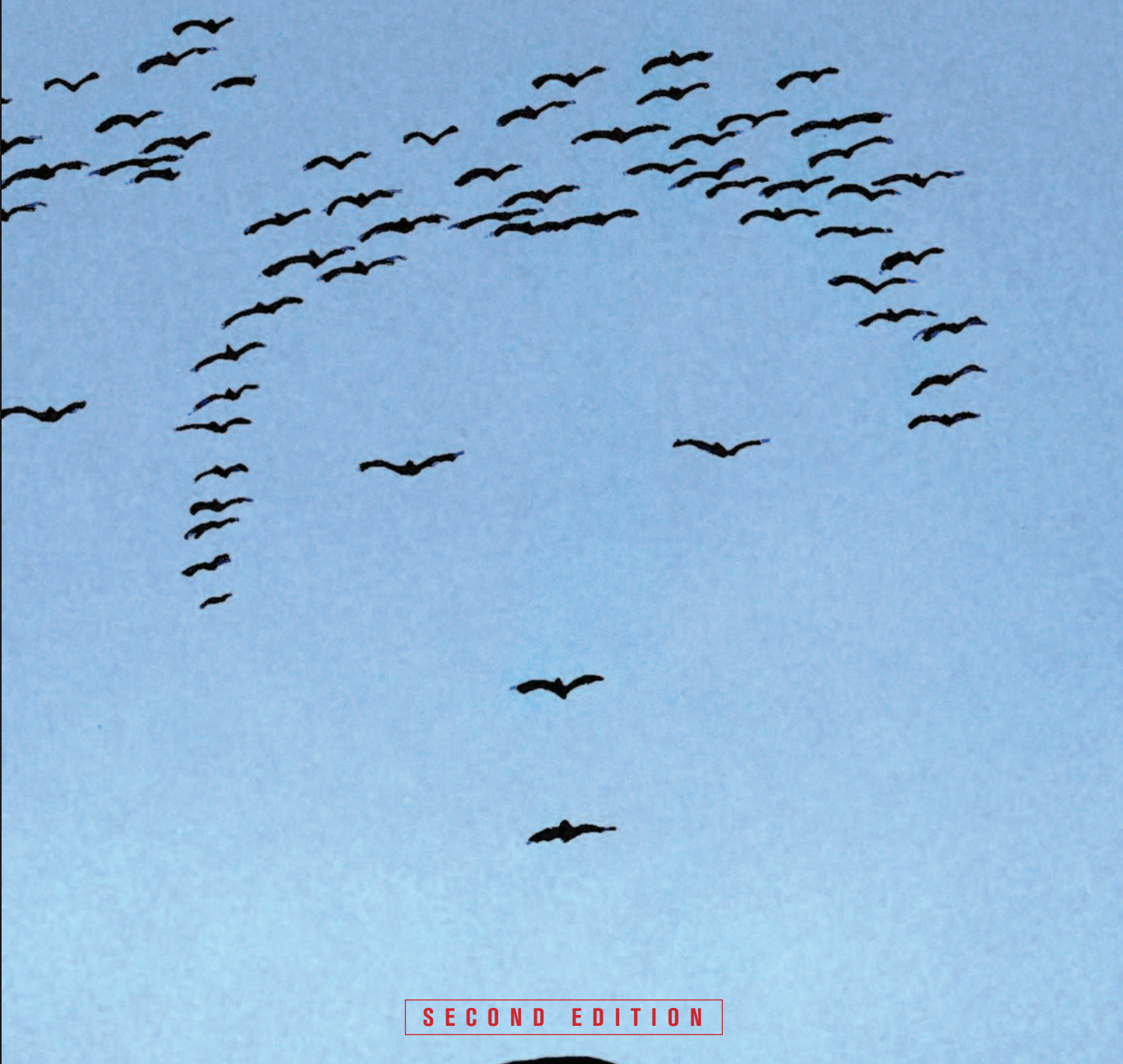

SECOND EDITION

CASE STUDIES IN ABNORMAL PSYCHOLOGY

Ethan E. Gorenstein and Ronald J. Comer

this page intentionally left blank

Case Studies in **Abnormal Psychology**

SECOND EDITION

Ethan E. Gorenstein
Behavioral Medicine Program
Columbia-Presbyterian Medical Center

Ronald J. Comer
Princeton University

WORTH PUBLISHERS
Macmillan Education

Vice President, Editing, Design, and Media Production: Catherine Woods
Publisher: Kevin Feyen
Senior Acquisitions Editor: Rachel Losh
Senior Developmental Editor: Mimi Melek
Assistant Editor: Katie Garrett
Marketing Manager: Lindsay Johnson
Marketing Assistant: Tess Sanders
Art Director: Diana Blume
Director of Editing, Design, and Media Production: Tracey Kuehn
Managing Editor: Lisa Kinne
Project Editor: Edgar Bonilla
Production Manager: Sarah Segal
Composition: Northeastern Graphic
Printing and Binding: RR Donnelley
Cover image: Gary Waters/Illustration Source

Library of Congress Control Number: 2014937988

ISBN-13: 978-0-7167-7273-6
ISBN-10: 0-7167-7273-6

Printed in the United States of America
First printing

Worth Publishers
41 Madison Avenue
New York, NY 10010
www.worthpublishers.com

For Margee, Eleazer, and Julian
—E. E. G.

For Delia and Emmett
—R. J. C.

this page intentionally left blank

CONTENTS

PREFACE

Several fine case study books available today provide in-depth descriptions of psychological disorders and treatments. In writing *Case Studies in Abnormal Psychology,* Second Edition, we wanted to maintain the clinical richness of such books and in addition offer a number of important and unique features that truly help bring clinical material to life. In both the previous edition and this one, our approach helps readers to appreciate the different perspectives of clients, friends, relatives, and therapists; reveals the nitty-gritty details of treatment programs; and challenges readers to apply their clinical insights, think critically, and make clinical decisions. We believe that *Case Studies in Abnormal Psychology,* Second Edition, can stimulate a deeper understanding of abnormal psychology by use of the following features that set it apart from other clinical case books:

1. **Multiple perspectives:** As with other case books, our cases offer in-depth descriptions of clinical symptoms, histories, and treatments. In addition, however, each case looks at a disorder from the point of view of the client, the therapist, and a friend or relative. These different points of view demonstrate that a given disorder typically affects multiple persons and help readers to empathize with the concerns and dilemmas of both clients and those with whom they interact.
2. **In-depth treatment presentations:** Extra attention is paid to treatment in this book, particularly to the interaction between client and therapist. Our detailed treatment discussions help readers to fully appreciate how theories of treatment are translated into actual procedures and how individuals with particular problems respond to a clinician's efforts to change those problems.
3. **Research-based treatments, integrated approaches:** The treatments described throughout the book represent approaches that are well supported by empirical research. In most of the cases, the treatment is actually an

integration of several approaches, again reflecting current trends and findings in the clinical research.

4. **Balanced, complete, accurate presentation:** Overall, a very balanced view of current practices is offered, with cases presented free of bias. Readers will find each of the major models of abnormal psychology—behavioral, cognitive, psychodynamic, humanistic, biological, and sociocultural—represented repeatedly and respectfully throughout the book, with particular selections guided strictly by current research and applications.
5. **Stimulating pedagogical tools:** An array of special pedagogical tools helps students process and retain the material, appreciate subtle clinical issues, and apply critical thinking. For example, every page of the book features marginal notes that contain important clinical and research points as well as other food for thought, each introduced at precisely the right moment. Testing shows that readers greatly enjoy this exciting technique and that it helps them to learn and retain material more completely.
6. **Readers' interaction and application:** The final three cases in the book are presented without diagnosis or treatment so that readers can be challenged to identify disorders, suggest appropriate therapies, and consider provocative questions (stated in the margins). By taking the perspective of the therapist, readers learn to think actively about the cases and apply their clinical knowledge and insights. These three special cases, each entitled "You Decide," are followed by corresponding sections in the appendix that reveal probable diagnosis, treatment approaches, and important clinical information about the disorder under discussion.
7. **Diagnostic checklists:** Each case is accompanied by a diagnostic checklist, a detailed presentation of the key DSM-5 criteria for arriving at the diagnosis in question.
8. **Real clinical material:** The cases presented in this book are based on real cases, as are the treatments and outcomes. They are taken from our own clinical experiences and from those of respected colleagues who have shared their clinical cases with us.
9. **Interwoven clinical material, theory, and research:** Each case weaves together clinical material, theoretical perspectives, and empirical findings so that readers can appreciate not only the fascinating clinical details and events but also what they mean. Similarly, they can recognize not only what and how treatment techniques are applied but why such techniques are chosen.
10. **Current material and references:** The theories and treatment approaches that are described reflect current writings and research literature. Indeed, we are proud to note that several exciting new cases have been added to this

second edition of *Case Studies in Abnormal Psychology.* In addition, the cases retained from the first edition have been carefully updated to reflect the clinical field's growing insights, new research findings, and DSM-5-based diagnostic changes. Similarly, the second edition's numerous margin notes are fully up to date, and like the cases themselves, they truly capture the state of affairs in the clinical field and world today.

11. **Readability:** Of course, every book tries to be interesting, readable, and widely appealing. But case books provide a unique opportunity to bring material to life in a manner that deeply engages and stimulates the reader. We have worked diligently to make sure that this opportunity is not missed, not only showing the diversity of our clients and therapists but making sure that readers walk away from the book with the same feelings of deep concern, passion, fascination, wonder, and even frustration that we experience in our work every day.

It is our fervent hope that the cases in this edition, like those in the first edition, will inspire empathy for clients, their relatives, their friends, and their therapists. The practitioners described in these pages struggle mightily to maintain both their humanity and their scientific integrity, and we believe that humanity is indeed served best when scientific integrity is maintained.

A number of people helped to bring this project to fruition. Foremost are the clinicians and patients who dedicated themselves to the efforts described in these pages. We are particularly grateful to Danae Hudson and Brooke Whisenhunt, professors of psychology at Missouri State University. These wonderfully talented individuals wrote the cases on somatic symptom disorder (Danae), and gender dysphoria (Brooke) for this edition. In addition, they helped revise and update the rest of the book. Throughout all of this work, their outstanding writing, teaching, clinical, and research skills are constantly on display.

Finally, we are indebted to the extraordinary people at Worth Publishers, whose superior talents, expertise, and commitment to the education of readers guided us at every turn both in this edition and the first edition of *Case Studies in Abnormal Psychology.* They include Kevin Feyen, Rachel Losh, Katie Garrett, Tracey Kuehn, Sarah Segal, Diana Blume, Edgar Bonilla, and developmental editor extraordinaire Mimi Melek. They have all been superb, and we deeply appreciate their invaluable contributions.

Ethan E. Gorenstein
Ronald J. Comer
April 2014

CASE 1

Panic Disorder

Table 1-1

Dx Checklist

Panic Attack

1. Persons experience a sudden outburst of profound fear or discomfort that rises and peaks within minutes.
2. The attack includes at least 4 of the following:
   (a) Increased heart rate or palpitations.
   (b) Perspiration.
   (c) Trembling.
   (d) Shortness of breath.
   (e) Choking sensations.
   (f) Discomfort or pain in the chest.
   (g) Nausea or other abdominal upset.
   (h) Dizziness or lightheadedness.
   (i) Feeling significantly chilled or hot.
   (j) Sensations of tingling or numbness.
   (k) Sense of unreality or separation from the self or others.
   (l) Dread of losing control.
   (m) Dread of dying.

(Based on APA, 2013.)

Table 1-2

Dx Checklist

Panic Disorder

1. Unforeseen panic attacks occur repeatedly.
2. One or more of the attacks precedes either of the following symptoms:
   (a) At least a month of continual concern about having additional attacks.
   (b) At least a month of dysfunctional behavior changes associated with the attacks (for example, avoiding new experiences).

(Based on APA, 2013.)

Table **1-3**

Dx Checklist

Agoraphobia

1. Pronounced, disproportionate, and repeated fear about being in at least 2 of the following situations: public transportation (e.g., auto or plane travel) • Parking lots, bridges, or other open spaces • Shops, theaters, or other confined places • Lines or crowds • Away from home unaccompanied.
2. Fear of such agoraphobic situations derives from a concern that it would be hard to escape or get help if panic, embarrassment, or disabling symptoms were to occur.
3. Avoidance of the agoraphobic situations.
4. Symptoms usually continue for at least 6 months.
5. Significant distress or impairment.

(Based on APA, 2013.)

Joe's childhood was a basically happy one. At the same time, it was steeped in financial hardship, as his Hungarian immigrant parents struggled to keep the family afloat in the United States during World War II. Joe's father, after a series of jobs as a laborer, ultimately scraped together enough money to start a small hardware store, which survived, but Joe had to quit school in the ninth grade to help run the business. He put in 9 years at the store before being drafted for the Vietnam War at age 23.

Panic disorder is twice as common among women as men.

Joe An American Success Story

When Joe returned from the army, he took more of an interest in the store, and with some far-sighted marketing strategies turned it into a successful enterprise that ultimately employed 6 full-time workers. Joe was proud of what he had accomplished but harbored lifelong shame and regret over his shortened education, especially as he had been an outstanding student. The store was thus both the boon and the bane of his existence.

Joe met Florence at age 45, after he took over the store from his father and established himself as a respectable neighborhood businessman. Before meeting Florence, the energetic businessman's social life was spare; his goal of making a success of himself was his overriding concern. Florence was a 40-year-old college-educated administrator for an insurance company when they met. She was

impressed with Joe's intelligence and wisdom and would never have suspected that his education stopped at the ninth grade. As their relationship progressed, Joe revealed his lack of education to her as though making a grave confession. Far from being repelled, Florence was all the more impressed with Joe's accomplishments. The couple married within a year.

Joe and Florence worked hard, raised a daughter, saved what they earned, and eventually enjoyed the fruits of their labor in the form of a comfortable retirement when he was 70. The couple continued to live in the neighborhood where Joe grew up and had his business. They spent much of their time with friends at a public country club that was popular among local retirees. Joe also enjoyed tinkering daily with the couple's modest investments.

Six years into Joe's retirement, when he was 76, Joe and Florence were returning from a Florida vacation when catastrophe struck. The catastrophe was not an airplane accident or anything like that. It was a more private event, not apparent to anyone but Joe. Nevertheless, it had a profound and expanding effect on the retired veteran, and it began a journey that Joe feared would never end.

Unlike Joe's case, panic disorder usually begins between late adolescence and the mid-30s, with the median age of onset being 20 to 24 years (APA, 2013).

Joe The Attack

After their plane took off from the Miami airport and Joe settled back in his seat, he noticed that it was getting difficult to breathe. It felt as if all the air had been sucked out of the plane. As Joe's breathing became increasingly labored, he began staring at the plane's sealed door, contemplating the fresh air on the other side. Then, suddenly, he had another thought, which frightened him. He wondered if he might feel so deprived of oxygen that he would be tempted to make a mad dash for the door and open it in midflight. He struggled to banish this vision from his brain, but soon he became aware of his heart racing furiously in his chest cavity. The pounding became almost unbearable. He could feel every beat. The beating grew so strong that he thought he could actually hear it.

Joe looked over at his wife, Florence, in the seat next to his. She was peacefully immersed in a magazine, oblivious to his condition. He stared at her, wondering what he must look like in such a state. His spouse glanced up for a moment, gave Joe the briefest of smiles, and went back to her reading. She obviously hadn't a clue as to what he was going through. Joe felt as if he were about to die or lose his mind—he couldn't tell which at this point—and she continued reading as if nothing were happening. Finally Joe had to say something. He asked Florence if the air in the plane felt stuffy to her. She said it seemed fine but suggested that her husband open the valve overhead if he felt uncomfortable. He did so and felt only slightly better.

The rest of the plane ride was sheer torture. Joe spent the entire time trying to get the cool air to flow directly onto his face from the valve above. This activity sustained him until the plane landed. When the passengers were finally permitted

to disembark, Joe couldn't get to the door fast enough. As he emerged from the plane, he felt released from a horrible confinement.

After arriving home at his apartment in the city, the retired store owner felt better. He was still shaky, but he said nothing to Florence, who remained unaware of what had happened. Joe slept well that night and by the next morning felt like his old self. He decided to put the whole episode behind him.

Joe continued to feel fine for the next few days. Then one night he awoke at 2:00 A.M. in a cold sweat. His heart felt as though it were about to leap out of his chest; his lungs seemed incapable of drawing any oxygen from the air. His first thought was to open the bedroom window to make it easier for him to breathe. But as Joe got out of bed, he suddenly drew back in alarm. He recalled the airplane door and what had seemed like an almost uncontrollable urge to force it open in midflight. He wondered if this meant he had an unconscious desire to commit suicide. Joe concluded he should stay away from the window. Instead, he sat motionless on the edge of the bed while his thoughts raced along with his heart toward some unreachable finish line. The man was frightened and confused. He was also gasping loudly enough to awaken Florence. She asked him what was wrong, and he told her his physical symptoms: he couldn't breathe and his heart was pounding so hard that his chest ached. Florence immediately concluded that her husband was having a heart attack and called an ambulance.

Many people (and their physicians) mistake their first panic attack for a general medical problem.

The ambulance workers arrived, administered oxygen, and rushed Joe to the emergency room. By the time the patient got there, however, he was feeling much better. A cardiologist examined him, performed a battery of tests, and eventually informed Joe that he had not had a heart attack. In fact, there was nothing obviously wrong with him. The doctor told Joe he could go home, that the episodes were probably "just anxiety attacks."

Joe felt relieved that his heart seemed to be okay but was confused as to exactly what was wrong with him. He wanted nothing more than to forget the whole matter. However, as time passed, that became increasingly difficult. In fact, over the course of the next few weeks, he had 2 more attacks in the middle of the night. In both cases, he just lay in bed motionless, praying that the symptoms would go away.

Then there was a new development. One morning, Joe was walking down a busy street in his neighborhood, on a routine trip to the store, when he was overcome by the same symptoms he had previously had at night. Out of the blue, his heart started pounding, his breathing became labored, and he felt dizzy; also, he couldn't stop trembling. He looked around for a safe haven—a store or restaurant where he could sit down—but he felt as if he were in a kind of dream world. Everything around him—the people, the traffic, the stores—seemed unreal. He felt bombarded by sights and sounds and found it impossible to focus on anything. The overwhelmed man then recalled the cardiologist's mention of the term *anxiety attack* and came to the sickening realization that the doctor must

have detected that he had mental problems. Joe feared that he was on the verge of a nervous breakdown.

He was several blocks from home but discovered, to his relief, that he could make his way back to the apartment with less difficulty than he anticipated. Once inside, Joe sat down on the living room sofa and closed his eyes. He felt certain he was losing his mind; it was just a matter of time before the next attack sent him off the deep end. As he became caught up in his private terror, he heard a sound at the front door. It was Florence returning home from her shopping.

Once again, Florence appeared to have no inkling that anything was amiss. She cheerfully related the details of her shopping trip: the neighbors she met at the store, the things she bought, and the like. Joe could barely follow what she was saying, further proof, in his mind, that he was rapidly losing his grip. Finally, his wife suggested that they go out for a walk. At this, Joe realized that the very thought of leaving the apartment was terrifying to him. What if he had an attack in the middle of the street and could no longer function, physically or mentally? He felt as if he had a time bomb inside him. In response to Florence's suggestion, he simply broke down in tears.

Florence begged her husband to tell her what was wrong. Joe confessed that he had just had another one of his attacks, this time on the way to the store, and that this one was so bad he was forced to return home. Now he dreaded going outside.

Florence could see that Joe was extremely upset, but at the same time she was puzzled. There didn't seem to be anything wrong with him. He was in no obvious physical pain, and he appeared vigorous and alert. She insisted they make an appointment with their primary care physician.

In the week before the appointment, Joe made a few tentative forays onto the street in Florence's company. He felt some symptoms while outside but did not have as intense an attack as he had that one time when he was alone. His nighttime episodes increased in frequency, however—to the point that he could count on waking up with an attack almost every time he went to bed.

The Family Doctor Armed with New Knowledge

At the doctor's office, Joe recounted his repeated attacks of racing heart, breathlessness, and tremulousness. He didn't know quite how to describe his fear of losing his mind, nor did he really want to, so he left that part out. He did convey, however, that he had now become so apprehensive about the attacks that he was reluctant to venture outside for fear of being overwhelmed. In describing his symptoms, Joe noticed that he was actually starting to have some of them.

Around 2.8 percent of people in the United States have panic disorder in a given year; 5 percent develop the disorder at some point in their lives (Kessler et al., 2010).

As he continued, his physician became increasingly confident that the patient had panic disorder. The doctor marveled to himself at how far medicine had come

since he started practicing. Years ago, a patient like Joe would have been hospitalized for weeks with a suspected heart problem and subjected to dozens of tests. If no major disease turned up, he would be released, but even then the suspicion would linger that he was on the verge of a major cardiac problem, and the patient would be advised to cut back on his activities and keep on the lookout for further symptoms. Far from being reassured, the person would feel like a ticking time bomb.

Now physicians were very aware of the power of panic attacks and of how their symptoms mimicked those of a heart attack. As soon as cardiac and other physical conditions were ruled out, practitioners usually turned their attention to the possibility of panic attacks. Indeed, Joe's was the fourth case of probable panic disorder that the doctor had seen this month alone. Even more gratifying, very effective treatments for panic disorder were available, with many patients benefiting from only 5 therapy sessions (Otto et al., 2012). Now he could offer patients 2 forms of good news: one, that their heart was fine; and 2, that their condition was fully treatable.

Today's physicians must also be careful to consider possible medical explanations before making a diagnosis of panic disorder. Certain medical problems, such as thyroid disease, seizure disorders, cardiac arrhythmias, and mitral valve prolapse (a cardiac malfunction marked by periodic episodes of palpitations) can cause panic attacks. Medical tests can rule out such causes.

After examining Joe, the doctor informed him that other than a slightly elevated heart rate, everything seemed normal. He told his patient that his symptoms were by no means imaginary; rather, he had a well-known condition known as panic disorder. He suggested that Joe see Dr. Barbara Geller, a professor of clinical psychology at the nearby university, who also saw clients 2 evenings each week in private practice. Dr. Geller specialized in panic-related problems.

Joe was encouraged by his doctor's pronouncement that his condition could be helped, but he was leery of the idea of seeing a "shrink." He had never had any psychological treatment of any kind, and the whole idea fueled his secret fear, not yet expressed to anyone, that he was on the brink of insanity.

When they returned home, Florence urged Joe to call Dr. Geller, but he continued to put it off for a few more days. Florence, growing increasingly impatient, said she would call the psychologist herself to arrange the appointment, and Joe reluctantly agreed.

According to research, people who are prone to panic attacks typically have a high degree of anxiety sensitivity. That is, they generally are preoccupied with their bodily sensations and interpret them as potentially harmful. Research has shown that cognitive-behavioral therapy can decrease anxiety sensitivity, which leads to a decrease in symptoms of panic disorder (Gallagher et al., 2013).

Joe in Treatment Regaining Control over His Mind and Body

After Joe recounted his experiences of the past few weeks in minute and animated detail, Dr. Geller asked him if he could recall ever having had similar attacks or sensations prior to these. Upon reflection, Joe realized that he had had these sensations before, during the Florida vacation itself. He recalled that the day after arriving in Florida he fell as he was walking down some steps toward the outdoor pool. His injuries were not serious, but a cut on his chin was deep enough to require a couple of stitches from the house physician. For the remainder of the vacation, Joe had momentary jolts of anxiety—including heart palpitations and mild

dizziness—at the slightest indication of physical imbalance. He also realized now that since falling, he had been very tentative in his walking.

Joe strained his memory to recall whether he had ever had similar attacks or sensations before the Florida incident. The only thing he recalled in this connection was an extremely upsetting experience he had had more than 50 years ago, when he was in his 20s. It was something that he had never discussed with anyone.

When he was in Vietnam, he and some buddies were driving a jeep back to base when they passed a local man walking along the side of the road. To demonstrate goodwill, Joe offered him a ride. The man was grateful for this kindness and took a seat in the open vehicle. After traveling only a few hundred yards, however, the jeep hit an enormous pothole, throwing the man onto the road, where his leg fell under the jeep's wheel. The soldiers quickly loaded him carefully back onto the jeep and raced to the nearest civilian hospital. They had to leave the injured man there and depart, however, as they were already close to being AWOL.

When Joe visited the hospital the next day to assure himself that their passenger would recover satisfactorily, he was shocked at what he saw. Due to lack of staffing or supplies, or some such difficulty, the hospital had done nothing more than provide a bed for the injured man. As Joe tried to talk to him, the man just lay there, obviously traumatized, gazing absently into space. Joe left the hospital even more shaken than when he had witnessed the actual accident. He was certain he had ruined the life of another human being. He drove back to the base in a trancelike state, with his heart pounding and his eyes barely able to focus on the road. That intensity of feeling was the closest he had ever experienced to what he was going through now.

After interviewing Joe and reviewing his medical reports, Dr. Geller concluded that his condition met the DSM-5 criteria for a diagnosis of both panic disorder and agoraphobia. His panic attacks typically included several of the defining symptoms: breathlessness, heart palpitations, chest discomfort, tremulousness, sweating, and fear of losing control or going crazy. Moreover, he was almost constantly apprehensive about the possibility of further attacks. He was also diagnosed with agoraphobia, because he was beginning to avoid leaving the house except in Florence's company.

The *fight-or-flight response* is so named because it prepares an organism to cope with a dangerous predicament either by fighting or fleeing. It primes the organism for a rapid use of energy by increasing heart rate, breathing rate, perspiration, blood flow to large muscles, and mental alertness.

Dr. Geller's reading of psychological literature and her own research on panic disorders had convinced her, along with many other clinicians, that panic attacks and disorders can best be explained by a combination of biological and cognitive factors. On the biological side, she believed that panic attacks are similar to the so-called fight-or-flight response, the normal physiological arousal of humans and other animals in response to danger. The difference is that with a panic attack there is no external triggering event. From this standpoint, a panic attack can be considered a false alarm of sorts. The body produces its reaction to danger in

the absence of any objectively dangerous event. People whose bodies repeatedly have such false alarms are candidates for panic disorder.

On the cognitive side, Dr. Geller believed that a full-blown disorder affects those who repeatedly interpret their attacks as something more than false alarms. They typically identify the physiological reactions as a real source of danger. They may conclude that they are suffocating or having a heart attack or stroke; or they may believe they are going crazy or out of control. Such interpretations produce still more alarm and further arousal of the sympathetic nervous system. As the nervous system becomes further aroused, the person's sense of alarm increases, and a vicious cycle unfolds in which anxious thoughts and the sympathetic nervous system feed on each other.

For many people with panic disorder, the panic experience is aggravated by hyperventilation. As part of their sympathetic nervous system arousal, they breathe more rapidly and deeply, ultimately causing a significant drop in their blood's level of carbon dioxide. This physiological change results in feelings of breathlessness, light-headedness, blurred vision, dizziness, or faintness—sensations that lead many people to conclude there is something physically or mentally wrong with them.

Panic disorder is similar to a phobia. However, rather than fearing an external object or situation, those who have it come to distrust and fear the power and arousal of their own autonomic nervous system.

Even if people with panic disorder eventually come to recognize that their attacks are false alarms set off by their nervous system, they may live in a heightened state of anxiety over what their sympathetic nervous system might do. Many also develop anxieties about situations in which they feel a panic attack would be especially unwelcome (in crowds, closed spaces, airplanes, trains, or the like). Because of such anticipatory anxiety, their sympathetic nervous system becomes aroused whenever those situations are approached, and the likelihood of a panic attack in such situations is increased.

Given this integrated view of panic attacks, panic disorder, and agoraphobia, Dr. Geller used a combination of cognitive and behavioral techniques, each chosen to help eliminate the client's anxiety reaction to his or her sympathetic nervous system arousal. The cognitive techniques were designed to change the individual's faulty interpretations of sympathetic arousal. The behavioral component of treatment involved repeated exposure to both internal (bodily sensations) and external triggers of the person's panic attacks.

Session 1 To begin treatment, Dr. Geller showed Joe a list of typical symptoms associated with panic attacks, including the mental symptoms "sense of unreality" and "fear of going crazy or losing control." She asked the client which symptoms he had personally had. Joe was astonished to see his most feared symptoms actually listed on paper, and he seized the opportunity to discuss them openly at long last.

About 80 percent of those who receive cognitive-behavioral treatment for their panic disorder fully overcome their disorder (Clark & Wells, 1997).

Dr. Geller explained to Joe that fears of going crazy were very common among panic sufferers; indeed, many people found them to be the most disturbing aspect