

case study:

THE OCCULT

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I. PRESENTATION OF THE PATIENT

A 30 + year old male presents for therapy 1) as part of his probation involving unspecified criminal convictions related to having had sexual relations with a minor that lead to the suicidal death by drug overdose of that minor; 2) recent criminal convictions related to drug dealing activities and corruption of minors; 3) having recently relocated to the local area in an effort to escape pursuing occult members; 4) suffering from ongoing struggles to resist occult involvement; 5) magical thinking involving occult members locating him via “looks” through strangers;

Further, 6) dramatic alleged encounters with multiple women who accosted the patient for sex which he rebuffed only with great difficulty; 7) trance states during which the patient alleges he “looses control;” 8) illegal drug use that lead to being apprehended by police in a drug induced stupor; 9) having been pursued by occult leaders who were pressuring him into becoming an occult leader; 10) having witnessed multiple gruesome murders by fellow occultists; 11) having been pressed into the occult as a child by his father, who allegedly forced him to attend an occult school to learn the arts of the occult.

II. DSM IV OF THE PATIENT

The following DSM IV evaluation of this patient is offered: 1) AXIS I (clinical disorders) - paranoid schizophrenia; 2) AXIS II (personality disorders and mental retardation) - histrionic; 3) AXIS III (general medical conditions) - illegal drug abuse; 4) AXIS IV (psychosocial and environmental stressors) - possible past child abuse; unmarried and without any stable long term meaningful love relationships; 5) AXIS V (global assessment functioning) - mental faculties present to recognize that others find stories are unbelievable; potentially volatile if confronted re same; delusional; sociopath; potentially violent.

The following more in depth Axis II personality disorder evaluation is offered: The primary Axis II personality disorder is again clearly histrionic - dramatic; seductive; encourages intimate relationships, but breaks off emotional contact as soon as others respond. This patient also exhibits components of other secondary Axis II personality

disorders: 1) antisocial - incorrigible; enjoys the rebellious identity; 2) borderline - impulsive; conflict prone; increased homicidality; increased suicidality; unreal belief system; possibly abused as a child; self identity is faulty; can't see himself loved by either GOD or other people; 3) narcissistic - self-centered; taken with an unrealistic high opinion of himself; cruel; incapable of living by Golden Rule; 4) paranoid - suspicious; 5) schizotypal - increased risk for schizophrenia; thought disorders; unconventional behaviors; magical thinking; 6) dependent - fearful; insecure.

III. THERAPY FOR THE PATIENT

In therapy - even though the patient had the insight to be aware that his stories were unbelievably fantastic, the patient's primary concern none-the-less was that the therapist did not believe his accounts. This gave the patient permission to view the therapist with suspicion and mistrust. The patient challenged the therapist to validate his stories. Avoiding giving a direct answer to the patient, the therapist instead focused on giving the patient 1) instructions for taking a moral stand in his relations with other people; 2) interacting with women with greater caution, so as not to place himself in sexually vulnerable situations;

Further, 3) working to be less judgemental of people he interacts with; 4) work to rely less on magical thinking of reading occult related signals from and in other people; 5) to rely instead on the teaching of The Holy Scriptures for guidance in conducting his life. This course of action seems justified, as direct confrontation in an outpatient therapy setting with this patient over the veracity of his stories by the therapist have the potential for eliciting unpredictable negative reactions from the patient.

It is not possible to adequately evaluate this patient in the outpatient therapy setting regarding if he is a pathological liar, still on drugs, psychotic, sincerely deluded or bewitched. Although the large number of stories shared by the patient together raise the probability that much of what he relates is untrue, caution must be taken in that at least some parts of his stories may well be true. However, the outpatient setting is not the place to be developing a strategy for confronting this patient on the veracity of his stories.

This patient clearly is a potential danger to others around him and possibly to himself, especially if he is forced to admit the veracity of his stories are faulty. Adequate staff should be gathered in the presence of the patient and police officers should be out of sight but made immediately available. The facility psychiatrist should be appraised of the situation and be present. The patient should then be offered on the spot inpatient psychiatric hospitalization on a voluntary basis; if the patient declines, then involuntary inpatient psychiatric hospitalization on the spot should proceed.

IV. PLAN OF CARE

As with all hospitalized psychiatric patients, the following should be immediately obtained: 1) nursing assessment of vital signs, complaints, medications, history, records; 2) medical clearance by a physician; 3) alcohol and drug screens; 4) mental health evaluation by a psychiatrist; 5) start short term and initial psychiatric medications as ordered; 6) family & social support system evaluation by a social worker; 7) physician contact with the patient's medical doctor, psychiatrist and family if any; 8) contact with the patient's probation officer; 9) contact with the patient's or family's clergy if any.

V. BIBLICAL FOUNDATIONS FOR INTERVENTION

Lastly, and most importantly, once the patient has been stabilized, given the Christian therapist is free to incorporate the Christian Faith into the patient's therapy, The Holy Bible offers resolution and peace to this patient: 1) GOD loves and helps the repentant sinner. "The LORD preserveth all them that love Him: but all the wicked will He destroy." [PSALMS 145:20]. 2) GOD forbids men to engage in the occult. "There shall not be found among you any one that maketh his son or his daughter to pass through the fire, or that useth divination, or an observer of times, or an enchanter, or a witch, Or a charmer, or a consulter with familiar spirits, or a wizard, or a necromancer. For all that do these things are an abomination unto The LORD." [DEUTERONOMY 18:10-12a].

Further, 3) GOD will deliver the repentant from the occult by the saving grace of JESUS CHRIST. "Giving thanks unto The Father, Which hath made us meet to be

partakers of the inheritance of the saints in light. Who hath delivered us from the power of darkness, and hath translated us into the kingdom of His dear Son; In Whom we have redemption through His blood, even the forgiveness of sins.” [COLOSSIANS 1:12-14].

4) Thus does GOD give us peace. “Therefore being justified by faith, we have peace with GOD through our Lord JESUS CHRIST.” [ROMANS 5:1].

VI. FINAL OBSERVATIONS

This patient presented to outpatient therapy in a highly unstable and potentially dangerous condition. Initial intervention focused first on assuring the safety of both the patient and others by direct admission to the hospital psychiatric ward. Only once the patient has been thus cleared medically and stabilized psychiatrically may the therapist pursue counseling strategies.

What, if any, are the levels of the patient’s suicidality and homocidality? What portions of the patient’s stories are actually true and what are not should be addressed gently but firmly. Has the patient truly been involved in the occult? What is the extent of his drug abuse? To what degree, if any, was the patient abused as a child? What common traits do his relations with other people - both failed and successful - exhibit? What is the level and nature of the patient’s religious faith?

It is not so important to challenge the patient on the details of the veracity of his stories, but rather to elicit how the patient feels about the stories he relays. Role playing with the patient in a role reversal mode - using the constructs of the stories he relates - may of great help in giving the patient insight into his own feelings and the feelings of others on the issues he relates. At this point, the patient having been medically and psychiatrically stabilized, counseling should begin to explore the Biblical perspectives and solutions relative to this patient.