Diagnostic Case of Mr. Jones

Jaclyn N. Cervo

Regent University

1. Indentify the cardinal diagnostic features.

Mr. Jones has exhibited behaviors and symptoms associated with both manic and depressive episodes. These episodes cycle rapidly, including four or more mood episodes during a twelve month period. When in a manic episode, Mr. Jones appears to be hyper, inquisitive, distractible, euphoric, egotistical and grandiose.

In great contrast to his manic episodes, Mr. Jones has also displayed a severely depressed mood for an extended period of time. During these periods of depression, which can last for several weeks, Mr. Jones suffers from extreme sadness, fatigue and suicidal thoughts. Mr. Jones has reported that he has attempted suicide during previous depressive episodes, once by attempting to overdose on aspirin.

1. Rational for significance of cardinal features of client.

The extreme nature of Mr. Jones’ behaviors and emotions during observed states of mania and depression provide cause for concern about his personal safety and wellbeing as well as that of those around him. During a recent manic episode Mr. Jones had to be hospitalized after he attempted to “fly” off the roof of a town home that he was working construction on. After being released from the hospital, during that same manic episode, he then barged onto a stage during an orchestra concert and attempted to take over conducting the orchestra before being arrested and transported again to the hospital.

1. Based on observable behaviors, as well as police and hospital records several differential diagnosis have been considered including: Mood Disorders (e.g. Mood Disorder Due to a General Medical Condition, Substance-Induced Mood Disorder, Major Depressive Disorder, Bipolar I Disorder, Bipolar II Disorder, Dysthymic Disorder and Cyclothymic Disorder), and Psychotic Disorders (e.g. Schizophrenia, Schizoaffective Disorder, and Delusion Disorder). Mood Disorder Due to General Medical Condition and Substance-Induced Mood Disorder were both ruled out based on medical observation during Mr. Jones’ recent inpatient stays. Mr. Jones’ history of both Manic and Mixed Episodes ruled out Major Depressive Disorder, Dysthymic Disorder, Bipolar II Disorder and Cyclothymic Disorder (American Psychiatric Association [*DSM-IV-TR*], 2000 p. 387). All Psychotic Disorders were ruled out because Mr. Jones’ has never displayed any psychotic symptoms “in the absence of prominent mood symptoms” (*DSM-IV-TR*, 387).
2. Identify behaviors, attitudes and interactions that support diagnosis.

During Manic Episodes, Mr. Jones exhibits rapid speech and a constant need for social contact or mental stimulation. He readily inquires about personal matters of those within his immediate physical proximity but offers no substantive information about himself in response. Additionally, while in a manic state Mr. Jones engages himself in very quickly formed romantic and sexual relationships displaying both physical and emotional intimacy with partners of whom he has limited or no prior knowledge. His behaviors are noticeably outside the realm of socially acceptable behavior and as such often catch the attention of passersby. When Mr. Jones is confronted about his bizarre or risky behavior his reaction is often dismissive although he can also, on occasion, react with agitated aggression. For example, when a friend tried to stall Mr. Jones from speeding off on a stolen motorcycle Mr. Jones became verbally aggressive with the friend.

Mr. Jones has also experienced multiple Major Depressive Episodes during which he is plagued by extreme feelings of sadness, fatigue, and a slowing of fine motor skills. “I can’t stop the sadness,” Mr. Jones remarked in reference to the emotional low he feels during a Major Depressive Episode. At the lowest peaks of his depressed episodes Mr. Jones presents in a dazed and confused state, unable to maintain minimal personal hygiene, or to communicate fluently with others.

1. Time issues, duration of disorder and essential characteristics of client.

Clinical notes and records regarding the mental health of Mr. Jones are only available dating back one year, all information gathered about symptoms and behaviors before that date are based on the self-reporting of the client. The client reports that he was a very bright child and that he reached major milestones, such as being able to read, at a very early age. Mr. Jones describes that:

“When I was three years old, I played Mozart, by the time I was nine I had read everything. When I was eleven, I was the centre of the universe. And then I woke up one day, and I was in a mental institution. I’m not normal. I’ve never been normal.”

The client self-reported the onset of severe symptoms to have occurred at the age of twenty which is consistent with the average age of onset for Bipolar I Disorder of 18 (Durrand & Barlow, 2010). Within the first year of onset, the client suffered a Major Depressive Episode and attempted suicide by ingesting a large quantity of aspirin. Again, based on Mr. Jones’ self-reporting he has previously been diagnosed with and treated for Bipolar I Disorder. Mr. Jones admittedly has not adhered to previously prescribed regiments of therapy and dosages of lithium because he felt that the treatments limited him in expressing himself. Currently, Mr. Jones does own an apartment, but is unable to hold down a job, has drained his financial resources, and has very limited social outlets.

1. Diagnostic Impressions: The following diagnosis was made based on pre-recorded videos of Mr. Jones in a clinical setting; therefore I chose to identify the current episode of Mr. Jones as “unspecified”.

**DSM-IV-TR Multiaxial Assessment**

**Axis I:** 296.7 Bipolar Disorder, Most Recent Episode Unspecified, Without Full Interepisode Recovery, With Rapid Cycling

**Axis II:** V71.09 No disorder present

**Axis III:** Deferred, pending general medical exam

**Axis IV:** **Problems with primary support group:** estrangement from parents, estrangement from long-term girlfriend.

**Problems related to the social environment:** living alone, inadequate social support.

**Educational problems:** none reported.

**Occupational problems:** currently unemployed, discord with boss at previous work-site.

**Housing problems:** none reported.

**Economic problems:** inadequate finances (recently depleted savings account during manic episode).

**Problems with access to healthcare services:** none reported.

**Problems related to interaction with legal system/crime:** prior arrests, crimes committed including theft of motorcycle, competency hearing.

**Other psychological and environmental problems:** Involved in an emotional and sexual relationship with previous mental health care provider (psychiatrist).

**Axis V: Global Assessment of Functioning Scale**

Highest score in past year:62

Lowest score in past year:10- occurred during depressed episode.

1. Identify and address spiritual component of Mr. Jones’ case.

Mr. Jones appears to experience the joys of life most readily through the arts, particularly music; connecting with things through whole body expressions. For example when he experiences a piece of music Mr. Jones will hum the sounds, use his hands and arms to orchestrate the sounds, and dance or move to the rhythm. Mr. Jones has not shared any association with a particular religious or spiritual movement but I would suggest that incorporating the practice of meditation or tai chi into his daily lifestyle would be spiritually beneficial. Tai chi, more formally known as tai chi chuan, is a form of meditation in which one practices moving his/her body slowly and purposefully through a series of choreographed movements in order to create balance in one’s life by balancing yin and yang and optimize the flow of energy called qi (National Center for Complementary and Alternative Medicine [NCCAM], 2009).

1. Treatment approach, including goals, objectives and anticipated length of treatment.

Based on all of the above information, I believe that the best course of treatment for Mr. Jones would include medication, interpersonal and social rhythm therapy (IPSRT), individual therapy, couples therapy, and some form of a spiritual element such as Tai Chi. Regarding the setting of his therapy, if Mr. Jones is living with his current girlfriend (and previous psychiatrist) I believe he is in a safe enough environment to be treated through outpatient care. If, however, Mr. Jones’ girlfriend is unwilling or unable to share a residence with him and provide him with a high level of support I believe that inpatient treatment, at least initially, would be the best option.

Mr. Jones, like many Bipolar I Disorder clients, has in the past been resistant and inconsistent with the use of medication to treat his disorder. Despite the client’s dislike of taking a medication such as lithium to curb his manic and depressed episodes and even his mood I believe that it is in his best interest to proceed with taking the medication as prescribed. It is not uncommon for client’s to lament the loss of the rush associated with manic episodes and so it will be pivotal to the success of Mr. Jones’ treatment that his medications be monitored closely to ensure that he does not stop taking them (Durand & Barlow, 2010, p. 242).

The psychological components of Mr. Jones’ treatment which should include IPSRT, individual therapy, couples therapy, and spiritual therapy will be essential components in helping Mr. Jones achieve stability. The combination of these treatments will provide Mr. Jones with significant emotional support and foster a pattern of daily life for him, which promotes self-care and general wellbeing. This combination of services will also serve a practical purpose of helping his therapeutic case manager to monitor his progress.

References

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