Case Study: “Terrell”

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Internship in Clinical Community Counseling (863.824)

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Identifying Information: “Terrell” is a 13-year-old African-American male of low socioeconomic status. He is the younger of two children in his family. His family consists of his mother and his 16-year-old sister (Terrell’s father is unknown). Prior to residential treatment, Terrell lived with his mother and sister in Baltimore City.

Nature of Referral: Terrell was referred to a residential treatment program because of a pattern of aggressive and impulsive behaviors. Terrell’s reported behavior at school included destroying property, running away, disobeying adults, becoming physically and verbally aggressive towards others, and attending school infrequently. A school official notified the Department of Social Services (DSS). DSS investigated his living situation and found that his mother had been keeping him out of school. They also found that his living situation was unstable – he moved frequently, there was drug use in the home and possible physical abuse by mother’s romantic partners. DSS then recommended that Terrell be placed in residential treatment.

Subjective Impressions: My impression of Terrell is that he is a young man who has had a number of unfortunate life events, and has a lot of unexpressed sadness because of these events. He has not had consistent parenting, and I believe that he has not learned the appropriate coping skills for dealing with his emotions. I also believe that he fears other people are out to hurt him or will be unfaithful to him. His unexpressed sadness and fear manifest as anger. He is a smart young man and can be very insightful at times, but I believe his fear of others prevents him from being successful in treatment.

Mental Status Exam: Appearance: He is a 13-year-old African-American male who appears to be his chronological age. He is dressed appropriately and well-groomed. **Attentiveness:** Distractible – at times he is able to be attentive; at other times he appears anxious and unable to focus. **Alertness/Orientation:** He is alert and oriented to person, place, time, and situation. **Motor:** Slightly agitated. He frequently changes his body position and location in the room. **Speech:** Normal for rhythm, volume, and articulation. **Affect:** Appears sad through his facial expression and speech content. **Mood:** "OK." **Thought Content:** He denies suicidal and homicidal ideation, but demonstrates hopelessness ("She's not going to come back to get me"). His thoughts tend to be directed towards believing that no one cares about him, and believing that other people are talking about him. **Thought Process:** Significant for flight of ideas. **Perception:** Denies auditory or visual hallucinations; denies depersonalization. **Intellect:** Consistent with age and grade level. **Judgment:** He demonstrates poor judgment in his daily activities. He makes poor behavior choices, which then lead to desired privileges being revoked. He often gets into confrontations with peers who larger and more aggressive than him. **Insight:** He demonstrates poor insight into his behaviors and their consequences. He often denies events or minimizes their severity.

Clinical Diagnosis

I	314.01 ADHD, combined type; 313.81 ODD; 269.9 - Mood D/O NOS
II	Deferred
III	Cocaine exposure in utero
IV	Problems with primary support
V	Lowest GAF in past year – 35; Highest GAF in past year – 50; Current GAF – 50

Content/Process: In group therapy, Terrell usually does not contribute to group discussion. If asked to contribute to the discussion, he usually responds minimally. If he participates in group, he tends to only participate in quiet activities such as art projects. Many times, Terrell is disruptive to the point of being asked to leave the group. At these times, he will peer at the group from outside the room to see what the group is doing.

In individual therapy, Terrell is more talkative. He often talks about his experience living on the residential unit, particularly things that he does not like about it. He also usually talks about his mother, and his desire to live with her when he is discharged from the program. He is usually verbal and insightful about his thoughts and feelings, but does not like to discuss his behavior. He often engages in play during individual sessions. He usually chooses games and activities that are below his age level, such as Barbie dolls.

Multicultural Issues: I believe the relevant issues in therapy were age, gender identity, and race.

Age – I believe that I was able to build a rapport with Terrell in part because of my age. I am one of the younger members of the residential team, and I believe that Terrell sees me as more of a peer. I could see this when he would use certain slang, ask me about current popular music, etc.

Gender identity – Although this was not addressed, I believe it is possible he struggles with issues of gender identity. He tends to engage in activities that are seen as more feminine. For example, he often plays with Barbie dolls – this does not seem typical of a young man his age. He also has a preoccupation with childbirth and talks about wanting to be able to give birth.

Race – I believe that I was also able to build a rapport with Terrell in part because of my race. Again, certain references he made led me to believe that he was more comfortable with me because

we are both African-American. I believe that talking to someone of the same race may have made him feel less "different," and also feel that I would be able to understand him.

Empathy: Surprisingly, the greatest barrier for me in developing empathy occurred outside of session. Terrell is the oldest child on his residential unit, and the child who has been on the unit for the longest amount of time. When I was on the unit, I frequently heard other staff making generalizations and judgments about Terrell, such as "He's too old to be acting like this" or "He's always going to be in a place like this." I found that these types of statements made me less sensitive to Terrell's perspective and more doubtful that he was capable of change. Once I realized this, however, I was able to put those judgments aside and develop empathy and a better understanding of my client. I was also able to use the situation clinically – for example, asking Terrell, "What is it like for you to hear people say you're too old to be here?"

Comfort Level: I felt very comfortable around my client. Although he is known for being aggressive towards others, I feel that I have been able to empathize with him, and relate to him in a way that did not trigger his aggressive behavior. Because I felt that Terrell related to me more because of my age and race, I tried to use this to build on our therapeutic relationship. The one factor that made me uncomfortable was the issue of gender identity. I was not uncomfortable with him as a person because of this – but his treatment team believed that this was not a primary issue of concern, and did not believe it should not be a focus of treatment. As such, I did not address this with him. I sometimes felt uncomfortable because I wondered whether I should raise these questions with him. I am not sure how much insight he has into this, so I wondered at times if we were both avoiding an "elephant in the room."

Strengths/Weaknesses: I believe that my biggest strengths were empathy, empowerment and emphasizing successes. Once I realized that I had initially made formations about Terrell based on others' opinions, I was able to reverse this and more fully listen to him and develop empathy. I also tried to work on helping Terrell feel that he was capable of changing his behavior, and praising successes, no matter how small. I believe that children with behavior issues often have their successes often go unnoticed.

As stated earlier, I believe I erred by internalizing others' judgments of Terrell. Another weakness was my handling of self-disclosure. Terrell often asked me questions about myself. Some of these questions appeared to be pretty innocuous, such as "Do you live in the city or the county?" Other questions probed deeper, such as "Have you ever lived in a group home?" I did not know how to deal with this issue, and I feel that I may have not been genuine at times. I did not want to be too impersonal, but I also wanted to set boundaries. Because of this I believe that I gave some overly-clinical answers, and I believe this hindered growth at the beginning of the relationship.

Conceptualization: I chose to conceptualize Terrell using object relations theory. Object relations theory looks at the relationships that individuals have with significant objects (an object is a person, place, or thing that satisfies a biological or psychological need). This theory suggests that individuals not only have relationships with their objects, but also form and maintain relationships with internal representations of their objects. An individual's internal and external object relationships may vary widely, but as a person matures, his or her internal object world should more closely resemble the external reality. Object relations theory also places importance on the first object relationship: that between an infant and its mother (specifically, the breast - feeding is the first significant event of the infant's life).

I chose object relations theory to conceptualize this case because of its emphasis on the primary relationship between infant and mother. I believe that Terrell and his mother minimize the impact of their relationship on Terrell's behavior. Also, disorders such as oppositional defiant disorder are sometimes conceptualized as a family issue, and I believe in this case it is important to look at the family dynamics because they appear to be contributing to Terrell's behavioral difficulties.

Good breast/bad breast is the idea that that the infant identifies the feeding breast as "good" and the withdrawn breast as "bad." I believe that Terrell has difficulty making sense of the "good" and "bad" of his mother's behavior. There have been times where she has visited him in the residential program and has showered him with affection and praise; yet, there have also been times where she has failed to show up for scheduled visits and did not tell her son that she would not be coming. This can be seen as a "feeding" and "withdrawal" of affection – a pattern that appears to be random and is therefore difficult for Terrell to make sense of. There are other important dynamics, such as the feeding and withdrawal of safety – the same mother who provided him with clothing and shelter also placed him in dangerous situations. His inability to make sense of these dynamics leads to splitting.

Splitting is a mental separation of objects as wholly good or wholly bad. The idea is that an infant separates good and bad objects to prevent bad objects from contaminating good objects. Terrell appears to split his mother into two objects, one loved and one hated. Sometimes she is a perfect mother; other times, "she hates me." He tends to react this way towards others as well. He tends to distrust or attach to someone very quickly. His behavior problems can be attributed to this – once he decides someone is "bad" he is quick to get into confrontations with that person.

Good-enough mothering is the theory that if the mother is "good enough," the infant will have enough consistency to learn that when the breast is taken away, it will return when it is needed.

I believe that Terrell's mother has not established good-enough mothering. Terrell often acts out during home visits and refuses to return when scheduled. This has been a major focus of Terrell's treatment team meetings. I believe that this is due to his mother's inconsistency in being involved in her son's life. I believe that if Terrell could count on his mother being there when he needed her, he would be less anxious about leaving her.

I believe that what is most significant to Terrell is having grown up without a **holding environment** - a consistent, structured environment which should foster feelings of safety and trust. Terrell's mother, unfortunately, has not provided him with a consistent environment. She has lived in several different places, has had numerous romantic partners acting as father figures, and has been inconsistent in her parenting methods. Currently, she has been ambivalent about whether she will allow Terrell to live with her when he is discharged from the program.

I believe that Terrell's behavior is often his way of trying to achieve the holding environment that he has been denied. For example, others are bothered by his preoccupation with childbirth. However, Terrell usually talks lovingly about wanting to raise a child. He talks about how he would feed the baby, hold the baby, support the baby, etc. I believe that he may be imagining a secure environment for himself that he has been unable to have.

Lastly, I believe that his acting out may be due to a desire to have a safe holding environment. Terrell has had several discharges scheduled (he was going to be discharged to his mother's care), but each time he acted out more, to the point where his discharge was revoked. He appears to have sabotaged his own discharge. I believe that this is because he is unable to trust his mother's consistency - and although he states that he hates the residential unit, this is the place that has provided him with consistency, structure, safety, etc. I believe that what Terrell needs most is to feel a sense of safety, security, and consistency – particularly from his mother.