

Class Assignment: Written Assessment and Treatment Plan

PSY/544

<date>

<student name>

Instructor Dr. Craig Childress

Dr. Childress Feedback in Blue

Structure of Intake Assessment:

Identifying Information
Presenting Problem
History of Presenting Problem
Family History
Social History
Academic History
Work History
Mental Status
Summary
DSM Diagnosis
Recommendations (general)
Treatment Plan (specific)

This client appears to have a history of trauma (childhood sexual abuse; abusive marriage), then the client focused on her career and role as a mother, then she has recently lost both self-definition roles. She lost her role as a mother and her role as defined by her career. She's feeling empty and lost in who she is, and frightened that she won't be able to find a job at age 60 and is too old to start over in a new career, so she's facing financial disaster.

The treatment plan seems twofold.

1. To help her recover her self-definition
 - a. Through the therapeutic relationship and discussion of her life narrative
 - b. Skype with daughter to maintain mother role
 - c. Relationship with current boyfriend
2. To help her develop and implement concrete plans toward finding employment

Written Assessment and Treatment Plan

NAME: Mary Jones

DATE OF BIRTH: March 24, 1953

PRIMARY LANGUAGE: English

Referred By: Self referred

INTAKE DATE: January 24, 2014

EVALUATED BY:

Description of Client:

Client is 60-year-old African American female that appeared younger than her stated age; she appeared with no wrinkles in her skin. She wore no makeup and was casually dressed with clean clothing. She maintained good eye contact, communicated in a clear articulate tone and, calm manner. She appeared to be anxious exhibited by patting her foot throughout the interview. She denied wanting to harm herself or others at this time. [\(this is mental status information and should be in the mental status section\)](#)

Presenting Problem:

Client was self referred. She indicates she has not been feeling good for awhile, "I've been in denial about it." She indicates she feels depressed, has low motivation, difficulty with sleep, poor concentration, no interest to leave the house, or socialize with others. She reports frequent anxiety about her everyday life, health, finding a job and her finances. [\(when identifying symptoms in this section, it's best to use the DSM equivalent terms that will ultimately link to your DSM diagnosis\)](#)

History of Problem:

She indicates she has felt depressed since 2010 when her daughter moved to Minnesota to go to college. [\(is she currently married? How many children? How old are her children? Does she work? What kind of job? These are the type of answers that need to be provided in the Description of Client or Presenting Problem sections. You need to orient your reader to the broad descriptive information and then lead them through the narrative story of how the problems originated\)](#) She indicates when she was working she would get anxious and has panic attacks [\(actual panic attacks meeting DSM diagnostic criteria? If so, you should identify the symptoms met, if not then don't use a clinical term in a non-exact way\)](#) that were triggered by deadlines. She indicates at the time she did not know what a panic attack was and thought she was experiencing side effects of high blood pressure medication. She indicates she would forget what she was doing and at times had to leave

the office go sit in her car and sometimes having to go home early. She reports recently going to the emergency room because she had thoughts of wanting to hurt herself, "felt like I didn't want to live...what was I good for."

She reports she lost her job about a year ago and her unemployment ran out the beginning of this year. She indicates she has been trying to cope on her own. She indicates her work experience has consisted of working for an advertisement agency. She reports having difficulty finding work and doubts her ability to work anymore.

Identifying Information

Mary Jones is a 60 year-old divorce African-American woman with one adult daughter (age 22) who recently moved out of state. Mary worked for an advertisement agency until she lost her job approximately a year ago, and since that time the client reported she has had difficulty finding employment.

Presenting Problem

Client is self-referred for counseling for reported symptoms of anxiety and depression related to unemployment and daughter's recent move out the household. Client reported sad affect, low motivation, difficulty with sleep, poor concentration, and no interest to leave the house or socialize with others. She also reported having "panic attacks" that were reportedly triggered by work deadlines, and frequent current anxiety about her everyday life, health, finding a job, and her finances. Client reported prior suicidal ideation, but current suicidal ideation, no intent or plan.

Mental Status Examination:

Activity: Client appeared anxious and sad becoming tearful and tapping her foot.
Mood and affect: Client appeared somewhat depressed mood was tearful and affect was sad. Client's affect was congruent with mood and appropriate to content.

Thought process, content, and perception: The client's thought process was concrete (concrete is a clinical term referring to the inability to engage in abstract thought, so that the person's thinking is anchored to tangible, concrete things). She denied suicidal or homicidal ideation. (what about "she had thoughts of wanting to hurt herself, "felt like I didn't want to live...what was I good for.") She denied perceptual disturbance and there were no response to internal stimuli observed.

Cognition, insight and judgment: She was oriented to time, place and situation with no evidence of impaired memory. She demonstrated adequate insight into her problem and demonstrated no delusional thinking. Her judgment seemed to be intact, given she openly states, she has been feeling good for a while but "has been in denial about it."

Physiological functioning: Client appeared to be in good health and reports she has high blood pressure. She reports taking medication for high blood pressure. Client reports she

maybe in menopause because she has not a had menstrual for over five years. Client reports seasonal allergies. She indicates that lately she has been drinking 1-2 glasses of wine every day for the past few months.

For the next paper, omit the sub-headings and describe mental status in a narrative paragraph format. Also, move the Mental Status section to just before the Diagnosis section

Family History generally follows History of Presenting Problem

Social History:

Client reports she has been divorced for 16 years, has a 22 year old daughter, and lives alone in an apartment (Family History). She reports living in her current residence for over 18 years. She indicates she has been in a relationship with her current boyfriend for 10 years (Family History - current). She indicates she divorced her ex-husband because he was a drug addict, physically and emotional abusive toward her (Family History). She is currently unemployed and has not worked since 2012 (Work History). She reports, "working all her life" in the advertisement/marketing industry (Work History). Client reports she was collecting unemployment, and recently had to reapply for unemployment benefits. (Work History)

She indicates that both of her parents and three siblings are deceased (Family History). Client indicate she has minimal social support and tends to isolates and attributes this to being unemployed and feeling worthless (Social History). What about her current boyfriend of 10 years?

Client reported her family life as a child was good, but indicates her parents often fought verbally and physically (Family History). She reports she was molested by a 16 year old neighbor when she was four years old and saw her babysitter have sex with her boyfriend at the same age (Family History). She reports she was a good student in school and indicates she should have been skipped a graded (Academic History). She feels she was not challenged in school and was not prepared for college (Academic History). She graduated from high school and attended some college (Academic History). She indicates she got involved in drug and alcohol in the late 80's (Social History). She indicates she got sober after realizing that she "was not raised that way and that she was a disappointment to her mother" (Social History). She indicates her mother had high expectations for her and her siblings (Family History). Clients reports she completed a substance abuse treatment program in the early 90's (Social History). She reports after getting sober she got married and had her daughter (Family History). Client indicates her husband was an addict and abusive (Family History). She indicates after making the decision that she wanted a better future for her and her daughter she left her ex-husband in Florida and moved to California (Family History). Client indicates she devoted all of her life to her daughter (Family History). She reports she provided a good life for her and her daughter (Family History). She indicates she worked all her life and now that she is unemployed she only qualifies for 22 weeks of unemployment (Work History) She reports no family history of mental illness. (Family History)

Strengths:

Client appears to have lived a stable life, has insight into her difficulties and wants help.

Discussion:

Client is currently experiencing depression, low motivation, sad mood, loss of pressure, poor memory, feeling worthless, difficulty with sleep, and no interest in socializing or leaving the house. She focuses on daughter leaving, lack of finances, unemployment, being 60 years old, and no one wanting to hire her because of her age.

Client is a 60-year-old woman who presents with dysphoric mood and congruent affect. She reports the following symptoms: sad mood, low motivation, loss of pleasure, poor memory, feels worthless, low energy, difficulty with sleep, and has no interest in socializing or leaving the her house. (you already said this in the preceding paragraph) She reports passive suicidal thoughts, but no plans or intent. She demonstrated some memory impairment in short term memory as she had to be reminded of the date several times. She denied auditory or visual hallucinations, mania or substance abuse. She has not worked since August and was collecting unemployment. She indicates before she was laid off she was experiencing depression and anxiety that made it difficult to perform her job duties. (so her symptoms aren't about her job loss, and actually precede her unemployment? Why is this?)

~~According to Adler, "a person's behavior is generated from his or her ideas." Albert Ellis' interpretation of client's problem suggests that~~ based on her thinking about being unemployed, her financial situation, and daughter leaving for college has caused anxiety. Client's thinking and feelings that she is worthlessness and is older has created anxiety. Client's anxiety exhibited by her low motivation, lack of sleep, no interest in socializing, and sadness (sadness is not a symptom of anxiety) has caused client to be depressed (so the "Client's anxiety... has cause the client to be depressed"? That doesn't make sense. How does anxiety cause depression? Anxiety and depression are simply two different emotional symptoms) Client's behavior is a result of her thinking, beliefs and how she is coping with her emotional problems. (Losing your job at age 60 and not being able to find a job, and then losing your daughter who represented a major focus of your life aren't necessarily "emotional problems" – they seem like very real life problems)

The therapeutic approach for the client's problem would be Cognitive-Behavior Therapy. The client's problem suggest that her thoughts are caused by her feelings and behavior, not the external things, such as her daughter going away to college, being laid off from work , and loss of finances (Craig Kain, 2007). (Cognitive behavioral therapy says our feelings are caused by our thoughts, or interpretations, of events – not, as your saying that "her thoughts are caused by her feelings and behavior"). The client will learn how to focus on the solutions and her distorted thinking (Psychology Today, 1991-2014). (references aren't needed in a clinical report) The specific therapeutic approach that will be used for this client is Rational Emotive Behavior Therapy created by Albert Ellis.

According to Rational Emotive Therapy individuals' do not experience distress by things, but by his or her perception of things (~~Cherry~~). **But even if you change her thoughts, she's still unemployed and facing financial disaster.**

The fundamental belief of Rational Emotive Therapy is the way that the client feels is influenced by her thinking and therefore, her irrational beliefs about herself and the world creates problems. Based on these beliefs, the goal of Rational Emotive Therapy is to help the client alter her unreasonable beliefs and negative thinking pattern in an effort to overcome her feelings of worthlessness, low motivation, sadness, and loss of interest to socialize (~~Cherry~~). For instance, the client's unrealistic expectation of herself: "I must be employed, and have money or I am worthless." This irrational thinking self-imposed demand creates anxiety, depression, and emotional distress (~~A.Thompson, 2007~~). **(is it an irrational belief that we needs to be employed and be able to pay our bills? What's irrational about this? From an Adlerian perspective, she has no role anymore, no place in the human community. She's expendable.)** The therapist teaches the client through the therapeutic process to reinforce her preference (~~A.Thompson, 2007~~): "I prefer to be employed and to have money; but if I am unemployed and do not have money, I will accept myself unconditionally and fully." **(but how will she pay her bills, and won't she be evicted from her home? How will she buy food and gas? Where will she live, in a homeless shelter?)**

Provisional diagnosis:

296.23 Major Depressive Disorder, single episode, severe without psychotic features

300.02 Generalized Anxiety Disorder

In the body of the report, define a bit more clearly the exact symptoms met for each diagnosis.

Major Depression:

Depressed Mood:

Depressed mood **most of the day, nearly every day**, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).

Loss of Interest

Markedly diminished interest or pleasure **in all, or almost all, activities most of the day, nearly every day** (as indicated by either subjective account or observation made by others)

Weight loss or gain

Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite **nearly every day**.

Sleep disruption

Insomnia or hypersomnia **nearly every day**

Slowed or agitated movement

Psychomotor agitation or retardation **nearly every day** (observable by others, not merely subjective feelings of restlessness or being slowed down)

Fatigue

Fatigue or loss of energy **nearly every day**

Guilt

feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) **nearly every day**

Concentration problems

Diminished ability to think or concentrate, or indecisiveness, **nearly every day**

Suicidal ideation

Recurrent thoughts of death (not just fear of dying), **recurrent** suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide^[SEP]

Recommendations:

- Cognitive Behavior Therapy (CBT) ; Individual therapy 50min. session per week for seven months.
- Referral to support groups e.g. women's process group and relapse prevention
- Referral to psychiatrist for medication evaluation
- Referral to general physician for physical

Treatment Plan:**Short-term goals**

- Establish therapeutic relationship
- Develop strategy to reduce symptoms (**too general, this is what this treatment plan is – what is the strategy to reduce symptoms?**)
- Be free of suicidal thoughts (**how?**)
- Call crisis hotline if having suicidal thoughts
- Make referral for psychiatric evaluation

Beginning-stage interventions:

- Establish a therapeutic relationship by actively listening (for what purpose, how will a “therapeutic relationship” be helpful if she can’t find work, loses her home, can’t afford to pay her bills, etc?)
- Help client identify personal strengths
- Help client to understand what problems are (what are they from your perspective? I suspect that her trauma history plays a part, as does the loss of self-identity roles of career and mother)
- If client is prescribed medication encourage compliance of medication
- Help client to develop new strategies for coping with problems identified. (what new strategies? What problems? The Treatment Plan needs to be more specific. If you went to see a doctor for treatment of your cancer, you’d want to know specifically what the treatment plan was, not simply that “we’ll kinda see what comes up”)

Progressive-stage interventions:

- Maintain therapeutic relationship
- Help client recognize anxiety provoking situations (I suspect her anticipation of financial disaster is the anxiety provoking situation)
- Help client identify a plan to cope with anxiety (how do we cope with anxiety? Instead, “teach client progressive relaxation techniques” although I would suspect that coming up with an action plan for finding a new job would do more to reduce her anxiety than relaxation techniques)
- Help client develop strategies for thought distractions when thinking about her age (hard to do when your facing financial disaster. From a humanistic-existential perspective, she is also confronting her own mortality, an anxiety about her death. Life changes, she’s lost her daughter/role as a mother. She’s alone. She’s facing the end of her life. She feels overwhelmed)
- Help client identify positive self talk
- Help client identify strategies for thought distractions when ruminating about her past. (I might instead try to have her develop a narrative of integrated meaning regarding her life’s story)

Long-term goals:

Improve overall mood (too general, of course this is the goal – instead, “Help client develop and implement a specific action plan for finding employment, which may include referral to job retraining programs)

Develop strategies to reduce symptoms (too general, it's like your cancer doctor saying the long term goal is to cure your cancer. Of course that's the goal, the question is how. "through a combination of surgery, targeted radiation therapy, and chemotherapy, eliminate tumor and achieve remission of cancer")

Reduce anxiety and improve coping skills (too general, the question is how?)

Interventions:

Client will discuss openly plan identified to cope with anxiety

Client will discuss openly strategies she uses to cope with thought distraction.

Client will get up daily shower, get dressed something positive

Client will communicate with at least one friend daily (this is good specificity)

Client will take medications/treatment as prescribed

Client will attend all scheduled appointments with doctors

Client will report any medications and concerns to the prescribing doctor