Mental Health Clinical Case Study and Treatment Planning Exercise

Clinician Training Exercise

Instructions

Read the following case scenario carefully.

Complete the following:

1. Identify **at least two ICD-10 mental health diagnoses**.
2. List the ICD-10 codes.
3. Provide the rationale for each diagnosis.
4. Develop a **person-centered treatment plan** that includes:
    - Presenting Problem
    - Long-Term Goal
    - Three Short-Term Goals
    - Three Interventions for each Short-Term Goal

Client Scenario

Client Name: Maria J. (Fictional)

Age: 36

Gender: Female

Marital Status: Divorced

Children:

- Daughter, age 14
- Son, age 9

Both children live with Maria full-time.

Presenting Concerns

Maria presents after being referred by her primary care physician for worsening depression and anxiety. She reports feeling "overwhelmed all the time."

She has experienced symptoms for nearly two years, which worsened after her divorce and the death of her mother eight months ago.

She reports:

- Persistent sadness
- Frequent crying spells
- Loss of interest in previously enjoyable activities
- Fatigue
- Difficulty concentrating
- Feelings of worthlessness
- Excessive guilt
- Difficulty making decisions
- Insomnia (4–5 hours nightly)
- Poor appetite
- Increased irritability

Maria also reports:

- Constant worry about finances
- Fear something bad will happen to her children
- Muscle tension
- Restlessness
- Difficulty relaxing

She denies current suicidal intent or plan but admits that she occasionally thinks:

"My kids would probably be better off without me."

She identifies her children as her primary reason for living.

Psychosocial History

Maria works full-time as a medical receptionist.

Financial stress has increased due to being the sole provider.

Her ex-husband has inconsistent contact with the children and pays child support sporadically.

Maria reports minimal social support.

She attends church occasionally but has stopped participating in activities she once enjoyed.

Trauma History

Maria reports emotional abuse during her marriage.

No physical abuse disclosed.

No history of psychiatric hospitalization.

Substance Use

Denies alcohol misuse.

Denies illicit drug use.

No history of substance use disorder.

Medical History

Hypertension

Migraines

No significant neurological history.

Mental Status Examination

Appearance: Appropriate hygiene

Behavior: Cooperative

Mood: Depressed

Affect: Tearful

Speech: Normal

Thought Process: Logical

Thought Content:

- No delusions
- No hallucinations

Orientation:
Alert and oriented ×4

Insight: Fair

Judgment: Good

Memory: Intact

Strengths

- Strong love for children
- Motivated for treatment
- Employed
- Stable housing
- Good insight
- Spiritual beliefs
- No substance abuse
- Willing to attend therapy
- Previously responded well to counseling

Clinician Worksheet

Part 1 – Diagnoses

Primary Diagnosis

Diagnosis:

ICD-10 Code:

Rationale:

Secondary Diagnosis

Diagnosis:

ICD-10 Code:

Rationale:

Additional Diagnoses (if applicable)

Diagnosis:

ICD-10 Code:

Rationale:

Part 2 – Person-Centered Treatment Plan

Client-Identified Goal

"What matters most to me is..."

Problem

Long-Term Goal

Short-Term Goal 1

Interventions

1.
2.
3.

Short-Term Goal 2

Interventions

1.
2.
3.

Short-Term Goal 3

Interventions

1.
2.
3.

Strengths to Support Recovery

Barriers

Discharge Criteria