

Term paper on kendra case study worksheet

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Use this format to submit your final product for this assignment.

1. Read the case study of Kendra at the beginning of Chapter 13 of the Mental Health in Social Work text.
2. Complete all sections of the assignment, as identified in this document.
3. Turn in the assignment to your instructor by the end of Week 7.

Questions to consider when formulating a diagnosis for Kendra

1. Do Kendra's presenting problems result from patterns of interaction with others?

Kendra's mentioned issues stem from a series of negative interactions in her social circles. She is very lonely, and when she is alone, she feels overpowered by the thought that she will be lonely forever and be abandoned. However, she refuses to become close with anyone—boyfriends and friends—even when they reach out to her.

2. Are there recent stressors that may account for Kendra's symptoms? Do these symptoms warrant an adjustment disorder? If so, is this an isolated situation or part of a general pattern?

Kendra has been living with three of her coworkers, but she cannot trust them. Moreover, she works as an EMT, which is stressful. Thus, these conditions have resulted in her being hospitalized up to ten times in the last year, and this is more often than not triggered by her anxiety when she is left alone.

3. Is Kendra under the influence of any substances or medical conditions that may account for her anxiety or depression?

She has been prescribed antidepressants, which she does not take. She does not and never has abused substances.

4. Might Kendra have a mood disorder? Can her self-mutilation behaviors be considered suicidal in nature?

Kendra might have a mood disorder, and it is possible she is a borderline, and has rapid mood changes—this could also be indicative of Bipolar disorder. She must also be observed for any personality disorders or/and attachment disorders. Kendra's self-mutilation habits can be potentially suicidal and she might consider indulging in them as they give her a sense of control. She has threatened to commit suicide in the past.

5. Are there any manipulative behaviors displayed by the client? If so, are they related to a desire for nurturance or personal gain?

The fact that she threatens to commit suicide shows that she is being manipulative. This is especially when she is left alone and fears being abandoned. She longs to be nurtured and looks to her therapist for gaining trust and has confided in being subject to incest. However, she is still contemplating and testing her therapist to know if she can actually trust and receive nurturing.

6. How would you characterize Kendra's sense of identity?

Kendra has a very unstable sense of identity because she feels accepted only when others let her know assuredly that she has been accepted. She

seeks attention and begins indulging in activities to gain attention; for instance, driving a car in great speed or entering into fights.

(From Corcoran, J. & Walsh, J. (2009). Mental health in social work (Appendix).

Part 1, Multi-Axial Diagnosis: Given the case information and your responses to the questions after the case, prepare the following: a multi-axial diagnosis, the rationale for the diagnosis and GAF score, and additional information you would have wanted to know in order to make a more accurate diagnosis.

Multi-Axial Diagnosis

Axis I: 309. 28 Adjustment Disorder with mixed anxiety and depressed mood

Axis II: 301. 83 Borderline Personality Disorder

Axis III: None known

Axis IV: Lack of Support System, Stressful Occupation

Axis V: GAF score: 50 Rationale and Differential Diagnosis

Kendra shows all indications of attachment disorder, which is in all likelihood perpetuated from the sexual abuse she has been subjected to and her inability for an attachment with her mother. She also appears to have borderline personality disorder, as she is suicidal, impulsive, and inflicts

injury on herself, and her relationships are often unstable. Her condition is aggravated without any support system and her stressful job. She has scored 50 in her GAF with her suicidal thoughts and inclination and her inability to adjust to her social settings.

Additional Information Needed

Any other medical problems in her history should be found and the medications and treatments she has undergone should be known. Kendra's past and her problems with incest should be further explored and her relationship with her mother should be better understood for the reasons for her attachment disorder. She does not have PTSD.

Part II, Biopsychosocial Risk and Resilience Assessment: Formulate a risk and resilience assessment, both for the onset of the disorder and for the course of the disorder.

TABLE 1 Biopsychosocial Risk and Resilience Assessment for the Onset of the Disorder

RISK INFLUENCES

PROTECTIVE INFLUENCES

Biological

Locus Coeruleus Dysfunction

Female

She might have health problems stemming from stress

Psychological

Lack of Intervention

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Lack of sufficient insight about the disorder/s

Feels abandoned

Has a daughter who can morally support her

Social

Lack of Support System

Negative Life Events: incest

Sensitivity to be left alone

Lack of Support System

TABLE 2 Biopsychosocial Risk and Resilience Assessment for the Course of the Disorder

RISK INFLUENCES

PROTECTIVE INFLUENCES

Lack of substance abuse

Attachment Deficits

Lack of substance abuse

Social

Social Maladjustment

Absence of Enduring Relationships

What techniques would you use to elicit additional strengths in this client?

Strength based techniques should be encouraged as they can help Kendra develop self-esteem and confidence, and thus, help her in focusing on her job and life. However, she needs to be further evaluated with therapy. She has, in all probability, attachment disorder along with depression and anxiety

as is shown from her fear of being abandoned and left alone. These problems can be traced to her childhood, where she did receive adequate attention from her mother. Moreover, she is also suicidal to gain attention and to avoid being left alone. Her possible borderline personality disorder can also be related to her abuse as a child. Her impulsiveness can be also because of adult ADD.

Part III, Goal Setting and Treatment Planning: Given your risk and resilience assessments of the individual, your knowledge of the disorder, and evidence-based practice guidelines, formulate goals and a possible treatment plan for this individual.

Treatment Goals:

1. Find childhood trauma source and provide methods to deal with it
2. Provide continuous support and trust
3. Review effectiveness after 10 sessions

Evidence-based Practices and Professional Practice Guidelines Applicable to this Client and this Disorder:

Identify the Evidence-Based Practices and Practice Guidelines by name, indicating their source, and provide a brief statement about how you might incorporate the practice or guideline in your work with this client.

Wraparound Program/Seligman Establish

Individual Psychology/Seligman Encourage

Part IV, Critical Perspective: Formulate a critique of the diagnosis as it relates to this case example. Questions to consider include: Does this diagnosis

represent a valid mental disorder from the social work/counseling perspective? Is this diagnosis significantly different from other possible diagnoses? Your critique should be based on the values of the social work/counseling profession (which are incongruent in some way with the medical model) and the validity of the specific diagnostic criteria applied to this case.

Suicide Risk Assessment

Using the information provided in the case study, conduct a Suicide Risk Assessment of Kendra. If the case study does not provide sufficient information for this purpose, use the space provided to identify what questions you would ask Kendra in order to be able to complete the assessment. Type narrative answers directly into the spaces provided. Use your cursor to highlight (select) the shaded area of the appropriate box, then highlight the box with red (instead of placing an X). Example:

Kendra Starnes

ID#:

DOB:

6/17/1991

123 Boulevard Road, Haines, New Jersey

Phone:

(666) 798-3908

Contact Type: Telephone Walk-in

Time:

12: 15 PM

Location of Person (if other than above):

Gender: M F

Primary/Preferred Language: English

Crisis Plan? N Y

SUICIDE RISK INDICATORS

1.

PRESENTING PROBLEM OR REQUEST FOR ASSISTANCE:

Suffers from suicidal tendencies along with depression, but no intake of medications; Causes injury to self, suffers from extreme anxiety when left alone, has a chronic fear of being deserted alone, and suffers from insomnia

2.

TRIAGE:

a. Are you able to keep yourself safe until this assessment is completed?

Yes

No

b. Are you in possession of a gun or weapon or do you have easy access to a gun or weapon?

Yes

No

c. Have you felt like hurting yourself?

Yes

No

or anyone else?

Yes - Refer to Core Risk Assessment for Harm to Others

No

d. Have you already hurt yourself or anyone else?

Yes

No

Note: If person answers " Yes" to 2d above and the level of risk is determined to be severe at this point, and a mobile crisis response team has been dispatched to continue the assessment, it is unnecessary to complete the remainder of this form.

3.

IDEATIONS: (Describe any thoughts of dying or killing oneself in detail, using person's own words. Include circumstances that trigger suicidal thoughts.)

Ideation is:

Fleeting

Periodic

Constant

Increasing in:

Severity

Urgency

Frequency

(No thoughts → ☹ Obsessive thoughts)

4.

PLAN: (How would person carry out ideations? Use details, person's own words.)

(Unclear ⇌ Detailed & specific)

5.

MEANS: (Instruments/methods to be used; access to instruments. Use details, person's own words.)

(No access ⇌ Continuous access)

6.

LETHALITY: (Dangerousness of plan. Use details, person's own words.)

(Minimal risk ⇌ Certainty of death)

7.

INTENT: (Reports desire and intent to act on suicidal thoughts. Use details, person's own words.)

(No desire/denial ⇌ Desire to complete plan)

8.

HISTORY: (Suicide and self-harming behaviors, self and family; Attempts: number, when, method, lethality, rescues, etc. Begin with past three months.)

What has prevented person from acting on suicidal thoughts in the past?

(No history ⇌ Multiple life threatening acts or severe attempts)

9.

SUBSTANCE ABUSE/USE: (History of use/abuse, access to substances, including family member substance abuse)

Is person currently using? If so, list substance(s), amount, and when taken.

(None \rightarrow \leftarrow Heavy use/dependence)

10.

ACUTE LIFE STRESSORS: (Situation/recent changes with family, relationship, job, school, health, divorce, marriage, grief, losses, financial, residential instability, bullying, etc.)

(Few stressors \rightarrow \leftarrow Many stressors)

11.

DEPRESSION/AGITATION: (Affect, anxiety, restlessness, symptoms of depression)

(Normal affect \rightarrow \leftarrow Severe depression)

12.

HOPELESSNESS: (Future orientation)

(Can see future \rightarrow \leftarrow Unable to see)

13.

PSYCHOTIC PROCESSES: (History/symptoms of psychosis, delusions, auditory/visual hallucinations. Include dates, diagnoses, meds.)

(No history \rightarrow \leftarrow Severe delusions)

14.

MEDICAL FACTORS: (History/current medical conditions including chronic and severe pain, terminal illness, etc.)

(No history ⇄ ☹ Multiple symptoms)

15.

BEHAVIORAL CUES: (Isolation, impulsivity, hostility, rage, etc.)

(Minimal ⇄ ☹ Extreme)

16.

COPING SKILLS: (Helplessness, negation of self and others)

(Good coping skills ⇄ ☹ Poor coping)

17. SUPPORT SYSTEM: (Family, friends, co-workers, roommates, spiritual affiliation, civic, school, etc. Define relationship(s) and details using person's own words.)

(Supportive contacts ⇄ ☹ No support)

18. OTHER FACTORS: (OPTIONAL. If previously mentioned, describe any recent lifestyle changes, sexual identity/orientation issues, involvement w/justice system, communication skills, other diagnoses.)

(Small significance ⇄ ☹ Severe impact)

19.

CULTURAL CONSIDERATIONS: (OPTIONAL. If mentioned, describe person's attitude towards suicide—acceptance, ambivalence, rejection, etc; cultural views on death and suicide; specific concerns)

20.

OVERALL RISK LEVEL (based on clinical judgment):

Low

Med

High

21.

REASONING: (Identify risk factors and factors offsetting/mitigating identified risks)

RISKS:

OFFSETS:

22.

ACTION TAKEN: (Client signed Crisis Plan? Y N Interim Service Plan Completed? Y N Include details of appointments/referrals made)

RISKS:

+++

Print Name & Credentials

Supervisor:

Print Name & Credentials

Mental Status Exam

Using the Mental Status Exam format below, complete a Mental Status Exam on Kendra.

If the case study does not provide sufficient information, add clinical information as needed so that you can complete the exam and incorporate a summary of your findings in Kendra's Intake Report.

RISKS:

++++*++++++

While prompts are provided below, you should be sure to describe your observations and impressions of the person for each question below. You may find it helpful to review the Key Mental Status Exam Phrases from the Module 3 readings.

If the case study does not provide answers to all of these questions, add information that you might have been able to gather, had you been Kendra's initial interviewer. Highlight the new information that you add (beyond the information provided in the case study) in yellow.

1. Describe the person's interaction with you and others in attendance; include general observations about the person's appearance, behavior, and social interaction:

RISKS:

+++++

RISKS:

+++++

RISKS:

+++++

RISKS:

+++++

RISKS:

+++++*+++++

2. Motor Activity (e. g., orderly, calm, agitated, restless, hypoactive, and what kinds of activity the person exhibits, such as tics, mannerisms, tremors, convulsions, ataxia, or akathisia):

RISKS:

+++++

RISKS:

+++++

RISKS:

+++++

3. Mood (Sustained emotional state, e. g., relaxed, happy, anxious, angry, depressed, hopeless, hopeful, apathetic, euphoric, euthymic, elated, irritable, fearful, silly):

RISKS:

+++++

RISKS:

+++++

4. Affect (Outward expression of person's current feeling state, e. g., broad

range, appropriate to thought content, inappropriate to thought content, labile, flat, blunted):

RISKS:

+++++++

RISKS:

+++++++*+++++

5. Self-concept (e. g., self-assured, realistic, low self-esteem, inflated self-esteem):

RISKS:

+++++++

RISKS:

+++++++

RISKS:

+++++++

RISKS:

+

6. Speech (e. g., mute, talkative, articulate, normally responsive, rapid, slow, slurred, stuttering, loud, whispered, mumbled, spontaneous, stilted, aphasic, repetitive):

RISKS:

+++++++

RISKS:

+++++*+++++

7. Thought Process (e. g., logical, relevant, coherent, goal directed, illogical, incoherent, circumstantial, rambling, pressured, flight of ideas, loose associations, tangential, grossly disorganized, blocking, neologisms, clanging, confused, perplexed, confabulating):

RISKS:

+++++

RISKS:

+++++*+++++

8. Thought Content (e. g., optimistic, grandiose, delusions, preoccupations, hallucinations, ideas of references, obsessions/compulsions, phobias, poverty of content, suicidal or homicidal ideation, prejudices/biases, hypochondriacal, depressive):

RISKS:

+++++

RISKS:

+++++*++

9. Intellectual Functions:

a. Sensorium (e. g., orientation – person, place, time, situation):

RISKS:

+++++

RISKS:

+++++*+++++

b. Memory (e. g., recent, remote, retention and recall (3 object memory, recall: immediate / 5 minutes; digit span memory):

RISKS:

+++++

RISKS:

+++++

RISKS:

+++++

RISKS:

+++

c. Intellectual Capacity (e. g., general information (current events, geographical facts, current/past presidents), calculations (serial 3's or 7's), abstraction and comprehension (comparison and differences, proverb interpretations):

She is okay intellectually. She is able to perform basic calculations. She can also compare two situations and outline their differences as well.

d. Estimated Intelligence (e. g., below average, average, above average, unable to determine):

RISKS:

+

10. Judgment and Impulse Control (e. g., good, partial, limited, poor, none)

RISKS:

+++++

RISKS:

+++++*+++++

11. Insight (e. g., good, fair, poor, none):

RISKS:

+++++

Intake Report

Write a narrative intake report using the format below. If the case study does not provide sufficient information to complete an intake report, the group should add details of the client’s life, history, current circumstances, strengths, and challenges in order to complete the report. In other words, you are helping to expand our knowledge of Kendra by providing more information than the case study itself contains. This additional information should be reflected in other components of this assignment, as well (e. g., Suicide Risk Assessment, Mental Status Exam, and Level of Care Assessment). Please highlight in yellow the new case information you are providing.

RISKS:

+++++*+

Interviewer:

Birth date:

Identifying Information

Kendra has certain psychological problems. She feels insecure on most occasions and thinks everyone is against her. She does not have close friends whom she can share most of her problems with.

RISKS:

+++++

The problem is that Kendra is sick. She has is undergoing trauma out of the fact that many of her friends always let he down. She feels she is a good lady but everyone is against her.

RISKS:

+++++

She does not have any mental problems.

Other Current Problems and Difficulties

She suffers from socialization problems. She is not outgoing. She has met most of her friends through John.

Present Life Situation

Kendra is in a dilemma. She feels insecure as she is alone. She does not have close confidants whom she can share her problems with.

RISKS:

She is away from her family and friends. She does not keep close contact with her family save for her 6 year old daughter.

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RISKS:

+++++

She started having these feeling immediately after she left home. She has a daughter who helps her to deal with her loneliness.

RISKS:

+++++

She has been diagnosed previously. She has been in hospital for a previous record of more than 10 times.

Substance use History

She does not abuse drugs.

The areas of difficulty include tracing her old friends and relatives. We are also not sure how she will take the rehabilitation process.

RISKS:

+++++

She is sad and lonely. She needs time to rest with close friends who can help her build her confidence back slowly. This will make her fell okay.

RISKS:

+++++

Identify four treatment plan goals that you might consider in your counseling of Kendra. These goals should reflect both your professional judgment and Kendra's own self-defined goals.

1. Psychological therapy.
2. Rehabilitation
3. She should meet her family and old friends so that she feels better.
4. Drugs should be administered to reduce depression levels.

RISKS:

+++++

Based on your assessment of Kendra’s problems, needs, and diagnosis, identify relevant two or more evidence-based practices (EBPs) that you could incorporate into your counseling strategy and treatment plan for Kendra. Identify the source from which you obtained your EBP information.

1. Spiritual guidance.
2. I may also incorporate her old friends and relatives to help.
3. She needs to exercise more often.
4. She needs to take time and go to places such as hiking and to perform other activities such as going out for dancing just to have fun.
5. Joining a program to develop mutual therapeutic alliances, and thus, having a support system

RISKS:

+++

Corcoran, J., & Walsh, J. (2009). Mental health in social work. Boston: Pearson Education.

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