

Case Study #1 Pete a Provisional Diagnosis

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The case study of Pete brings up a great number of needs that will, hopefully, when properly addressed, lead to opportunities for Pete to consider his life thus far and seek to make progress in establishing healthy relationships and goals. According to the American Psychiatric Association, *DSM-5's Integrated Approach to Diagnosis and Classifications*, a clinician using the *Diagnostic and Statistical Manual-5* is not attempting to identify a “concrete threshold” between normal and abnormal behaviors or conditions (2013). This dimensional approach when applied to Pete’s presenting symptoms seem to put him on the continuum of several major spectra: Trauma and stressor-related disorders, Disruptive, Impulse-control, and Conduct disorders, and Substance-related and Addictive Disorders. In comparing the different features of these DSM-5 categories, I came to the conclusion that Pete’s cardinal diagnostic spectrum is **312.82 Conduct Disorder, adolescent onset, (provisional)**. Pete’s reason or presenting need for admission to the hospital was his self-report of self-injury. This immediate medical need must be addressed alongside his psychological needs.

The specific presenting behaviors that lead me to make this particular diagnosis are his treatment of animals (shooting squirrels with bb guns), fire-setting and destruction of property (blowing up mailboxes with firecrackers), fighting at school. Granted, these behaviors are beyond the 12 month timeframe of diagnostic criteria, but I mention them because . He still has 3 significant behaviors within the last 12 months, namely, “broken into (a car)”

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and “stolen items (a car) of nontrivial value without confronting victim”, “is often truant from school” (though from case I am not aware of frequency of truancy before age 13), and “1 within the last 6 months” his disturbances in his behaviors (using various substances despite adverse consequences, while hallucinating on LSD he severely sliced his hand, recent expulsion from military school) have caused “clinically significant impairment in social, academic, and occupational functioning”. There are certainly environmental prognostic factors that indicative of CD due to Pete’s early childhood experience with abuse by a care-giver, “frequent changes in care-givers”, and community risk factor of “association with a delinquent peer group”. His current location at the psychiatric unit of a general hospital is secure. From this location, he will be able to undergo further observation and assessment, and begin treatment. In the course of treatment, I would highly recommend his attachment trauma be addressed. Most likely, this is a prognostic factor in all of the problems Pete faces. Acknowledging this and working through it will assist Pete in the healing process.

As mentioned above, Pete’s case includes many behaviors that fall into the diagnostic criteria of several other disorder spectrums. Pete’s behaviors have most definitely been shaped by his early childhood experiences of trauma. The instability of his first three years of life are definitely significant to his early attachment. First, he was adopted outside of his country of birth and away from his biological mother. This trauma would not, by definition of the DSM-5 of Post-traumatic stress disorder (PTSD), because the presenting

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information we have does not include a record of Pete having “recurrent, involuntary, intrusive memories”, “distressing dreams”, “avoidance of stimuli” associated with the events. Pete’s traumatic physical abuse and removal from his birth home occurred before 6 years of age, by definition this would rule out PTSD, according to DSM-5 criteria, as well.

Reactive Attachment Disorder (RAD) was, in my estimation, the next closest diagnosis that Pete’s behaviors seemed to indicate. However, my reason for ruling it out was due to lack of evidence that he displayed “evidence of the disturbance before age 5” (2013). Also the functional consequences of RAD seem to only have affected his relationship with parents and that not to the level described in the diagnostic criteria. According to the vignette, he never had problems with interacting among his peers. I did find mention of a Teen Reactive Attachment Disorder (Horner, 2019), but I was not able to conclude this was Pete’s cardinal issue, especially due to his being successful in peer relationships through out his life.

There was not sufficient detail in the vignette to diagnose Substance Use Disorder nor Other Hallucinogen Use Disorder. In treatment, it will be necessary to address Pete’s substance abuse. Pete was fortunate not to die from the injuries he inflicted upon himself when while under the influence of acid (LSD). Drug education should certainly be an element of both individual treatment and group help for Pete.

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There are several admitting reasons that will need to be addressed immediately. First, the wound on his left hand. Next, the substance abuse that began 3 1/2 years ago. And finally, the trauma Pete has experienced, which is likely driving much of his behavior. Once his injury to hand is attended to a thorough diagnostic substance abuse screening test can be performed. Early relational stress is trauma, whether the experience can be consciously remembered or not, his body, his limbic system, is aware that he cannot trust his caregivers. According to attachment styles proposed by Mary Ainsworth, Pete would fit the avoidant type, characterized by an infant being avoiding or ignoring a care-giver (2017, Cengage.)

References

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders - 5*

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