PSY615: Week Two Counseling-Based Personality Assessment Scenario

PSYCHOLOGICAL EVALUATION

(Williamsburg Mental Health Center)

Jane Smith Date of Evaluation: 10/12/2013

Case No.: 12783A

Admission Date: 10/8/2013

PURPOSE FOR EVALUATION:

This is the second admission of a 32-year-old female to the Center. The client has 14 years of formal education and is employed as an administrative assistant at a local community college. She was admitted due to signs of major depression with possible psychotic features.

The purpose of this clinical evaluation is to assess the client's current mental well-being and the extent of her need for clinical intervention.

ASSESSMENT PROCEDURES:

The clinical psychiatrist on duty recommended the following assessments:

- Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
- Mental Status Examination
- Review of Prior Psychological Assessment
- Review of Prior Medical Records
- Clinical Interview

ASSESSMENT RESULTS:

Note: Typically, this section reports test results of all the recommended assessments. Here you are provided with the abbreviated results from the MMPI-2, the Mental Status Examination, Review of Prior Medical Records, and Clinical Interview.

Adjustment Level

Jane's elevated scores on Depression (T = 94) and Psychasthenia (T = 92) scales indicate her dissatisfaction with her life situation and feelings of hopelessness and inadequacy.

Symptoms

Jane appears to suffer from major depression, which is evident in her elevated Harris-Lingoes subscales on depression (D1, T = 101; D2, T = 89; D3, T = 80; D4, T = 99; and D5, T = 80). These scores and a high score on the Social Introversion scale (T = 79) indicate chance of suicidal

tendencies. She may withdraw from personal relationships and struggle with separation, which links to her depression.

Perceptions of Environment and People

Jane's elevated scores on Fears (T = 77) and Anxiety (T = 80) indicates that she does not feel safe or comfortable in most environments.

Reaction to Stress

Jane's elevated D1 subscale and low ego strength indicate that she is not able to cope well with stress, even under normal circumstances. Jane likely reacts to stress by withdrawing and isolating herself from the stressors.

Self-Concept

Jane's score on Low Self-Esteem (T = 89) is evidence of low ego strength and a poor self-concept.

Emotional Control

Jane seems to have a lack of emotional control with her depression. She appears to be struggling with feelings of hopelessness and despair. Elevations in level of depression should be monitored, particularly if the elevations extend over a long period of time.

Interpersonal Relationships

In addition to her depression, Jane's score on Social Introversion (t = 79) indicates she is aloof, ruminative, and withdrawn. Other indicators include elevated scores on Familial Discord (T = 72) and Family Problems (T = 83), which supports the evidence that she may have turmoil in the family.

Psychological Resources

Jane has attended college and appears intelligent. She has some satisfaction with work, so she knows that she is successful on some level. Her high score on Negative Treatment Indicators (TRT, T = 85) coupled with depression may indicate a negative attitude toward therapy.

Social Dynamics

Jane's parents are divorced and her home life was likely filled with conflict and dissention. Her parents were highly critical, which may be the source of her isolated introversion, anxiety, and depression.

Diagnostic Impressions

Jane's MMPI profile indicates that she suffers from major depressive disorder and she is at risk for suicidal tendencies. Jane may also have a bipolar personality and problems with mental processes, but she does not appear a danger to others at this time.

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BACKGROUND INFORMATION:

The client is a 32-year-old, single white female who was previously admitted one year ago for possible suicidal ideation and major depression. She has an associate's degree and is currently working for a local community college as the administrative assistant for the dean of the business school. She does not have a record of suicide attempts or long-term hospitalization in a mental health facility. She is a single female with no family history of mental illness.

MENTAL STATUS EXAMINATION:

Observational conclusions of the patient's attitude were as follows:

Open and cooperative, and her mood was euthymic. Her affect was appropriate to verbal content and showed broad range. Her memory functions seemed grossly intact and she was able to recall events and factual information. Her thought process was intact, goal oriented, and well organized. The client indicated no evidence of delusions, paranoia, or suicidal/homicidal ideation. Her level of personal insight appeared to be good, as evidenced by ability to state her current diagnosis and by ability to identify specific stressors that precipitated the current exacerbation. Social judgment appeared good, as evidenced by appropriate interactions with staff and other patients in the center and by cooperative efforts to achieve treatment goals required for discharge.