Journal of Coastal Life Medicine
www.jclmm.com
ISSN: 2309-5288(Print)/2309-6152(Online)
Volume 6 No.2 (2018), Page No. 07 – 11
Article History: Received: 08 April 2018, Revised: 15 May 2018, Accepted: 25 May 2018, Publication: 30 June 2018

Applying the DSM Decision Tree to the Case of Jenny and Marisol: A Case Study Approach

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Abstract

This study has established that for the case of Jenny, there is a need for a medical referral due to the severity of her condition, as well as the foreseeable negative features that continue to endanger her social, psychological, and physical health. This inference is informed by major insights arising from the evidence-based research. For the case of Marisol, several symptoms point to dysfunction. Some of these features include a conflict between the family system (in which it is a tight-knit Puerto Rican system) and the social system in the workplace (which constitutes a larger workgroup that has interfered with her initially family-linked comfort zone that she experienced while working for small companies. Also, Marisol presents with symptoms of anxiety because she is not used to a larger social group whenever she goes out with friends and there is evidence of a conflict between her inner feelings and preference for a close-knit system and the nature of the external environment in which she is to accommodate the new group with different demographic characteristics compared to her family and initial work contexts.

Introduction

For the case of Jenny, one of the presenting concerns involves a feeling of social isolation and a lack of interest in the social world and people with whom she is supposed to live and interact. Another aspect of concern involves withdrawal, besides a significant drop in functioning. In the selected case, Jenny tends to sleep most of the time before and after work, rather than socialize with her friends and the mother. According to Bardhoshi, Duncan and Erford (2016), this state reflects dysfunction and deviation from normal living and it is evident when individuals lose interest in activities that they might have enjoyed previously (just as Jenny is no longer interested in conversing with her mother or going out to shop with her friends or colleagues), as well as difficulty in performing familiar tasks. In a related observation, Boenisch, Kocalevent and Matschinger et al. (2012) stated that the dysfunction is likely to manifest itself when individuals have problems thinking, exhibit mood changes (dramatic or rapid shifts in depressed feelings or emotions), increased or heightened sensitivity, apathy in which they lose the desire or initiative to engage in activities, and illogical thinking. For Jenny, these symptoms are evident because she has developed exaggerated beliefs about life, her mother, and the rest of the social world surrounding her. Apart from feeling disconnected, it is also evident that Jenny exhibits illogical thinking and this attributes reflects a state of dysfunction. She says, “Sometimes I'm just too tired because I don't know how this is possible.” According to Erford, Johnson and Bardoshi (2016), the situation tends to be exacerbated by changes in appetite and sleep. For Jenny, she has resorted to sleeping every time she gets an opportunity, failing further to resort to her usual eating routine.

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Methods

From the DSM decision tree, the first step entails ruling out factitious and malingering disorder. The latter involves avoiding responsibilities while the former entails the assumption of the role of sickness based on psychological reasons (Prevatt, Dehili, Taylor & Marshall, 2015). It is also expected that clinicians proceed to rule out possible substance etiology (which is absent in Jenny's case) proceeding to the third step that entails examining the presence or absence of a general medical condition (van Krugten, Kaddouri & Goorden et al., 2017). In this case, the case description suggests that Jenny does not have a general medical condition. The fourth step is to determine specific primary disorders before differentiating residual from adjustment disorders (Grande, Newmeyer, Underwood & Williams, 2014). For Jenny, the latter feature is present. The process culminates into the establishment of boundaries without a mental disorder (Bardhoshi, Duncan and Erford, 2016). Based on the case description, the differential diagnosis points to possibilities of the presence of a major depressive disorder (because of the adjustment problem with which the patient presents), as well as possible premenstrual dysphoric disorder.

Results

For Jenny, symptoms include decreased focus, the danger of suicide or death, feeling worthless, changes in activity, changes in appetite, changes in sleep, loss of pleasure and interest, and evidence of a depressed mood. These attributes point to an adjustment problem in the form of major depressive disorder. Another possibility entails premenstrual dysphoric disorder. According to Boenisch, Kocalevent and Matschinger et al. (2012), the condition is characterized by appetite change, poor concentration, fatigue, decreased interest, anxiety or tension, depressed mood, and irritability.

In marriage and family therapy (MFT), assessments enable counselors to improve the understanding of family patterns (Erford, Johnson and Bardoshi, 2016). Also, the assessments enable family counselors to make informed decisions regarding intervention strategies that are relevant to or align with the client's culture (Prevatt, Dehili, Taylor & Marshall, 2015). Based on Kenny's case presentation, an application of the assessment by Hamilton and Carr (2016) implies that the major issues that will be of concern include family strengths and resources, the problem(s) at hand, family organization, family affects, and the family process. Particularly, family strengths and resources will constitute the capacity to self-repair while problems will constitute the motivation to solve issues, past solutions, and the intensity of the problems. The family organization on focus will constitute boundaries, expectations, rules, and roles surrounding the subsystems of the family. Regarding family affect, Hamilton and Carr (2016) advocate for the need to focus on how emotions are expressed (emotional separateness and closeness) among members of the family. Lastly, the family process will be assessed in terms of problem-solving, and conflict management approaches.

Based on the current DSM, a major depressive disorder or episode needs to satisfy at least five out of nine symptoms (van Krugten, Kaddouri & Goorden et al., 2017). These

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symptoms include suicidal ideation, concentration difficulty, worthlessness, fatigability, and subjective or objective psychomotor activity (Grande, Newmeyer, Underwood & Williams, 2014). Others include sleep problems, appetite or weight changes, loss of interest (anhendonia), and depressed mood. For Jenny, the symptoms with which she presents coincide with this DSM provision for a major depressive episode because she exhibits negative features such as suicidal ideation, worthlessness, and sleep problems; as well as loss of interest, depressed mood, and even concentration difficulty. Regarding ICD-10 components, some of the issues with which the selected condition is associated include nonreactive depressed mood, appetite and weight changes, objective psychomotor activity, self-reproach, loss of confidence, fatigability, sleep problems, and loss of interest. According to Bardhoshi, Duncan and Erford (2016), patients diagnosed with this condition ought to satisfy at least eight out of ten criteria symptoms. Dominated by issues such as depressive mood and loss of interest, Jenny satisfies the ICD criteria for major depressive disorder.

For the case of Jenny, there is a need for a medical referral due to the severity of her condition, as well as the foreseeable negative features that continue to endanger her social, psychological, and physical health. This inference is informed by major insights arising from the evidence-based research. According to Erford, Johnson and Bardoshi (2016), patients diagnosed with major depressive disorder call for physicians or clinicians to consider hospitalization, psychiatric consultation, or referral if the patients meet certain criteria. The criteria include severe psychosocial problems, the risk to oneself or others, and failed medication trials. In this case, suicidal ideation is evident and points to a possibility of self-harm, as well as severe psychosocial problems accruing from sleep problems, feeling worthless, and withdrawal or lack of interest in the social context. For such patients, some of the interventions that have been recommended include psychological counseling and the use of antidepressants (Boenisch, Kocalevent and Matschinger et al., 2012). For Jenny, there is also a need to evaluate her status via follow-up care and regular monitoring (and suicide assessment and screening) to determine her response to therapy, as well as possibilities of medication tolerance.

For the case of Marisol, several symptoms point to dysfunction. Some of these features include a conflict between the family system (in which it is a tight-knit Puerto Rican system) and the social system in the workplace (which constitutes a larger workgroup that has interfered with her initially family-linked comfort zone that she experienced while working for small companies. Also, Marisol presents with symptoms of anxiety because she is not used to a larger social group whenever she goes out with friends and there is evidence of a conflict between her inner feelings and preference for a close-knit system and the nature of the external environment in which she is to accommodate the new group with different demographic characteristics compared to her family and initial work contexts. According to Prevatt, Dehili, Taylor and Marshall (2015), such characters depict an anxiety disorder. Some of the symptoms of anxiety disorders, as contended by van Krugten, Kaddouri and Goorden et al. (2017), include excessive worrying, feeling agitated, restlessness, fatigue, difficulty concentrating, and restlessness. As documented by Grande, Newmeyer, Underwood and

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Williams (2014), other features include panic attacks, irrational fears, feeling nervous or tense, and having trouble sleeping. In Marisol, most of these symptoms are evident and can be inferred to account for her deviation from the expected normal living.

Three main types of anxiety disorders can be discerned relative to the case of Marisol. One of the disorders involves panic disorder, which is characterized by feelings of terror that strike randomly and makes one feel like having a heart attack (Erford, Johnson and Bardoshi, 2016). Another condition involves social anxiety disorder in which an individual feels overwhelmingly self-conscious and worried about daily social situations. According to Bardhoshi, Duncan and Erford (2016), the DSM-5 criteria holds that this disorder also implies that individuals fixate about other people judging them or on being ridiculed or embarrassed; a feature that best describes Marisol's situation. Another form of anxiety disorder that can be linked to the case scenario entails generalized anxiety disorder in which individuals feel unrealistic and excessive worry, as well as tension with no or just little reason (Boenisch, Kocalevent and Matschinger et al., 2012).

Based on DSM-5, all anxiety disorders exhibit general symptoms such as dizziness, tense muscles, nausea, dry mouth, heart palpitations, shortness of breath, inability to stay still or calm, sleep problems, and uneasiness, fear, and panic. Indeed, the three disorders mentioned above are seen to abide by the DSM-5 criteria because most of the characteristics with which they (the anxiety disorders) are associated are also contained in DSM-5 specifications. From the affirmations by Hamilton and Carr (2016), systemic assessments seek to unearth family patterns surrounding a patient's case and also aid in ensuring that interventions are aligned to the health condition of the patient. For Marisol, family strengths and resources will be assessed to predict the ability of the patient and her parents to repair the problem. On the other hand, the nature of the family's organization will be assessed to unearth boundaries or rules and also understand how emotions flow or are manifested within the system. Lastly, Prevatt, Dehili, Taylor and Marshall (2015) advocated for the need to examine the conflict management and problem-solving capacity of a family to discern possible success after concluding the intervention; a step that will also be applied to Marisol's case scenario.

In the case presented, the most appropriate condition is a social anxiety disorder. Based on the current DSM and ICD, social anxiety disorder accrues from a persistent and marked fear of at least one performance or social situation where an individual gets exposed to possible scrutiny by other members or when they interact with unfamiliar people (van Krugten, Kaddouri & Goorden et al., 2017); a feature depicted in Marisol's case. Also, DSM and ICD hold that the individuals experiencing this condition tend to fear that they might act in an embarrassing or humiliating way (Grande, Newmeyer, Underwood & Williams, 2014). For individuals to be diagnosed with the condition, they are expected to have marked fear of behaving in a humiliating or embarrassing way or to be the focus of attention. Also, they exhibit a marked avoidance of situations where they fear to behave in embarrassing or humiliating ways or being the focus of attention. To be diagnosed with the condition,

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individuals ought to exhibit either of these aspects; with Marisol's case description proving suitable for the diagnosis of social anxiety disorder. Also, these individuals ought to satisfy at least two symptoms of anxiety in the form of fear or urgency of defecation or micturition, fear of vomiting, and blushing, Marisol satisfies the criteria because the first and third symptom is evident in her behavior.

Conclusion

For Marisol, a referral for a medication consultation is appropriate because she has failed to accommodate the new work context that has a large workgroup, yet she continues to prefer close-knit ties with her family and friends, relatives, or friends in her immediate neighborhood. To ensure that her psychosocial and career lives are not hampered, there is a need for appropriate intervention. For such individuals, some of the procedures that have been documented to improve outcomes include medication or cognitive behavioral therapy, or a combination of these interventions. The therapy sessions range from 12 to 16 sessions (to build one's confidence) while medications include antidepressants.

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