) Brief Diagnostic Summary:

(2.5 points) Cardinal Diagnostic Features (with rationale):

(4.0 points) Differential Diagnosis (with rationale):

(3.0 points) DSM Multi-axial Diagnosis (with critical information):

(4.5 points) Interaction of Psychopathology and Spirituality (with implications):

(4.5 points) Treatment Approach (with goals, objectives and length of treatment)