Practice Assessment Measures

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GCN 602.NZ (Hybrid) Measurement and Assessment

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2023.3.6

CONFIDENTIAL

MENTAL HEALTH EVALUATION

Client Name: Robert Thomson(M) **Date of Evaluation:** January 7, 2020

Date of Birth: Month Day, 1994 **Date of Report:** January 10, 2020

Age: 26

Tests Administered: Clinical Evaluation, Beck Depression Inventory-2 (BDI-2), Beck Anxiety Inventory, Spiritual Well-Being Scale & Psychiatric Diagnostic Screening Questionnaire (PDSQ)

Client History

Robert Thomson. is a 26-year old male who presented to the evaluation after being referred by the human resources department at his job. Mr. Thomson. works as an Engineering in government Job and he has held this job for the past 4 years. His performance has recently declined, which prompted his supervisor to discuss several concerns with his related to motivation and attention on the job. Mr. Thomson. shared with his supervisor that he has been struggling with personal issues for the past months. Human resources ultimately referred Mr. Thomson. to therapy and he was granted a medical leave of absence from work. During his first session, Mr. T. shared that he had a "humiliated." incident at work about a recent stressor and that he was neither an introvert nor an extrovert. therefore, there was no problem with giving an oral presentation. however, He said that canceled the presentation at the last minute because he felt nervous and pressured. Afterward, he said he found it difficult to face his colleagues and

supervisor and felt like a loser. He also said that his life plans began to crumble as he questioned why he went to graduate school with so much debt. After that incident, he took four sick leave during the two weeks at work, and did not attend any classes or submit assignments for three weeks at graduate school. He said he had no history of mental health counseling but later said that when he was 12, his mother took him to a counselor because he had difficulty adjusting to middle school in a new area.

Presenting Symptoms

Mr.T. reported that his symptoms of concern include sadness; loss of interest in activities he enjoys (e.g., dating with women, going to the gym, meets with his friends on weekends); he had a "nervous stomach" and lost his appetite for food. he could only eat light meals in the evening. He said that his parents came to clean the apartment, which had been messy for several days, and his Parents mentioned his weight loss. He described his parents as "very supportive" and shed tears when he mentioned them. Robert was questioning his own life purpose, and he said he thought about death all the time and he said he cries almost every night. He says that he is pathetic himself and that he does not want to show it to anyone.Mr. T. absent several working days as a result of these depression.Mr. T. stated that difficulty concentrating at work.

Test Results & Interpretation

Validity Statement

Mr. Thomson. was able to sustain attention and concentration throughout the evaluation and assessment process and appeared to understand the contents of the assessment measures

administered to him. All results are considered a valid assessment of her present emotional functioning.

Beck Depression Inventory-II (BDI-II)

Mr. T. obtained a score of 47 on the BDI-II, which indicates that she endorsed symptoms of depression on the higher end of the moderate range. A score over 40 is indicative of Extreme depression. Item 16 is question about sleep patterns and Item 18 is a question about appetite. Based on the his answers, it can be seen that the loss of appetite has been going on for a long time.

Beck Anxiety Inventory (BAI)

Mr. Thomson. obtained a score of 22 on the BAI, which indicates that he endorsed symptoms of anxiety on the higher end of the moderate range. A score between 22 and 35 is indicative of moderate anxiety.

Psychiatric Diagnostic Screening Questionnaire (PDSQ)

Results of the PDSQ indicated that Mr. T. endorsed items that correspond with the diagnoses of Major Depressive Disorder scoring a 11 on the subscale and exceeding the cut off and scored an 10 the Social Phobia sub scale and exceeded the cut off. Mr. T's total raw score was 22 which corresponds to a T-Score of 43, indicating "average" symptoms.

Spiritual Well-Being Scale (SWB)

Mr. T scored a 75 on the Spiritual Well-Being scale indicating a " high spiritual well-being". He scored an 42 on the Religious Well-Being subscale indicating a "moderate sense of religious well-being". She scored a 34 indicating a "moderate level of life satisfaction and purpose."

Diagnosis

Mr. T. meets diagnostic criteria for the following DSM 5 &DSM 5 TR disorders:

(300.23/F40.10) Social Anxiety Disorder(Social Phobia)

(296.22/F.32.1) Major Depressive Disorder, Moderate, Single Episode

Treatment Recommendations

Mr. T. would benefit from receiving Talk therapy, often known as psychotherapy, which entails discussions with a mental health expert. Your therapist assists you in recognizing unhelpful feelings, attitudes, and actions and changing them. Psychotherapy comes in a variety of forms, with cognitive behavioral treatment (CBT) being the most popular. Cognitive Behavioral Therapy (CBT) is to address his anxiety, worrying, and depressive symptoms. CBT sessions should consist of psychoeducation to help Mr. T. understand how maladaptive thought patterns contribute to his symptoms. CBT interventions would include cognitive restructuring, problem-solving skills, and relaxation exercises. Mr. T. may also benefit from a psychiatric evaluation, as he might consider the option of taking psychotropic medication if his symptoms do not improve with therapy. The brain chemistry that underlies depression can be altered with the aid of prescription drugs referred to as antidepressants. Finding the right antidepressant for you may take some time because there are numerous varieties available.

Conclusion

Mr.T. is a 26-year old male referred by the human resources department at his job. He presents with symptoms of depression and anxiety, which began after his followed by a depressive episode, which began 3 weeks ago. Mr. T. has displayed deficits in social and occupational functioning and is currently on a medical leave of absence from his employment due to his symptoms. Results of the BDI-II indicate depressive symptomology at the higher end of the range which is sadness, loss of pleasure, self-criticalness, agitation, loss of interest, concentration difficulty, loss of interest in sex. Results of the BAI indicate anxiety symptoms at the end of the moderate range which is unable relax. Mr. T. endorsed items on the PDSQ indicative of a diagnosis of Major Depressive Disorder and Social Anxiety Disorder(Social Phobia). According to the clinical evaluation, behavioral observations of Mr. T., and the results of the tests administered, Mr. T. meets diagnostic criteria for Social Anxiety Disorder and Major Depressive Disorder, Moderate, Single Episode. It is recommended that he receive psychotherapy, applying CBT interventions to address her symptoms. he will also be referred to a psychiatric evaluation.

Clinician Name and Credential Signature.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Depression: Causes, symptoms, types & treatment. Cleveland Clinic. (n.d.). Retrieved March 6, 2023, from https://my.clevelandclinic.org/health/diseases/9290-depression