Case Example **Jenni Bearden**

A. Identifying Information:

JW, 7 yo AA female.

Ct is repeating kindergarten for the 3rd time due to client running out of the classroom, not completing work and having no grades in the system.

B. Chief Complaint:

Ct has multiple suspension for fighting. Mother states that she fights herself and others, can't still, and talks constantly. Reports that she will bite herself and pinch herself. Ct is defecating on herself and putting it on everything. Ct will stand in the hallway and urinate on herself. Mother states that she will pull her braids, hair out and this happens whether she is nervous or happy. Mother reports that she also picks at her skin and scratches her face. Onset of issues was when pt was 4 y/o.

Ct reports hearing screaming all the time. Ct reports hearing voices telling her to hurt herself and others. Ct reports seeing a shadow that looks like a girl. Ct reports feeling scared when she sees the shadow.

C. History of Present Illness:

a. **Emotional Symptoms:** Ct will become angry without warning and will bang her head on the floor until her nose bleeds. Ct reports feeling compelled to target one specific sibling with aggression.

b. **Cognitive Symptoms:** Ct is repeating kindergarten for 3rd time. Ct is being tested for developmental delays. Ct is unable to recite alphabet, write name, or read.

c. **Behavioral Symptoms:** starts fights at school "leaving visible marks on peers", attempting to choke self, knives, setting fires. Has left the house in the middle of the night and was found sitting on the curb. Ct reports "I was mad". Ct reports having scary dreams sometimes. Ct has torn headboard apart, will defecate in bags and hide in her headboard. Ct will urinate on entertainment center, stairs, etc.

d. **Physiological Symptoms:** Not sleeping.

D. Parent-Child Attachment History:

Family mental health history:

M - schizoaffective;

MGM - bipolar;

MGF - schizophrenia;

father's side - "they have a card they have to carry around for their mental illness"

Ct does not have close attachment with mother as it is usually a strained relationship due to behaviors. Mother repeatedly asks for client to be referred to long term residential program.

E. **Childhood Trauma:**

Family denies trauma history

F. Psychiatric History:

Ct referred post hospital in January 2020 from Lakeside for suicidal attempt, aggression, assault on teacher, students and siblings. Ct admitted to St Francis Hospital in August 2020 due to physical aggression, self-harm, defecating and urinating throughout the house.

G. Personal and Social History:

Ct lives with both parents and 6 siblings. Ct denies having friends at school or in the community.

H. Medical History:

Mom reports normal pregnancy with no complications and no delays.

Ct currently prescribed Clonidine 0.1mg/24 hr patch Transdermal every 7 days. Mom reports client takes the patch off and throws it away.

I. **DSM Diagnoses:**

DSM-5 Diagnoses:
314.01 (F90.8) Other Specified Attention-Deficit/ Hyperactivity Disorder
312.89 (F91.8) Other Specified Disruptive, Impulse-Control, and Conduct Disorder

DSM-5 Diagnoses Rule Out:
299.00 (F84.0) Autism Spectrum Disorder
295.90 (F20.9) Schizophrenia; Multiple episodes, currently in acute episode