Intervention Paper

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Bio-Psycho-Social Summary of Ms. S

I. Identifying Information

Ms. S is a retired 74-year-old female who resides in the Bronx, New York. She lives alone after being widowed in 2004. Client has lived in the Bronx all her life and has resided in her apartment for a little over 20 years. She has a high school education but never had the means nor desire to go to college. Ms. S is white and of Irish decent. Client dresses nicely but her wardrobe is noticeably tight as she admits since she has not updated her wardrobe in a long time while at the same time gaining weight. Client has gray hair and does not seem to try to alter her appearance to look any different. Her face is noticeably wrinkled for a person who is not that far into their late adulthood. Client does not have any mobility issues, only using a cane for stability. Ms. S communicates very clearly and concisely in a slightly raspy voice. She has excellent intelligence and memory based of the many sessions we have had together.

II. Presenting Problem/Reason for Referral

Ms. S came to our attention in August of 2015 when she called our NORC program director asking to help pick up her prescription for Xanax. A home visit by agency staff after the phone call led to Ms. S being hospitalized and to her being on our radar since. Much of my agency's staff has been involved with this client's case since the incident, and thought she would be a good client for me to work with. The presenting problem with Ms. S is that she rarely leaves her apartment, suffering from agoraphobia. Before I contacted client, she left her apartment only 2 times in 2017 alone. This problem has been going on since at least August 2015. Client admitted in our first session that she agrees that she needs to go outside so she can go shopping for new clothes that fit as well as completing day to day errands. Her initial reason for not wanting to go outside was her fear of falling, but that seems to have changed to more

personal reasons in our sessions since. Client also works with mental health professionals for a myriad of issues including her agoraphobia.

III. Client Description/History

Ms. S grew up in the Kingsbridge section of The Bronx with both of her parents, but primarily her mother as caretaker. Client is the oldest of 4 as she was followed by her sister Maddie, her brother Joe, and youngest sister Jane. Her youngest sister Jane died tragically but I did not find out the exact cause. Her father was an abusive alcoholic who put strains on her entire family while growing up. Her employment consisted of working as a bartender and waitress earlier in her adult life, followed by her working in a medical office doing administrative work. Client is a practicing Catholic, but cannot attend services. Client has a small social network mainly consisting of our agency, mental health workers, and her younger sister Maddie. Her closest relationship she had was with her mother who passed away in 2011 and she has not had a similar relationship since. Ms. S rarely speaks with her brother Joe who now lives in Florida or any other family.

Ms. S got married in the 1990's to her husband Matt who she knew while growing up. Her husband was previously divorced before they got together later in life. They did not have any children together and she did not have any children with anyone else before him. They stayed together until his death in 2004 due to complications from colon cancer.

In terms of physical health, client has a history of back pain from sciatica and high blood pressure. From a mental health aspect, Ms. S has been diagnosed with major depression and has been hospitalized multiple times to a psychiatric ward. Though she has not been diagnosed with agoraphobia, she fits the DSM V criteria. She is taking both Wellbutrin and Prestiq to help with her depression and is taking two different blood pressure medications to help maintain her high

blood pressure. Client is currently seeing a psychiatrist and a clinical social worker that we referred her to help with her major depression and anxiety. She is a recovering alcoholic and has claimed to not have had a drink since 1984 with help from AA. Ms. S smokes a pack of cigarettes a day and has noted she would like to cut down

IV. Current Functioning

Currently, client's functioning has been limited to inside her one-bedroom apartment where she spends practically all her time. Since I have started seeing my client, we have been able to have multiple sessions outside and have gone to the library together. This has been a huge breakthrough for the client since she has only left her apartment only for doctor's appointments in the past few years. The only social aspects of client's life outside of our agency and mental health workers is with her sister Maddie who lives a few buildings away. She visits Ms. S occasionally and they talk on the phone at least once a week. Client has expressed disdain toward her sister even though she is the only family she keeps in touch with. Ms. S has no desire to see any of her grandnieces and grandnephews because of the strained relationships she has with her family. If the nieces want to contact or invite Ms. S somewhere, they normally tell her sister Maddie to relay the information to client, who always declines the invitations.

V. Evaluation

Ms. S has gone through a lot of pain and suffering throughout her life. Growing up she experienced a very dysfunctional household with an alcoholic father who made forming relationships with her mother and siblings hard. This has led to client being unable to form close relationships with many people and when they do, they normally do not last. Client has expressed multiple times she does not want to be bothered by anyone including her sister who is the only person she keeps in touch with.

Client developed alcohol and tobacco dependency early in her teenage years that stemmed from her complicated home life. Ms. S still smokes a pack of cigarettes a day to help with her anxiety. When she did form a close relationship with her husband Matt, it was premised on how they were both alcoholics along with their familiarity with each other growing up. Matt became that male figure in her life that she was not able to have with her own father. When she was finally able to develop a relationship with her mother, it was late in her life in a caretaker role. Once she lost her mother in 2011, her agoraphobia started to manifest. With no close relationships and an unwillingness to form new ones, client started to isolate herself inside her apartment.

Intervention

My work with Ms. S as a first-year intern has been very extensive and I have utilized various intervention methods as I have learned them. One thing that is learned very rapidly is that there is no one size fits all approach when it comes to working with complicated clients. A lot of trial and error has been the norm with Ms. S, and before I started with more theoretical approaches, I made sure that my client was comfortable with me. If you cannot build that rapport, it will be hopeless to try using theory because it will most likely result in a failed intervention. Luckily, I was able to quickly build a good relationship with Ms. S and we were able to accomplish goals over the year that we worked together.

Systems Theory

Using systems theory was the foundation of my intervention with Ms. S. By learning about her physical, social, and emotional environment, I was able to utilize those systems to help benefit my client. The systems theory is based on the principle of connectedness, and after a couple of sessions, I learned that my client has a complicated connection between all her

systems. These complicated connections were determined after looking at them through the second principle of wholeness (Walsh, 2009). The point being is that only knowing the initial problem will not be sufficient in doing an intervention, but knowing all the factors influencing one's life, which I did with Ms. S, helped me know where to go next. All this culminated in having Ms. S look at her situation in a differently in hopes her future actions will change the feedback mechanisms of her systems in a positive way (Walsh,2009).

Since Ms. S is an agoraphobe, her current systems are limited to a few people in her family, our agency, and a couple of agencies we have referred her to. With these limited systems, I knew the main objective was to have a better interaction with them and to try to expand on them at my client's pace. One way to help accomplish this was, at my client's request, to get a cell phone. Ms. S wanted something more advanced than just a flip phone, so we decided to get an iPhone. Once she was able to get through the learning curve, it had forever changed the way she would interact with her environment. Instead of just interacting with her sister Maddie through phone calls, they have now started texting each other, a new dynamic in their relationship. She was introduced to the internet, which for someone who has trouble getting out to see the world, helps expand her knowledge of what is going on in that world. I would help reinforce using her cell phone by exclusively calling it when making appointments or following up with her.

Another system that we spoke about frequently and one that I tried to emphasize the importance of was her family. The history alone helps explain many of the issues that have manifested in Ms. S throughout her life, like the impact of her abusive alcoholic father. While Ms. S has aged, much of her family system has slowly disappeared due to neglect, death, and her deciding not to have a family of her own. Understanding this, I wanted to help maintain the one

relationship she still has with her sister Maddie. Their relationship is based on the fact that Ms. S suffers from depression and agoraphobia, an example of how family relationships can be dictated by one family member having a chronic illness (McGovern, 2015). I have tried to facilitate a more of a collaborative relationship in the eventual hopes that their relationship could grow from one on dependence to one of more meaning. I attempted to address this with a session with each of them before termination in hopes that this may eventually happen.

Object Relations Theory

Piggybacking off the family system that my client is currently interacting with, I have gotten to understand how my client views herself and the personal relationships she has with people. Due to Ms. S growing up in a dysfunctional environment, she was never able to form close attachments with most people in her life. Due to this, she has trouble with the process of introjection and representation, resulting in rarely being able to view people like her sister Maddie as whole objects (Walsh, 2009). I have experienced multiple times when Ms. S in one session says everything is fine with her sister and in another that she is sick of her. Individually, she has developed a negative self-object by internalizing and concentrating on only the negative aspects of the way she views herself and her surrounding environment.

Using object relations for me was more of an in the moment intervention than trying to strategically use it. I always tried to reframe and show my perspective of situations and see if it resonated with Ms. S. For example, in our last session I wanted to emphasize to her a strength that when she decides to do something, like when we went to the library together, she does it (See Recording). Getting her to decide to do it is a different beast, but once she starts doing it, she always completes it. When it comes to her sister, I have tried to point out contradictions in the things she says about her and dig in deeper into why that is. When the 3 of us did a session

together, I focused on the positive to keep the mood light and asked open ended questions to get a better sense of how they interacted together.

Another important aspect of using object relations theory with Ms. S is the relationship we developed together throughout the year. Cognizant of the fact that our relationship became an important factor in her life, in our last session I asked what she got out of our time together (Process Recording). This made the transition out of our relationship less difficult for Ms. S and for myself (Walsh, 2009). She clearly did not expect us to connect well, but our relationship flourished and a lot of good came out of it.

Motivational Interviewing

Motivational interviewing (MI) was probably one of the most often utilized interventions I have used with Ms. S. One of the things I find funny is that before learning a lot about MI, I tended to intervene using a lot of its principles without knowing it was a technique. By this I mean I always begin where Ms. S is, explore and accept her perceptions as valid, reinforce her want to change, and affirm her declarations about her ability to change (Walsh, 2009). It can be a frustrating endeavor when Ms. S says one thing and does another, but as a social worker it is one of things you need to accept about clients. Often, I would try to elicit self-motivational statements by asking certain types of questions. Questions I would usually ask, like in our final session of where she sees herself in the next couple of months, and where she wants to be long term are important in the MI process (See Recording).

Other aspects of MI like reflection and shifting focus were used when needed, but those are almost always based on the flow of conversation. When I reframed, which is not exclusive to MI, I did so whenever I tried to present a situation in a different light to Ms. S. I also reframed

when Ms. S uses vocabulary to describe something that gives it a negative connotation, as shown in our final session (See Recording). Free choice is another aspect of MI that I constantly use with Ms. S where I want her to know that everything that she does is her choice, not mine. This is especially the case when we plan on going outside but Ms. S decides she no longer wants to, so I do not try to force it and we do a session within her apartment instead.

Using MI helped Ms. S realize her goals, like going outside and she tried to attempt them due to the motivational influence of the technique. MI has been shown to be a great precursor to help lower anxiety levels before attempting to use behavioral therapy (Westra & Dozois, 2006). It also gave her hope that she will be able to accomplish things she rarely thought about. Without the positive influence MI had on Ms. S, I do not think we would have gone outside the amount of times that we did.

Behavioral Therapy

The whole point of Ms. S's intervention was to try to change her behavior, so she would be able to go outside more often. Therefore, there were many elements of behavioral therapy that I used to try to promote this change. The first and most vital way for this to start was to develop a good relationship with the client, which we did almost immediately. The stated behavior that needs changing would be that Ms. S does not leave her apartment, and it is measurable by the amount of times she has gone outside in the past year (Walsh, 2009). A plan was created to have Ms. S do at home physical therapy and weekly psychotherapy sessions in her apartment with me. The physical therapy was to strengthen muscles to mitigate the fear of falling and the session with me was to help reduce anxiety about going outside by using the afore mentioned techniques like MI.

In the four sessions that we did go outside, I would make sure that she is aware of how important this all was and how positive it is, in a way a reward for her behavior. This was especially true when we went to the library together to renew her library card, enabling her to take out books on her new iPhone, a very big reward for her. This is all in hopes that she sees the opportunities that become available when she does go outside. This type of Cognitive Behavior Therapy (CBT) has been shown to significantly reduce agoraphobic behavior (Liebscher et al., 2014). The ideal scenario would be to continue the therapy and to continue exposing Ms. S to the outside world, but we unfortunately ran out of time together. Though this was the case, the progress that we made for about 20 sessions over the semester cannot be discounted.

Strengths

Many of my client's strengths have been discussed throughout this paper and some will be repeated here. Ms. S is a very intelligent and witty person with a great sense of humor. She has a young personality and you would never know that she was a 74-year woman in the way she presents herself. When she puts her mind to something she does it, despite her initial reluctance. She is fully aware of her situation and wants to change it despite the obstacles she faces. Ms. S lives within a supportive community with resources like my agency that have improved her quality of life. She acknowledges and accepts the help that we give her and wants to give back in some way.

Barriers and Transference

The biggest barrier that I have faced in working with Ms. S is Ms. S herself. There are no issues of finance, social injustice, or anything of that sort that prevented her from going outside.

It is her own social anxiety and agoraphobia that prevent her from leaving her apartment. We did not have any issues regarding inter-professional collaboration, which was surprising given the complexity of the case. I would say the only issue was in the beginning where she would cancel our appointments often, but this semester we have seen each other every week except spring break. There were times where Ms. S's negative attitude, mainly at the start of therapy, where her emotions counter transferred to me. I quickly realized that I needed to remain positive and keep our eyes on her goals that we set to achieve. I hope my transference reflected a positive goal-oriented tone and I believe it did because of all that Ms. S was able to accomplish. It is something you must keep in mind when working with someone with mental health illnesses like depression and agoraphobia.

Ethical Concerns

My biggest ethical concern was when I had a session with both Ms. S and her sister. Ms. S and I were never able to discuss what was off limits to talk about with her sister Maddie. I had to think on my feet to make sure that I did not disclose information I thought Ms. S would be uncomfortable sharing with her sister. There were also times where I had to use my laptop to help purchase things and set up accounts when she received her cell phone. Not that I see an ethical challenge here, I deleted the information and had her consent, but there are unethical people out there. I think the challenge I am having coming up with ethical issues in the grand scheme of things is a good thing.

References

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