PSY 450 Counseling and Clinical Psychology

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These three short paper assignments are designed to introduce undergraduate students to the principles and application of evidence-based practice. Each student receives their own hypothetical case (they are given a brief description (1-2 paragraphs) of their case at the beginning of the semester), and follows that case from assessment to termination.

**Paper #1**

In the first paper, your job will be to present a hypothetical assessment of your client. This paper should be 4-5 pages long (double spaced, 12 pt Times New Roman, 1 inch margins).

You need not follow APA style EXCEPT when you are citing particular assessment instruments (for example, if you conduct the Structured Clinical Interview for DSM-IV you would cite the manual for that interview in the text and in your reference list).

Please note that you can take creative license with this assignment—take the information you have been given and build on it however you see fit. Since this is a hypothetical assessment, you have the freedom to generate information to flesh out your case. However, be sure that you do not disregard the facts you have been given.

The following is an outline that can guide your paper. You need not follow this outline exactly. But, each of these topics should be covered at some point in your paper.

1. **General Information**

This section should be 1 paragraph long; it will include your client’s name, age, how they were referred to you, and a brief description of the major symptoms that your client has.

*“Mr. X is a \_\_-year-old divorced Caucasian man who was self-referred to this clinic seeking a psychological assessment and evaluation of mood symptoms for the purpose of treatment recommendation and planning. Presenting complaints at the time of this referral included low mood and anhedonia. This writer saw the patient on the following dates: X, X, X, X. Information contained in this report was obtained through patient interview, self-report measures, and the patient’s medical records.”*

1. **Appearance and Behavioral Observations**

This section should be 1-2 paragraphs and will summarize your client’s nonverbal behaviors and appearance. While much of your assessment will be a summary of verbal information (i.e., the answers your client gave to certain questions), this is where you can summarize important information about HOW they appeared to you, how they seemed to process information, etc. Items you may want to cover in this section include:

* 1. Alertness
	2. Cooperative?
	3. Does reported mood match appearance?
	4. Eye contact
	5. Thought processes
	6. Judgment/Insight
	7. Memory functioning
	8. Presence of Suicidal or Homicidal Ideation
	9. Attention/Concentration
	10. Attendance
	11. Hygiene/General appearance
1. **Assessment Procedures**

This section will be about one paragraph long and will describe what procedures you used to assess your client. You should include an interview and AT LEAST two self-report measures in your assessment. The interview(s) and measures you select should be appropriate for your initial diagnostic impressions (for example, if you suspect your patient may have major depressive disorder, you might want to give them the mood disorders section of the SCID and the Beck Depression Inventory (BDI)). You might also include observations conducted at the client’s home, school, place or work, or other relevant setting, or have them self-monitor. Finally, you may also seek information from the client’s spouse, parents, teachers, etc.

1. **Relevant Background Information**

This section should be about 2-3 paragraphs long and should detail any historical/social/environmental factors that are relevant to the case. This includes the client’s family status, occupational/educational history, psychiatric history, developmental history, etc. For a complete list of topics that may be relevant, see p. 76 of your text, but do not include all of these topics, just the few that are most important to your case.

1. **Assessment Findings**

This section will be the bulk of your paper (4-5 paragraphs long), and will describe the findings of your assessment. You should summarize the findings from each of the procedures you describe above. For the interview, you should talk about the symptoms they endorsed for each section that you covered. For the self report measures, you should summarize scores and what that particular score means clinically (i.e., what does a total score of 54 mean on the BDI?)

1. **Conclusions**

This section will be 1-2 paragraphs long and will summarize the results of the assessment, highlighting the parts that you feel are particularly relevant to your diagnostic decisions.

1. **Diagnosis**

Give the multi-axial diagnosis. Example:

Axis I: 309.81 Posttraumatic Stress Disorder, chronic

 296.22 Major Depressive Disorder, recurrent

303.90 Alcohol Dependence With Physiological Dependence

Axis II: None.

Axis III: Chronic Headaches, Pancreatitis

Axis IV: Problems related to the social environment, problems with primary support group.

Axis V: 55

**Paper #2**

In this paper you will present a treatment plan for your client based on the principles of evidence-based practice. This paper should be about 4 pages long (double spaced, 12 pt Times New Roman, 1 inch margins).

You need not follow APA style EXCEPT for citations (in text and reference list). For this paper you may be citing measures and/or treatment manuals, empirical papers, or theoretical papers that relate to the treatment techniques you will be using.

The following is an outline that can guide your paper. You need not follow this outline exactly. But, each of these topics should be covered at some point in your paper.

1. **Brief Case Conceptualization**

This section should be 1 or 2 paragraphs long, and should outline the main environmental/psychological/social factors that you believe have caused and/or are maintaining your patient’s symptoms. This need not be exhaustive, but you need to have some ideas about the main factors that may be contributing to your patient’s symptoms.

1. **Overview of Treatment Plan**

This section should be 1-2 paragraphs and will give an overview of the psychosocial treatment approach you plan to take. You should specify the theoretical orientation that will guide your treatment, as well as treatment package or packages that you will draw your techniques from. You must also give your rationale for selecting this treatment approach (which should include both empirical validity [i.e., efficacy] and any other factors that guided your choice of this treatment). While you may mention medication as an adjunctive treatment, keep in mind that the focus of this paper is on psychotherapy.

1. **Specific Therapeutic Techniques**

This section should be 3-4 paragraphs long and should describe the specific therapeutic techniques you will be using in your intervention. These techniques can be drawn from one or from multiple treatment packages. You may even draw techniques that have origins in different theoretical orientations (although you should use one orientation to guide most of your interventions). For example, techniques you may want to use could include things like: psychoeducation, skills training, unconditional positive regard, transference/countertransference, the “empty chair” technique, in vivo exposure, functional analysis and behavior modification, mindfulness, cognitive restructuring. There are many other techniques, these are just some examples to get you thinking. We will learn about these and other techniques in class and in your readings, but you will also learn about more as you are researching your treatment approach.

Make sure you are not just “throwing the kitchen sink” at your patient—pick three or four techniques that you will focus on, and make sure that the techniques come together to form a coherent treatment plan.

For each technique, write about a paragraph that describes specifically how you will use the technique. For example, if you are using cognitive restructuring, what are the thoughts you will focus on? If you are using unconditional positive regard, how will that process look like in the therapy session?

1. **Treatment Progress Assessment Plan**

This section will be about one paragraph long and will describe how you plan to monitor you patient’s treatment progress over the course of the therapy. Please specify the measure you will use to track symptoms, or the specific behavior you will track, and how often/how the assessments will be conducted.

**Paper #3**

In this paper you will present a case study for your patient based on the evidence-based treatment plan that you developed in paper #2. This paper should be about 4-5 pages long (double spaced, 12 pt Times New Roman, 1 inch margins).

You need not follow APA style EXCEPT for citations (in text and reference list). For this paper you may be citing measures and/or treatment manuals, empirical papers, or theoretical papers that relate to the treatment techniques you used.

The following is an outline that can guide your paper. You need not follow this outline exactly. But, each of these topics should be covered at some point in your paper.

1. **Brief Introduction to Patient and Approach**

This section should be 1 paragraph long, and serve as a very brief introduction to the patient (i.e., some important background info, age, gender, diagnosis, and referral source), and to the treatment approach you outlined in paper #2 (this section is mainly to remind me of who your patient is and how you plan to approach treatment).

1. **Treatment Goals**

This section should be 1 paragraph and will be an opportunity to outline the two or three of the main goals you and the patient plan to accomplish in therapy. These could be a reduction (or increase) in specific behaviors, or specific symptoms you wish to reduce, or it could be specific skills you wish to enhance. You can write this section in paragraph form or as a list, as long as you are providing some details on the goals you wish to accomplish. Try to “operationalize” the goals (i.e., make them measurable based on the treatment progress tracking plan you devised in paper #2).

For example:

Goal #1- To reduce alcohol use to three drinks a week (defined as 12 oz beer, 5 oz wine, or 1.5 oz. hard liquor) with no more than two drinks in any one day.

1. **Progress in Therapy Narrative**

This section should be 4-5 paragraphs long and should describe the progress of your patient over the course of therapy. There are a few ways you could organize this section. You could organize it chronologically (i.e., describe the techniques you used in the beginning, then middle, then end of therapy and relate how the client did in each of these phases of therapy). Or, you could organize it based on the specific goals you attempted to address (i.e., In terms of goal #1 to reduce the patient’s use of alcohol, how did the patient respond to the interventions).

Some things you might consider addressing in terms of therapy progress:

 Was the patient compliant with treatment?

What were obstacles that arose in the course of treatment? How did you respond to these obstacles?

 What techniques did the patient seem more/less receptive to?

 How did the targeted symptoms/behaviors change in response to the interventions?

1. **Progress in Therapy – Visual Data**

This section of the paper will be in either chart or graph format. You will display your data from the treatment tracking plan—often a line graph will display this data adequately. Make sure you have a separate chart or graph for each of the symptoms/behaviors/skills you outlined as targets for treatment in paper #2. For ideas about how to organize your visual data, refer to the Rizvi and Nock paper on single subject design. (The visual data should be consistent with the treatment progress you described in your narrative.)

1. **Summary and Post-treatment Multi-Axial Diagnosis**

This section will be about one paragraph long. Provide a summary of your patient’s response to treatment including whether this was a treatment success and what you might have done differently. Do you think your patient needs additional treatment, and if so, what would you suggest for additional intervention?

Finally, give your patient’s multi-axial diagnosis post-treatment. Do they still meet criteria for the diagnoses they had at the beginning of treatment? Have their medical problems/psychosocial environment/and or GAF changed?