**AUBURN UNIVERSITY SYLLABUS**

**Course Number:** COUN 7250

**Course Title:** Advanced Assessment and Diagnosis in Counseling

**Credit Hours:** 3 Semester credit hours

**Class Meeting:** Asynchronous

**Class Location:** N/A

**Office Hours:** By Appointment/via Zoom

**Professor:** Sarah Flint, PhD, LPC-S, NCC

**Email:** sam0058@auburn.edu

TA:Derriya Sankey, Doctoral Student: dzs0134@auburn.edu

# Text(s)

**Required:**

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

# Recommended:

First, M. (2013). (Ed.). *DSM-5 Handbook of Differential Diagnosis.* Arlington, VA: American Psychiatric Publishing.

# \*\*The DSM-5 Handbook of Differential Diagnosis is available as a free resource through the Auburn Library Resources (you will be required to sign it with your AU User ID and Password)\*\*

**Syllabus Prepared:** Syllabus revised December 2024

# Course Description:

Process of assessment and diagnosis as it applies to the counseling process. This includes but is not limited to: diagnostic criteria, bias in diagnosis, cultural issues in diagnosis, assessment in the diagnostic process, and treatment planning.

# CACREP (2024) objectives/student learning outcomes:

1. Historical perspectives concerning the nature and meaning of assessment and testing in counseling (CACREP 3.G.1)
2. Methods of effectively preparing for and conducting initial assessments (CACREP 5.C.4, CACREP 5.D.9)
3. Identify and apply ethical and legal guidelines pertaining to assessment and diagnosis (CACREP 3.G.6)
4. Use of culturally sustaining and developmentally appropriate assessments for diagnostic and intervention planning purposes (CACREP, 3.G.7)
5. Use of structured interviewing, symptom checklists, and personality and psychological testing (CACREP, 3.G.10)
6. Diagnostic processes, including differential diagnosis and the use of current diagnostic classification systems (CACREP, 3.G.11)
7. Procedures to identify substance use, addictions, and co-occurring conditions (CACREP, 3.G.12)
8. Procedures for assessing clients’ experience of trauma (CACREP, 3.G.14)
9. Psychological tests and assessments specific to clinical mental health counseling (CACREP 5.C.1, 5.C.4)
10. Psychological tests and assessments specific to clinical rehabilitation counseling (CACREP 5.D.9)
11. Procedures to identify client characteristics, protective factors, risk factors, and warning signs of mental health and behavioral disorders (CACREP 3.G.16)
12. Classification, effects, and indications of commonly prescribed psychopharmacological medications (CACREP 3.E.18)

# Course Requirements

**Quizzes (80 points)**

There will be 8 reading quizzes throughout the semester. The quizzes will focus on the DSM-5TR content covered in each lecture to ensure that the material has been **read prior to class**. The quiz will open at the conclusion of class the week prior, so you have a full week to take the quiz prior to the start of the following class. Each quiz is due by 11:59 PM CST on Canvas on dates indicated on the syllabus. Each quiz will be worth 10 points. Quizzes not submitted by 11:59pm will result in a 0. Please note you **WILL NOT** need or use class lecture videos on the quizzes – the quizzes align with your reading requirement therefore will be due before the lecture for that content is posted. These are open book but are to be completed individually.

**Group Discussions/Case Studies (80 points)**

Beginning week 5, case studies will be posted on Canvas, a worksheet will be provided for students to work through to identify pertinent information in the case study, discuss client symptomology, identify diagnostic criteria, and identify a possible diagnosis. You will post your response to the case study in a discussion board to create a larger conversation about diagnosis and will also be required to respond at least one peer’s response each week. The case study discussions are the best way to prepare for the Midterm and Final Exam. Students will be awarded up to 10 points for their participation in these discussion board posts, and full credit will be awarded only to meaningful, detailed responses.

# Mid-term (100 points)

The midterm will consist of a series of clinical case vignettes. You will derive and justify a DSM-5 TR diagnosis for each client, including your reasoning and any differential diagnoses considered. You will have one week to complete the midterm. These will be open note/open book but must be completed **individually**.

# Final (100 pts)

The final will consist of a series of clinical case vignettes. You will be required to derive and justify a DSM-5TR diagnosis, to include a differential diagnosis (if indicated) and/or dual diagnoses for each clinical case. You will have one week to complete the final. These will be open note/open book but must be completed **individually**.

# Diagnosis Case Study Project (100 pts): Tevera Assignment\* (CACREP 2024, 3.G.)

Students will select a character from a movie or TV show to serve as the basis for a comprehensive case study. See the addendum at the end of syllabus for a complete description.

**Cultural Bias in Diagnosis - Case Conceptualization Assignment (10 Pts) Tevera Assignment\* (CACREP 2024, 3.B.)**

Students will complete a case conceptualization worksheet (see template below for “Phillis” OR “Lee”) to identify symptomology, diagnostic criteria and impressions, and cultural factors relevant to diagnostic decision-making. Please see the addendum at the end of syllabus for a complete description.

Please note: Course assignments are due on the dates specified. When assignments are turned in late, without an excused or approved absence, scores for the assignments(s) will be reduced by 5% per day, with no assignments accepted more than 1 week past due. Please refer to the Class Policy Statements in the course syllabus for information about excused absences and making up assignments.

Students in this course are required to complete the specified course requirements. Student’s final evaluation is based on these components.

1. Quizzes 100 points
2. Group Discussions/Case Studies 50 points
3. Midterm Exam 100 points
4. Final Exam 100 points
5. Diagnosis Case Study Project 100 points
6. Cultural Bias in Diagnosis - Case Conceptualization Assignment 10 points

 Total: 460 point

**Grading Scale**

A 90-100%

B 80-89.99%

C 70-79.99%

D 60-69.99%

F Below 60%

# Course Content:

Please note: This schedule is subject to change. Students should read the sections of the DSM-5 TR corresponding to the topics scheduled.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Topic** | **Assigned Reading** | **CACREP****Standards** |
| Week 11/13 – 1/19 |  Syllabus/Course Overview Introduction to DSM-5 Historical Perspectives Mental Status Exam/Clinical Interviewing Read pg. 5 – 25 of DSM  |  | 3.G.15.C.45.D.93.G.10 |
| Week 2 1/20 – 1/26 | Intro to Differential DiagnosisNeurodevelopment Disorders (p. 35 – 99)Neurocognitive Disorders Other Mental Disorders (p. 667 – 732) | **Quiz 1 due 1/19 by 11:59pm** | 3.G.113.G.165.C.15.C.45.D.9 |
| Week 3 1/27 – 2/2 |  Schizophrenia Spectrum and Other  Psychotic Disorders (p. 101 – 138) | **Quiz 2 due 1/26 by 11:59pm** | 3.G.113.E.183.G.16 |
| Week 42/3 – 2/9 |  Depressive Disorders (p. 177 – 214) Bipolar and Related Disorders (p. 139 – 175) | **Case Study 1 &****Quiz 3 due 2/2 by 11:59pm** | 3.G.113.E.185.C.1 5.C.43.G.16 |
| Week 52/10 – 2/16 | Anxiety Disorders (p. 215 – 261)Obsessive-Compulsive &Related Disorders (p. 263 – 294) | **Case Study 2 &****Quiz 4 due 2/09 by 11:59pm** | 3.G.113.E.185.C.1 5.C.43.G.16 |
| Week 6 2/17 – 2/23 |  Feeding and Eating Disorders (p. 371 – 397)Somatic Symptom and Related Disorders (p. 349 – 370) | **Case Study 3 due 2/16 by 11:59pm** | 3.G.113.E.185.C.1 5.C.43.G.16 |
| Week 72/24 – 3/2 | Substance Related and Addictive Disorders (p.543 – 665)***Derriya Sankey*** | **Case Study 4 &****Quiz 5 due 2/23 by 11:59pm** | 3.G.123.E.183.G.11 |
| Week 83/3 – 3/09 | MIDTERM – no lecture**DUE 3/9 by 11:59 PM CST**  |   | 3.G.113.G.103.G.125.C.1 5.C.45.D.93.G.16 |
| Week 9 3/10 – 3/16 | **Spring Break** |  |  |
| Week 10 3/17 – 3/23 |  Disruptive, Impulse Control and Conduct Disorders (p. 521 – 541)***Derriya Sankey*** | **Case Study 5 &****Quiz 6 due *3/17* by 11:59pm** | 3.G.115.C.1 5.C.43.G.16 |
| Week 113/24 – 3/30 |  Trauma & Stressor-Related Disorders (p. 295 – 328)Dissociative Disorders (p. 329 – 348)Personality Disorders (p. 733 – 778)  | **Case Study 6 &****Quiz 7 due 3/23 by 11:59pm** | 3.G.143.G.113.E.185.C.1 5.C.43.G.16 |
| Week 12 3/31 – 4/6 | Sexual Dysfunctions (p. 477 – 509)Gender Dysphoria (p. 511 – 520) Paraphilic Disorders (p. 779 – 801)  | **Case Study 7 &****Quiz 8 due 3/30 by 11:59pm** | 3.G.115.C.1 5.C.43.G.16 |
| Week 13 4/7 – 4/13 | Work Day – no lecture this week | **Cultural Bias in Diagnosis - Case Conceptualization Assignment Due 4/13 by 11:59 PM CST**  | 3.G.7 |
| Week 14 4/14 – 4/20 | Cultural Formulation Culture Bound SyndromesEthical and legal aspects of diagnosisOther Conditions that may be a focus of clinical attentionReview of differential diagnosis |  **Diagnosis Case**  **Study Project**  **Due by Sunday,**  **4/20 by 11:59 PM CST**  | 3.G.63.G.7 |
| Week 154/21 – 4/27 | **Final Exam****Due 4/30 by 11:59 PM CST** |  | 3.G.113.G.103.G.125.C.1 5.C.45.D.93.G.16 |

# \*4/30 – classes end

# Class Policy Statements

1. Attendance: This is an online course so there are no in person class meetings, however it is very important that you keep up with the work throughout the semester. Lectures for the week will be posted to the Canvas site Monday mornings.
2. Excused absences: Students are granted excused absences from class for the following reasons: illness of the student or serious illness of a member of the student’s immediate family, trips for student organizations sponsored by an academic unit, trips for university classes, trips for participation in intercollegiate athletic events, subpoena for a court appearance, and religious holidays. Students who wish to have excused absences from class for any other reason must contact the instructor in advance of the absence to request permission. The instructor will weigh the merits of the request and render a decision. When feasible, the student must notify the instructor prior to the occurrence of any excused absences, but in no case shall notification occur more than one week after the absence. Appropriate documentation for all excused absences is required. Please see University Policies https://sites.auburn.edu/admin/universitypolicies/default.aspx for more information on excused absences.
3. Readings and participation: Students are expected to have completed the assigned reading prior to watching the lecture.
4. Make-Up Policy: Arrangement to make up a missed major examination (e.g., hour exams, mid-term exams) due to properly authorized excused absences must be initiated by the student within one week of the end of the period of the excused absence(s). Except in extraordinary circumstance, no make-up exams will be arranged during the last three days before the final exam period begins.
5. Course Assignments: Course assignments are due on the dates specified on the syllabus. When assignments are turned in late, without an excused or approved absence, scores for the assignment(s) will be reduced by 5% per day, with no assignments accepted more than 1 week past the due date.
6. Course communication: Canvas will be used as the medium to transfer educational materials for this course. Students will upload completed assignments to Canvas and bring them to class only when instructed. University e-mail (**NOT** messages through Canvas) will be the primary avenue of communication with the instructor in between class sessions.
7. Course contingency: If normal class and/or lab activities are disrupted due to illness,

emergency, or crisis situation, the syllabus and other course plans and assignments may be modified to allow completion of the course. If this occurs, an addendum to your syllabus and/or course assignments will replace the original materials.

1. Professionalism: As faculty, staff, and students interact in professional settings, they

are expected to demonstrate professional behaviors as defined in the College’s conceptual framework. These professional commitments or dispositions are listed below:

* 1. Engage in responsible and ethical professional practices
	2. Contribute to collaborative learning communities
	3. Demonstrate a commitment to diversity
	4. Model and nurture intellectual vitality
1. Professional Behavior: As students preparing to work within professional counseling settings it is expected that you demonstrate the appropriate professional behaviors that are discussed in program handbooks, policies and professional standards:
2. Demonstrate appropriate professional behavior in the classroom including appropriate use of technology
3. Demonstrate respect for peers and faculty
4. Demonstrate responsible behavior related to attending class, completing assignments and participating in your educational training

**Academic Honesty Policy:**

Academic Honesty Statement: All portions of the Auburn University Student Academic Honesty Code (Title XII) found in the *Student Policy eHandbook* will apply to university courses. All academic honesty violations or alleged violations of the SGA Code of Laws will be reported to the Office of the Provost, which will then refer the case to the Academic Honesty Committee.

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Policy Related to the Use of AI for Classroom Assignments

The Counselor Education Programs (CED) has a comprehensive policy on the use of Artificial Intelligence (AI). As the acceptable use of AI varies, please consult your instructor on how AI can be used within specific courses and/or clinical settings. Please understand that violations of this policy can be considered a form of plagiarism. Please see the CED Programs Handbook for the full AI policy.

Diversity Statement

A central foundation of the mission of the Counselor Education programs is the preparation of counselors and counselor educators to work in an increasingly diverse society. The program’s understanding of diversity encompasses culture, sexual and gender identity, race, ethnicity, socioeconomic status, ability, and other aspects of individual identity. The program believes that meeting these goals requires that students and faculty engage in advocacy, equity, inclusion, and culturally sustaining practices. This includes students demonstrating these principles in their academic, clinical practice and professional development engagement.

These principles are in alignment with our professional, ethical, and accreditation standards including: Council for the Accreditation of Counseling and Related Programs (2024 standards) American Counseling Association’s Code of Ethics (ACA, 2016), American Rehabilitation Counseling Association (ARCA), the Commission on Rehabilitation Counselor Certification (CRCC), American Mental Health Counselors Association (AMCHA), and the American School Counselor Association (ASCA). Overall, we seek to create educational and learning environments that support, sustain, and challenge students to address their development as professionals related to and representative of culturally sustaining practice.

Accommodations Statement

Auburn University and the Counselor Education program are committed to ensuring student success by providing them with the appropriate supportive resources when necessary. We encourage students to exercise their right under the Americans with Disabilities Act to access academic accommodations. Students who need accommodations should submit their approved accommodations through the AIM Student Portal on AU Access and follow up with the instructor about an appointment. It is important for the student to complete these steps as soon as possible; accommodations are not retroactive. Students who have not established accommodations through the Office of Accessibility but need accommodations should contact the Office of Accessibility at ACCESSIBILITY@auburn.edu or (334) 844-2096 (V/TT). The Office of Accessibility is located in Haley Center 1228. Once a student has begun the process for accommodations, they are responsible for scheduling a meeting with faculty to discuss how these accommodations will be implemented in practice. Faculty are committed to working with students to support their needs in conjunction with the Office of Accessibility.

# Justification for Graduate Credit:

This course includes advanced content crisis intervention. This includes content as specified by the Council for the Accreditation of Counseling and Related Programs (CACREP, 2009). All academic content approved by CACREP is for advanced Masters and/or Doctoral graduate study. This includes rigorous evaluation standards of students completing the student learning outcomes specified in this syllabus.

**SYLLABUS DISCLAIMER:**

The instructor reserves the right to make changes to the syllabus as needed due to the developmental needs of the students. In the event that changes are deemed necessary, the instructor will inform students at the earliest date possible in class or via email.

**COUN 7250 Advanced Assessment and Diagnosis**

**Diagnosis and Assessment Case: Final Case Rubric**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Rating** | **Diagnosis and Assessment Skills**  | **Exceeds Expectations****(Full credit)** | **Meets Expectations****(Full-partial credit)** | **Does not Meet Expectations****(Minimal credit)** |
|  | Summary of background information and intake | Able to identify and integrate intake information into providing a strong rationale for diagnosis decision-making | Provides a summary of the primary intake areas that correspond to diagnostic decision-making.  | Unable to integrate intake information into the rationale for the diagnostic decision- making  |
|  | Applies knowledge of testing and diagnosis to assessment process  | Able to identify appropriate assessment tools required for this diagnosis. This includes a strong justification for the use of the assessment tool(s) or procedures  | Provides a summary of the appropriate assessment tools and procedures required for this diagnosis. This includes providing support for the assessment recommendation  | Unable to provide or limited rationale for the appropriate assessment tools and procedures for this diagnosis.  |
|  | Identification of specific criteria and descriptors | Able to integrate intake, assessment and presenting information into a strong presentation of critical criteria and diagnostic descriptors  | Provides a summary of intake, assessment and presenting information to support identification of critical criteria and diagnostic descriptors | Unable to provide intake, assessment and presenting information to support identification of critical criteria and diagnostic descriptors |
|  | Principal Diagnosis and Differential Diagnosis Rationale  | Integration of all supporting information to provide a detailed and strong rationale for the Principal Diagnosis and Differential Diagnostic Rationale. This should include identifying significant culture, gender and other diagnostic issues | Integration of supporting information to provide a rationale for the Principal Diagnosis and Differential Diagnostic Rationale. This should include identifying significant culture, gender and other diagnostic issues | Unable to integrate supporting information to provide a rationale for the Principal Diagnosis and Differential Diagnostic Rationale, and not adequately addressing significant culture, gender and other diagnostic issues |
|  | Identify potential treatment recommendations  | Provides a strong and well supported discussion of recommended treatment and therapy recommendations, based on empirical research.  | Discusses recommended treatment and therapy recommendations, based on empirical research. | Unable to provide empirically supported recommendations for treatment or therapy.  |
| **Overall Rating**: **Feedback**:  |

**Diagnosis Case Study Project – Final Case Study (100 pts):**

Students will select a character from a movie (see list below) to serve as the basis for a comprehensive case study.

Please address the following components:

**Assessment and Intake:** Identify critical background and intake information that will provide the foundation for your diagnostic process. You are also asked to identify assessment tools including assessment measures that would be considered as part of the process of diagnosis in this case.

**Diagnostic Considerations:** This discussion should focus on any diagnostic considerations that may help you make a differential diagnosis, rule in or out a diagnosis or consider a dual diagnosis. This may include cultural, gender, or other components of the diagnostic process.

**Principal Diagnosis and Rationale:** Outline you full diagnosis (and if appropriate dual diagnosis). Using the diagnostic considerations discuss briefly your rationale and justification (based on presenting information and intake) for the diagnosis you have outlined.

**Potential Treatment Recommendations:** You are asked to develop a brief summary (2-3 pages APA format, and 1-2 pages of references) of the recommended and empirically supported treatment options for your primary diagnosis. This may include psychopharmacological, group and individual counseling, specific theoretical models, and other treatment modalities. As outlined in the module, this should also include strengths and limitations of these approaches.

# Movie List

|  |  |
| --- | --- |
| *Forrest Gump* | *The King’s Speech* |
| *One Flew Over the Cuckoo’s Nest* | *A Beautiful Mind* |
| *Radio* | *The Fisher King (1991)* |
| *I am Sam* | *Awakenings (1990)* |
| *Shutter Island* | *The Soloist* |
| *Any Day Now* | *Take Shelter (2011)* |
| *There’s Something About Mary* | *Black Swan (2010)* |
| *Adam (2009)* | *He Loves me, He Loves Me Not (2002, France)* |
| *Breaking and Entering (2006)* | *The Beaver (2011)* |
| *Rain Man* | *It’s a Wonderful Life (1946)* |
| *Silent Fall (1994)* | *Silver Linings Playbook (2012)* |
| *To Kill A Mockingbird* | *Mr. Jones* |
| *Thumbsucker (2005)* | *Running with Scissors (2006)* |
| *Michael Clayton (2007)* | *Boy Interrupted (2009)* |
| *House of Sand and Fog (2003)* | *The Hours (2002)* |
| *Dead Poets Society (1989)* | *The Aviator (2004)* |
| *Matchstick Men (2003)* | *As Good As It Gets (1997)* |
| *Somethings Gotta Give (2003)* | *Panic Room (2002)* |
| *Kissing Jessica Stein (2002)* | *The Dryland (2010)* |
| *The Manchurian Candidate (2004)* | *The Upside of Anger (2005)* |
| *The Three Faces of Eve (1957)* | *What About Bob?* |
| *Psycho (1960)* | *Sybil (1976)* |
| *Swimming Pool (2002)* | *Frankie and Alice (2010)* |
| *Nurse Betty (2000)* | *Insomnia (2002)* |
| *Lost In Translation (2003)* | *Girl Interrupted (1999)* |
| *What’s Eating Gilbert Grape? (1993)* | *Boys Don’t Cry (1999)* |
| *Soldier’s Girl (2003)* | *We Need to Talk About Kevin (2012)* |
| *My First Mister (2001)* | *Little Miss Sunshine (2006)* |
| *Flight (2012)* | *Smashed (2012)* |
| *I’m Dancing As Fast As I Can (1982)* | *Memento (2000)* |
| *The Notebook (2004)* | *No Country For Old Men (2007)* |
| *Lakeview Terrance (2009)* | *Reign Over Me (2007)* |
| *Blue Jasmine (2013)* | *Leap Year (2010)* |
| *Kill Bill (2003; 2004)* | *What About Bob? (1991)* |
| *When A Man Loves A Woman (1994)* | *The Lost Weekend (1945)* |
| *Iris (2010)* | *Away From Her (2007)* |
| *A Clockwork of Orange (1971)* | *Silver Linings Playbook (2012)* |

\*Students may request to do additional characters, but this request must be communicated **and** approved by the professor\*

**Cultural Bias in Diagnosis - Case Conceptualization Assignment (TEVERA)**

**Description:** Students will complete a case conceptualization worksheet (see template below) to identify symptomology, diagnostic criteria and impressions, and cultural factors relevant to diagnostic decision-making. Students will choose either “Phillis” or “Lee”.

**Rubric**

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnostic Conceptualization Skills**  | **Exceeds Expectations****(Full credit)****2 pts** | **Meets Expectations****(Full-partial credit)****1-2 pts** | **Does not Meet Expectations****(Minimal credit)****0-1 pts** |
| Summary of symptoms (onset, duration, intensity, precipitants)  | Identifies all relevant biopsychosocial symptoms within case. Indicates onset, duration, intensity and precipitants of each symptom.  | Identifies most of the relevant biopsychosocial symptoms within case. Indicates onset, duration, intensity and precipitants of each symptom. | Does not identify relevant biopsychosocial symptoms within case. Lacks information on onset, duration, intensity and precipitants of symptoms. |
| Diagnostic Decision-Making (initial diagnosis/es, differential diagnoses)  | Identifies relevant diagnostic criteria, as evidenced by symptomology. Dictates initial diagnosis correctly, with applicable specifiers and Z codes. Considers multiple relevant differential diagnoses.  | Identifies relevant diagnostic criteria, as evidenced by symptomology. Dictates initial diagnosis correctly, with applicable specifiers and Z codes. Considers at least one relevant differential.  | Does not identify relevant diagnostic criteria. Dictates initial diagnosis, but lacks applicable specifiers and Z codes, or lacks differential diagnoses.  |
| Client’s cultural background considerations (client’s culture, alternative/culturally-situated explanations for symptoms) | Describes known and relevant cultural identities/experiences of the client. Indicates multiple possible alternative, culturally-situated explanations for symptoms.  | Describes some relevant cultural identities/experiences of the client. Indicates at least one possible alternative, culturally-situated explanation for symptoms. | Does not describe relevant cultural identities/ experiences of the client. Does not indicate a possible alternative, culturally-situated explanation for symptoms. |
| Student cultural considerations (cultural bias, relevant contextual factors impacting diagnostic criteria)  | Describes multiple cultural identities/experiences that influence personal view of the symptom(s)/issue at hand. Indicates multiple contextual factors that impact diagnostic criteria. | Describes some cultural identities/experiences that influence personal view of the symptom(s)/issue at hand. Indicates some contextual factors that impact diagnostic criteria. | Does not Describe cultural identities/experiences that influence personal view of the symptom(s)/issue at hand. Does not indicate contextual factors that impact diagnostic criteria. |
| Rationale for Diagnosis  | Integration of all supporting information to provide a detailed and strong rationale for the Initial Diagnosis and Differential Diagnoses.  | Integration of all supporting information to provide a rationale for the Initial Diagnosis and Differential Diagnoses. | Does not integrate supporting information to provide a rationale for the Initial Diagnosis and Differential Diagnoses. |
| **Overall Score**: /10**Feedback**:  |

**Case Conceptualization Worksheet**

**Student Name:**

**Case Number:**

|  |  |
| --- | --- |
| **Prompt** | **Response** |
| Identify symptoms  |  |
| Rank symptom severity (1- severe, 2-moderate, 3-mild) |  |
| Duration and onset of symptoms |  |
| Precipitant(s) of symptoms |  |
| Initial Diagnosis/ Diagnostic Impression (include specifiers and Z codes as needed) |  |
| Differential Diagnosis/es (including differential Z codes as appropriate)  |  |
| Discuss how the client’s cultural background may influence the manifestation of symptoms |  |
| Discuss how cultural bias may influence your diagnostic decision-making |  |
| Discuss relevant historical, political, religious, and/or cultural issues that need to be considered before applying this diagnosis and developing a treatment plan |  |
| Discuss any alternative explanations for the client’s symptoms/behavior given contextual factors noted above |  |
| Summarize your rationale for diagnosis* Include narrative description of diagnostic decision-making
* Indicate how/why you ruled out the differential diagnosis/es
 |  |

**Case Descriptions**

**Phyllis**

Phyllis is a 15 year-old African American female in the 9th grade. She has been court ordered to attend counseling due to an assault charge that occurred in her neighborhood. Apparently, she was angry at one of her friends when they came back from the store with the wrong type of soda. She punched her in the face and chased her home with a stick. Phyllis lives with her 44 year-old mother and is described as a spirited, tough-acting, confident young lady who does not like to be told what to do. Both her teachers and her mother describe Phyllis as having a “bad attitude”. Phyllis is most angry with her mother; she blames her mother for their current state of affairs.

When Phyllis was 7 years old, her father left her and her mother for another woman. Since that time, her behaviors became increasingly worse. She began to have attitude problems in school, including talking back to the teachers and refusing to do her schoolwork. The teachers report that Phyllis does a great job on her work and is a very bright kid, but she does not seem motivated to do anything related to school. She had to be removed from the gifted and talented reading program in the 2nd grade because of her disruptive behaviors. Phyllis reports that she has not seen her father since she was 7 and that she does not care (“… as far as I am concerned, he and his little whore can go straight to hell…”).

Though she had significant behavioral problems at school, she seemed to have minimal problems in her neighborhood. Her mother stated that Phyllis had a small group of friends that she spent time with in the neighborhood after her father left and that she rarely had any problems in the community. Also, her grandmother came to live with them during the summer before her 3rd grade year. This seemed to help Phyllis greatly; she started to display better behavior in school and to improve her grades and her attitude.

During the summer before her 6th grade year, Phyllis’ mother stated that two significant events happened that she believes changed her daughter’s life. First, her grandmother passed away suddenly. This was devastating for Phyllis because she was extremely close to her grandmother (“her grandmother was the only one who could keep her under control”). Phyllis went to see a grief counselor but refused to talk to her. After about 4 or 5 sessions of this type of behavior, the counselor suggested that they take some time off until Phyllis was ready to deal with her grandmother’s death.

The second significant event occurred towards the end of the summer. One day when she was walking home from Vacation Bible School at her church, three girls jumped her and beat her up really bad. She had to be hospitalized with cracked ribs and a severely sprained arm. Apparently, one of the girls thought that Phyllis had been messing around with her boyfriend and was angry about it. Phyllis was able to identify her attackers and they were punished for their crime. However, the attackers vowed to beat her up again “because she talks too much and she thinks she’s pretty”. Her mother stated that she believed the most effective thing to do was to move to another neighborhood so that they could have a fresh start. Phyllis admits that she was not always tough. She stated that she used to be the type of kid who would ignore people when they hit her because she learned from her mother and grandmother that turning the other cheek was the best way to handle conflict. Phyllis stated that ever since three girls jumped her in 6th grade and beat her badly she stopped avoiding fights.

Since those incidents, Phyllis has had numerous problems at home and at school. She is constantly fighting in school and in her neighborhood; her mother reports that her behavior is totally out of control. Over the past year, she has initiated physical fights (“especially if someone is looking at me the wrong way”) and is known as a bully in the neighborhood. She set fire to her neighbor’s yard after the neighbor threatened to call the police because Phyllis chased her daughter home by threatening her with a knife. She often stays out past curfew and her mother has appeared in court due to frequent absences from school. Due to her infrequent attendance, she is in danger of failing the 9th grade. After being charged with assault and being adjudicated as delinquent, Phyllis was placed in a temporary foster home. The client’s foster family lives in a nearby neighborhood and reports that Phyllis was “in and out” of the placement, often times coming in after curfew and refusing to do assigned chores. The assessment counselor reports that Phyllis expressed some desire to at least examine her issues but did not make a commitment to change during her initial assessment.

**Lee**

Lee Evans was a 25-year-old single, unemployed multiracial (White and Asian-American) man who had been seeing a psychiatrist for several years for management of psychosis, depression, anxiety, and abuse of marijuana and alcohol.

After an apparently normal childhood, Mr. Evans began to show dysphoric mood, anhedonia, low energy, and social isolation by age 15. At about the same time, Mr. Evans began to drink alcohol and smoke marijuana every day. In addition, he developed recurrent panic attacks, marked by a sudden onset of palpitations, diaphoresis, and thoughts that he was going to die. When he was at his most depressed and panicky, he twice received a combination of sertraline 100 mg/day and psychotherapy. In both cases, his most intense depressive symptoms lifted within a few weeks, and he discontinued the sertraline after a few months. Between episodes of severe depression, he was generally seen as sad, irritable, and unmotivated. His school performance declined around tenth grade and remained marginal through the rest of high school. He did not attend college as his parents had expected him to, but instead lived at home and did odd jobs in the neighborhood.

Around age 20, Mr. Evans developed a psychotic episode in which he had the conviction that he had murdered people when he was 6 years old. Although he could not remember who these people were or the circumstances, he was absolutely convinced that this had happened, something that was confirmed by continuous voices accusing him of being a murderer. He also became convinced that other people would punish him for what had happened, and thus he feared for his life. Over the ensuing few weeks, he became guilt-ridden and preoccupied with the idea that he should kill himself by slashing his wrists, which culminated in his being psychiatrically hospitalized. Although his affect on admission was anxious, within a couple of days he also became very depressed, with prominent anhedonia, poor sleep, and decreased appetite and concentration. With the combined use of antipsychotic and antidepressant medications, both the depression and the psychotic symptoms remitted after 4 weeks. Thus, the total duration of the psychotic episode was approximately 7 weeks, 4 of which were also characterized by major depression. He was hospitalized with the same pattern of symptoms two additional times before age 22, each of which started with several weeks of delusions and hallucinations related to his conviction that he had murdered someone when he was a child, followed by severe depression lasting an additional month. Both relapses occurred while he was apparently adherent to reasonable dosages of antipsychotic and antidepressant medications. During the 3 years prior to this evaluation, Mr. Evans had been adherent to clozapine and had been without hallucinations and delusions. He had also been adherent to his antidepressant medication and supportive psychotherapy, although his dysphoria, irritability, and amotivation never completely resolved.

Mr. Evans’s history was significant for marijuana and alcohol abuse that began at age 15. Before the onset of psychosis at age 20, he smoked several joints of marijuana almost daily and binge drank on weekends, with occasional blackouts. After the onset of the psychosis, he decreased his marijuana and alcohol use significantly, with two several-month-long periods of abstinence, yet he continued to have psychotic episodes up through age 22. He started attending Alcoholics Anonymous and Narcotics Anonymous groups, achieved sobriety from marijuana and alcohol at age 23, and had remained sober for 2 years.