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Safe House: A Case Formulation for Adult Psychopathology

CSSW

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Biopsychosocial Assessment

Demographic, Background, Referral Information

Ms. S is a 68-year-old single retired Latina. For the past 40 years she has occupied the same apartment in Williamsburg, Brooklyn. Her landlord recently brought a Collyer' case against her in housing court, as the hoarding conditions in her apartment—along with her refusal to allow her landlord to exterminate for bed bugs and make much-needed repairs—have created a nuisance in her building. Ms. S now faces eviction if the physical conditions in her apartment are not improved and building management is not allowed to make necessary renovations.

Ms. S has not left her apartment in the past three months, but, has stayed indoors with her two rescue cats and taken to barricading her front door with various household objects. When asked why she prefers to stay inside, Ms. S stated that she fears "what might be out there," and has, by her own admission, been in the midst of a major depressive episode. The thoughts of having to rid her apartment of her belongings and allowing strangers in to make repairs are overwhelming, and leave her in a paralyzed state of anxious distress. Last fall, APS attempted to perform a deep cleaning of her apartment; this appointment had to be cancelled after Ms. S suffered from a major panic attack at the sight of seeing her possessions discarded by the workers. Due to her mental health status, the threat of eviction, and her low-income eligibility, she has been referred by the court to ABC Legal Services.

Biological

Ms. S has previously been diagnosed with bipolar I disorder and suffers from extreme anxiety and panic attacks. Along with her mental health conditions, Ms. S has limited mobility as she was hit by a car in 2011 and was left with a broken leg and significant spinal damage. She had major spinal surgery in 2012 and another surgery for her leg in 2014. Despite these procedures, the accident left her physically disabled.

Ms. S has had several episodes of major depression and mania, and was first hospitalized at the age of 14. Subsequently, she was well enough to attend trade school in late adolescence and begin a

successful career working as a radio studio technician. However, she was hospitalized for mood disturbances at least three other times during early and middle adulthood. Since entering late adulthood, she has experienced several untreated depressive episodes and reports that she is depressed "nearly every day" as she has gotten older.

Throughout the course of her illness, Ms. S has experienced suicidal ideations. She is reluctant to speak about her hospitalizations, but hinted that one or more may have been related to suicide attempts. Ms. S is averse to psychiatric medication and treatment, as she has had bad experiences with psychiatrists in the past and does not like the physical effects of psychiatric medication, saying it makes her "foggy." Her primary care physician prescribed Lorazepam for her anxiety attacks, which she is also reluctant to take as she "does not trust pills." Recently, after noting her depressed mood, Ms. S' primary care physician also strongly urged her to make an appointment for an updated psychiatric evaluation.

Ms. S is 5-foot-4 and slightly overweight for her height. Apart from the occasional use of her anti-anxiety medication, she takes medication for high blood pressure. She does not have a history of drug or alcohol use, or a history of significant medical conditions. She has one biological daughter.

Psychological

Ms. S reports that she began to have bouts of extreme sadness beginning in early childhood. Due to family poverty, she was placed in an orphanage at the age of six, along with her elder and younger sister. She stayed at the orphanage for seven years, until the age of 13, at which time she was reunited with her parents. When asked about her time in the orphanage, Ms. S shut down. She only commented that it was a topic she and her parents have trouble discussing, and that she sometimes wonders if her bipolar symptoms might have been caused by her formative experience of being "abandoned."

Ms. S' bipolar symptoms began at the age of 14—around the age she returned from the orphanage. While she did not become involved in substance use during her adolescence, both her

sisters had trouble adjusting to life outside of the orphanage and developed patterns of substance abuse that continued throughout adulthood, spiraling into major drug use. While Ms. S' older sister eventually recovered from her substance use, she contracted HIV through needle usage and has been battling this disease ever since. Her younger sister passed away five years ago due to health issues related to a long-term crack addiction. In addition to raising her biological daughter as a single-mother, Ms. S raised her younger sister's son and daughter. When asked about her niece and nephew, Ms. S commented that they were "like her own children".

Ms. S often alludes to her role as the "caretaker" of the family. Her caretaking takes the form of financial support (apart from her groceries, rent, and medical bills, her monthly pension checks go to her parents and her older sister—she does not currently have a savings account), emotional support (she is viewed as the most stable member in her family), and extreme thoughtfulness, which takes the form of objects she collects that "might be of use" to someone she is close to. Her self-identification as the family's "caretaker" has impacted Ms. S' psychological well-being. Though she is proud of taking care of her family and her affect is generally positive and enthusiastic when discussing her family and her role as a caregiver, at times, she expresses frustration with this role. During one session, she admitted that staying inside her apartment is a "relief" and often easier than going out and having to take care of her family, or being asked to do things for them. She places great responsibility on herself—often criticizing herself aloud for not "just getting it together"—and is reluctant to accept any assistance or public benefits she might be entitled to, stating that she has to "take care of herself**."** When her tendency toward extreme self-reliance was brought up, Ms. S, showed signs of racial trauma and internalized devaluation, stating that her parents, "even though they are Latino," taught her "never to take handouts" or ask others for help (Hardy, 2013).

During our third session, Ms. S revealed that suicidal ideations accompany her depressive episodes and panic attacks, and have been coming more frequently as the pressure to clean her apartment and get rid of her things has intensified. After this admission, Ms. S felt ashamed, stating

"you must think less of me now." Ms. S knows that she has "reasons to live," chiefly her family and her cats, but simply "does not want to live." She expressed envy toward her younger sister, stating she wished she could just "pass away from natural causes." When asked about a potential suicide plan, she stated that she was not entirely sure but "it would have to look like an accident" to save her family pain and shame. She takes great pride in keeping her illness and suicidal thoughts to herself; as a result, she admits that her daughter does not know the severity of her mental health history (she was a child during her mother's last long-term hospitalization) or current legal case.

She also admitted that she has recently begun to sees wires coming out of people's mouth (though she expressed insight and acknowledged that this was a hallucination) and has a recurring nightmare of her cats' tongues being cut out. Ms. S mentioned that, in the past, sleep disturbances (including auditory hallucinations, sleepwalking, and nightmares) and visual hallucinations (seeing things move in the corners of her eyes) were two signs that her mania was beginning to return. Ms. S' primary care physician urged her to seek psychiatric treatment 3 months ago, during her last appointment. Ms. S stated that she knows she needs to see a psychiatrist, and has to start taking anti-psychotic medication again, but is overwhelmed at the thought of leaving her house and working with a new psychiatrist.

Social

Ms. S grew up in a working-class Latino family. Her mother was an immigrant from the Dominican Republic and her father was originally from Puerto Rico. Ms. S' mother was the product of an extramarital affair between her grandmother and a man who was known for having severe mental health issues. Her mother's birth caused a scandal in her devout Catholic family, and her grandmother was shunned as a result. Ms. S speaks little of her father's family. Neither of her parents appear to have significant ties to their immediate relatives.

Apart from her family, Ms. S' main social interactions resulted from her job—which she held from the age of 25 through her retirement six years ago at the age of 62. Ms. S appears to have been a

very skilled worker: she was one of the first female radio studio technicians in NYC, and she rose up the ranks to a senior position at a major station. She does not seem to keep in touch with her former work colleagues. Ms. S was never married and does not speak of her daughter's father or any past or current romantic relationships.

This winter, perhaps as a result of the stress of her legal situation, Ms. S, again, entered a deep depression. During an initial home visit, she admitted that she had not left her house in over three months, and stated that she spends the majority of her day in bed. As the walls in her bedroom have begun to crumble due to disrepair, she has moved her bed into the living room. She now sleeps in front of the television, next to a broken window and a wall that is partially covered in black mold. Ms. S rarely bathes or changes out of her pajamas.

When questioned about her choice to stay inside, Ms. S says she knows she should leave her apartment, but is recently "very afraid of getting sick" or having "something terrible happen." Because of her difficulty walking and lifting, Ms. S has taken to having her groceries, household supplies, and cat food delivered to her apartment. While helpful in certain respects, these services have enabled Ms. S to further isolate herself in her apartment. Apart from visiting her parents in upstate NY and seeing her primary care physician, Ms. S has very few reasons to leave her house. During her rare trips outside her apartment, she uses ACCESS-A-RIDE—a service she is not fond of—taxis and public buses, as she is physically unable to walk significant distances or use the subway.

Though Ms. S has lived in her neighborhood for 40 years, she has lost touch with most of her neighbors and local friends—they have either passed away or moved out of the neighborhood due to rent increases. Her neighborhood was once a predominantly lower working-class Latino community, but has experienced a major demographic change due to gentrification. As a result, Ms. S' social circle and sense of community have been greatly impacted. When she does go out, she "feels like an outsider" in a neighborhood now filled with overpriced restaurants and new, wealthy neighbors. This change has been the cause of great tension within her building: Ms. S is the last rent-stabilized tenant

and does not appreciate the attitudes of her buildings new tenants, which she feels are patronizing and arrogant.

Spiritual

Ms. S describes herself as "non-religious," though she has recently expressed an interest in Buddhism, which her daughter has converted to. She enjoys speaking to her daughter about meditation and mindfulness practices.

Relevant Assessment Tools

Suicide Risk Assessment

Ms. S' admitted that she is deeply ashamed of her suicidal ideations. She was encouraged to speak frankly during our sessions, and her statements were received without judgement. After Ms. S shared her thoughts, a suicide risk assessment was administered. Ms. S' bipolar diagnosis places her at a higher risk for completing a suicide (Leahy, 2007). Given Ms. S' additional risk factors— her co-morbidity, suicidal ideations, suspected previous suicide attempts, isolation, lack of a social support network, physical disability, mental distress, and current legal issues— her comments were taken very seriously.

Among the protective factors identified that might mitigate the risk of suicide, "responsibility to family and cats" were the only protective factors mentioned by Ms. S. Again, when asked if she had a suicide plan, she reported that she did not have a specific plan, but knew that if she were to take her life, it would have to be done in a way that made her death appear to be accidental, so as not to hurt her family members. Ms. S was asked to contract for safety, and she was given the number of two 24-hour suicide hotlines, in case she needed to speak to someone before her next session.

Mental Status Exam

Ms. S appears to be her stated age, and she was wearing what appeared to be her pajamas during the visits. She was polite and highly cooperative. However, at times it felt like she was making a great effort to please and that her cheery and attentive affect was forced—this may have been a way

for her to deflect the conversation away from her own thoughts. For example, after sharing her thoughts about her depression, Ms. S was quick to change the subject and inquire about my own health. When discussing her anxiety and how she would go about cleaning her apartment, Ms. S' affect shifted and became panicked. During these times, she was quick to scold herself and repeat things like "I know I can do this if I can just get my act together." Hence, it was observed that Ms. S is highly anxious, and that her anxiety level quickly escalates in conversation when asked about making future plans for cleaning and psychiatric treatment.

It took a great effort for Ms. S to clear the doorway and allow us into her apartment, and she sat through the visits. Her psychomotor movements appeared to be slow while sitting, and her speech was generally ordinary and lively, but her voice became louder and her speech became pressured and repetitive when she became anxious. Though she often expressed suicidal ideations— which, at times were tangential— she appeared to be logical and coherent, and her thoughts were often very insightful.

DSM-V Diagnostic Impression

-Bipolar I Disorder, depressive episode, with mood incongruent psychotic features **(F31.5)**
-Hoarding Disorder **(F42)**
-Panic Disorder **(F41.0)**
-Generalized Anxiety Disorder **(F41.1)**
-Agoraphobia **(F40.00)**- PROVISIONAL
-Unspecified Housing or Economic Problem **(V60.9)**
-Problem Related to Living Alone **(V60.3)**
-Problems Related to Other Legal Circumstances **(V62.5)**

Treatment Plan

Ms. S' treatment plan includes a team of individuals, including the following: her attorney, a guardian ad litem (GAL), her family, supportive cleaning services, her APS caseworker, her primary care physician, a new psychiatrist, and a psychotherapist. This treatment plan will address her psychiatric and psychological needs, as well as the social supports needed for her to successfully address her hoarding disorder and fight her eviction.

Problems	**Goals**	**Objectives**	**Interventions**
Weak social support network	Strengthen social supports	1) Identify and connect with existing supports/individuals 2) Find additional supportive resources	1) Motion for a court-appointed GAL to help her with legal and, potentially, medical matters 2) Connect with supportive cleaning services 3) Ct will discuss illness and court case with her daughter and granddaughter, and ask for support in cleaning apartment
Unaddressed psychiatric needs	Ct would like anti-psych medication and to find a psychiatrist she feels comfortable working with; she would also like to explore antidepressant medication and have psychiatrist re-evaluate her anxiety medication	1) Ct will find in-network psychiatrists 2) Ct will make appointment for psych evaluation 3) Ct will comply with antipsychotic/antidepressant/ anti-anxiety treatments	1) SW will connect with ct's PCP 2) SW will accompany ct to psych evaluation to reduce ct anxiety and ensure suicidal ideations are discussed 3) Ct will notify family of any change in medication
Unaddressed psychological needs	Reduce anxiety, depression, and suicidal ideations and improve hoarding conditions	1) Ct will complete bi-weekly therapy sessions 2) Ct will keep a daily mood journal and will comply with any homework 3) CT agrees to maintain safety contract	1) SW will schedule bi-weekly phone sessions with ct 2) SW will be available by phone from 9-5pm on non-session days 3) SW will refer to DBT specialist if suicidal ideations increase

Proposed Theoretical Orientation and Purpose

A combination of CBT and long-term psychodynamic therapy may alleviate anxiety and depressive symptoms, and may serve to support Ms. S if her psychiatrist determines that her suicide

risk is severe and chooses not to treat her with an antidepressant (Leahy, 2007). Though CBT may be helpful in improving Ms. S' daily functioning, reducing her panic attacks, and assisting her in working with her medical and legal team, she would likely also benefit from long-term psychodynamic therapy to address potential developmental and attachment trauma resultant from her parental abandonment and subsequent stay in the orphanage. For clients with hoarding disorder, psychodynamic therapy that addresses unprocessed material is necessary in "clearing out on the inner as well as the outer world of the person who hoards" (Brien, O'Conner, & Russell-Carroll, 2016).

Clinical Event

Ms. S' description of her wire hallucinations contributed to her current diagnosis of "bipolar 1, depressive episode, with psychotic features." She also expressed her fear of leaving her apartment during this session, leading to the provisional diagnosis of "agoraphobia disorder." However, it is difficult to determine whether Ms. S experiences true agoraphobic disorder (she is sometimes but not always able to leave the house to visit her parents) or the effects of extreme anxiety and depression.

Engagement Strategies/Methods for Building a Therapeutic Alliance

In working with Ms. S, the common core themes of hoarding identified by Brien, O'Conner, and Russell-Carroll (2016)—"in two minds," "covered-up shame" and "meaningless carrying-on"—resurface again and again. At times, Ms. S appears to be eager to change her living conditions, but this motivation generally fades as she becomes anxious about inviting strangers into her home, beginning a new psychiatric treatment, or decluttering her space. Anxiety and shame seem to have contributed most to her depression. With this in mind, it has been important to reaffirm Ms. S' humanity and reassure her that she is not being judged by the conditions in her home or her previous psychiatric history; such reassurances have become a feature of our interactions and strategy for engaging and strengthening the therapeutic relationship.

Once an alliance had been established, listening to Ms. S and allowing her to direct the course of her case (as much as our legal timeline would permit) enabled her to gain confidence and a sense of agency regarding her mental health treatment. Use-of-self and self-disclosure (Ms. S was very curious about my cultural background and religious beliefs) were employed to help alleviate anxiety and to build a meaningful connection and sense of "personalismo" in our conversations (Hays, 2001). A successful therapeutic partnership was formed by approaching Ms. S as a human first, before labeling her as a client or a pathology.

Working Hypothesis

Ms. S' hypothesis that her abandonment at the age of six and her experiences in the orphanage may have contributed to her depression and subsequent mental health symptoms showed a high degree of insight. The causes leading to her placement were not discussed in great detail, but extreme poverty majorly influenced her parents' decision to place her and her sisters in the foster care system. Poverty has been associated with higher levels of depression in women in the U.S. and it is one of the most consistent predictors of female depression, due in part to the stress produced by economic insecurity and inadequate social systems (Belle & Doucet, 2003).

As indicated, Ms. S expressed a great deal of shame and embarrassment when revealing her potential weaknesses (e.g., her suicidal ideations and familial history). This shame, along with her judgmental attitude towards accepting help (in our initial visit, she was very proud that she was not on public assistance and did not "accept handouts") may be the result of internalized oppression, and intergenerational racial and colonial trauma she inherited from her parents. Teaching Ms. S that people who are self-reliant and refuse assistance are more valuable than those who ask for help (as observed in her comment "even though my parents were Latino, they did not accept help") may have been a way for her parents to distance themselves from dominant economic stereotypes about Latinos and overcorrect for their earlier decision to place their children in foster care.

Finally, Ms. S has played the role of caregiver throughout her life: to her adolescent siblings, to her own daughter, to her niece and nephew, to her sisters in their adult illnesses, and, finally, to her parents in their old age. This responsibility (and the unexplored parentalization that may have occurred in her early childhood) along with her internalized values of self-sufficiency and aversion to therapy have left Ms. S little space for self-care. Ms. S described staying inside as a "relief" from her familial responsibilities: by physically surrounding herself with objects and blocking herself off from the world, she has found a way to distance herself from her responsibilities. She may be attempting to create a containment space for herself—a space that was not available to her in her early life (Brien et al, 2016).

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