ASSESSMENT PACKAGE ON A FAMILY SYSTEM

Your Family Assessment Package contains the following:

1. **Family Bio-Psycho-Social-Spiritual History**

2. **The Genogram**

3. **The Ecomap**

4. **The Family Treatment/Service Plan**

5. **The Family Progress Note**

6. **Single Subject Evaluative Design**

7. **Discharge Summary**

PROCESS RECORDING

Process Recording is a tool used in field education to enhance students' abilities to communicate effectively with clients and other professionals. Through completing Process Recordings, students learn to attend to verbal and nonverbal communication while applying theoretical analysis to the interactions as they happen. The exercise is structured to enhance social work students' self-awareness by analyzing his/her responses to the client. It also assists the student in seeing the connection between the intervention and the results of that interaction, enhancing purposeful interactions. The exercise further allows the Instructor to help students identify helpful communication patterns as well as those that are unproductive.

For this exercise, students will need to have face-to-face contact with a person while conducting an interview, home visit, office visit, intake, etc.

Please use the format below to record the interview. In the first column, record students' and clients' statements (verbatim). Be sure to include any nonverbal communication (e.g., "the interviewee cried," "shifted in her seat," "crossed his arms, frowned and appeared angry," "hung her head as if ashamed,"...). In the second column, the student will identify the skills utilized during the interaction/session. The third column will note what the student was thinking/feeling throughout the session as the client talked, became emotional, resistant, etc. (e.g., "I began to feel uneasy as she began to cry…;" "he looked at me as if he hoped I had the answer to his problem and I didn't know what to say next…;" etc.). In the fourth column, write an analysis of the interview and its process. (E.g. "It sounds as though he and his father have not developed a way of relating to one another now that they are both adults. She said she was happy, but her body language seemed to indicate that she was conflicted. I decided to probe this area with her further.). The fifth column should note values and standards utilized during the contact. Failure to note the standard and number of the standard will result in zero points. The sixth column will include social work knowledge as specified: the specific theory (i.e., Family Systems); biological, psychological, social, spiritual, and cultural components. The seventh column must include the plan for that client from that contact moving forward. Leave the last column blank for the Instructor's comments and feedback to the student.

Analysis: Address what student observed throughout the session---behavior and affect. Whether or not affect/behavior was appropriate, and explain. Identify major themes/issues that emerged during the session. Progress or break through if any.

Plan for next session: Brief statement of plans for next session, long range goals, short-range goals, relevant to client. Plans should focus on what was discussed or addressed in this session

BSW PROCESS RECORDING OUTLINE

Student's Name	
Client System	
Date	
Policy	
Presenting Issues	
Purpose of Contact	
Preparation for Contact	

VERBATIM RECORD OF INTERVIEW	Social Work Skills Used	Self-Reflection	Analysis	Social Work Values	Social Work Knowledge	Plan	Field Instructor's Comments
Describe at least one interaction with a client from past week: *Content of contact* • *Verbatim Recording* • *Outcome*		**Your feelings**	**Reasoning during interaction**		**THEORY:** **Biological:** **Psychological:** **Social:** **Spiritual:** **Cultural/Ethnic:**		

INTERVIEWING AND RECORDING COMMUNICATION RESP0NSES
(RATE EACH RESPONSE EITHER POSITIVELY "+" OR NEGATIVELY "-"
1 the lowest & 10 the highest

STUDENT'S NAME:_____

TYPES OF RESPONSES	**-1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**+10**
	Lack Competence			**Emerging Competence**		**Competent**		**Advanced Competence**		
EYE CONTACT										
Culturally appropriate eye contact										
FACE										
Congruent Facial features										
Appropriate nodding of head (Attending)										
BODY										
Body Squarely Faces Client										
Body leans slightly forward										
Body is relaxed										
Appropriate body language (open posture)										
No distracting body movements										
RELATIONSHIP BUILDING										
Rapport (Initial--Confidentiality)										
Empathic responses										
Authentic responses										
Comfort with all emotions										
LISTENING RESPONSES										
Clarification										
Paraphrase (Content)										
Reflection (Affect)										
Summarization										
ACTION RESPONSES										
Probe										
Ability potential										
Confrontation										
Interpretation										
SHARING RESPONSES										
Self-Disclosure										
Immediacy										
TEACHING RESPONSES										
Operation Setting										
Information Giving										
Instruction										

COMMENTS:

FAMILY ASSESSMENT PACKAGE

BSW Students will create a Family Assessment Package consisting of the following multi-problem, complex family case in the following scenarios. **After designing a family case scenario for each of the following, conduct research into the best practice method of intervention**. The student will assess the case utilizing the Person-in-the-Environment [PIE] model of practice. Ensure that you document:

The Family Assessment Package **must be typed** and double-spaced with appropriate references (APA format). The completed manual must be **submitted in a folder/binder** to the Instructor on or prior to the date stated in the syllabus.

Choose:

- Lesbian female who is single and is head of household with two sons
- Unemployed African American male with wife and three daughters
- Homosexual son of a Baptist Minister living in rural Georgia
- Elderly female who has custody of her two adolescent granddaughters
- Native American female with a physically challenged son
- African American female with a mentally challenged daughter
- Asian American female engaged to an African American Male
- Homeless Person with AIDS whose parents, sisters and brothers live in town

FAMILY BIO-PSYCHO-SOCIAL FORMAT

Client Name	
Family Member Names	
Case Number	
Date	
Social Worker	

I. PRESENTING PROBLEM

State the names, ages, race, and status (e.g., husband/partner, child, etc.) of each person in the family system. Identify any individuals outside of the family system that are involved in the problem and/or the proposed solutions. State how this family came to your agency (.e.g., self-referral, courts, etc.). What led the family to seek assistance for these problems at this time? What problems are presented by this family? Who says they are problems? Which members say they are not? Note all past attempts to remedy the problems by the family. Identify what each family member desires as a resolution to the problems. How do other family members view the proposed solutions to the problem? Are other agencies or organizations involved with this family? If so, in what way? What are presenting strengths identified in this family system?

II. HISTORY OF THE PRESENTING PROBLEM

Describe the factors leading up to the family's admission to the agency *in chronological order*. Note any family strengths, coping skills, support systems, and environmental stressors.

III. GENERAL HEALTH HISTORY

State any physical health problems within the family system. Note any prescription and nonprescription medications currently being taken by any family member. Include any psychiatric treatments (e.g., inpatient, outpatient, residential, etc.) that family members have had, including diagnoses given and treatment methods used. Indicate any addictive disorders (e.g., alcohol, drugs, eating disorders, etc.) experienced by family members. Note any alternatives to traditional medical treatment the family ascribes to, particularly those sanctioned by their cultural groups.

IV. THE FAMILY SYSTEM IN CONTEXT

What cultural implications are evident in this family? What impact does race play in the functioning of the family? How does gender affect the status and roles of family members? If this family is bicultural, incorporate a "Family Culturegram" into this assessment. Analyze the impact of economic class on the family throughout several generations. What impact has class had on family development? How does this family's reality (e.g., culture, biculturalism, ethnic status, language, social class, customs, history, religious/spiritual practices, sexual orientation, etc.) compare to that of the dominant society? Are the basic needs of this family being consistently met (e.g., food, clothing, health care, housing, financial and material resources, education, job training, safety, etc.)?

V. OUTER BOUNDARIES OF THE FAMILY SYSTEM

[Address the following issues in the context of the family's cultural background.]
Determine the degree to which family members are open to transactions with other individuals, families, groups, or institutions. To what degree are:

1. Outsiders permitted or invited to enter the family system?
2. Members of the family allowed to invest emotionally and engage in relationships outside of the family system?
3. Information and materials exchanged with the social environment?

Does this family system show evidence of being a *closed/enmeshed* system:

1. Strict regulations that limit transactions with the external social environment and restrict incoming and outgoing of people, objects, information, and ideas. Some instances might include:
    a. Doors carefully locked at all times, including inside doors (beyond what would be considered prudent for safety reasons)
    b. Rigid parental control over input from external sources (e.g., the media, books, magazines, etc.)
    c. Excursions that are closely supervised
    d. Close scrutiny of strangers
    e. Trespass prohibitions
    f. High fences
    g. Unlisted telephone numbers
    h. Few guests outside of the family system allowed in the home
    i. Family members either not allowed, or pressured not to seek, outside friendships

Does this family system show evidence of being an *open* system:

1. The movement of individual family members are regulated by the process of group consensus
2. Members are flexible about extending the territory of the family into the larger community
3. External cultures are brought into the family space and celebrated
4. Individuals are allowed to regulate their own coming and going, provided it does not adversely affect other family members or violate family norms
5. Numerous guests appear in the home over time
6. Family members visit with friends, both individually and together as a family system
7. Family members participate in community affairs
8. A free exchange of information is permitted, with minimal and appropriate censorship

Does this family system show evidence of being a *disengaged* system:

1. Family members are highly individualistic
2. Each member determines her/his own patterns in establishing and defending their lifestyle and territory
3. Family life appears chaotic, having little leadership
4. Members make impulsive decisions
5. There is little role clarity
6. Rules are frequently changed
7. There is little discipline within or among family members
8. Members feel emotionally separated from one another
9. There is little interaction among family members
10. Children are not monitored and are at liberty to behave with little fear of reprisal

VI. INTERNAL BOUNDARIES AND SUBSYSTEMS

[*Answer the following issues in the context of the family's cultural background.]*

Determine the various subsystems that exist in this family system (e.g., husband/wife, mother/daughter, father/son, brother/sister, grandmother/granddaughter, uncle/nephew, mother-in-law/son, etc.).

Assess whether each of these subsystems are temporary or more enduring in nature.

Are the generational boundaries clearly-defined and appropriate (e.g., children are not allowed to assume parental roles beyond their developmental levels, etc.)?

Are family members consistently expected to sacrifice personal autonomy, exploration, and independent action (enmeshment)?

Are family members consistently so individualized that there is little feeling of family solidarity, loyalty, or sense of belonging (disengagement)?

VII. FAMILY SYSTEM POWER STRUCTURE

[*Answer the following items in the context of the family's cultural background.]*

"Power" is the capacity of one member to bring about change in the behavior of another family member. With this definition in mind, analyze the multiple power structures within this family system. Who:

1. Provides economic support for the family?
2. Provides social status for the family?
3. Provides, love, affection, and approval to family members?
4. Provides valued resources to family members?
5. Makes decisions regarding:
    a. Where the family members will live?
    b. What job the husband/partner takes?
    c. How many hours the husband/partner will work?
    d. Whether the wife/partner will work outside of the home?
    e. What job the wife/partner takes?
    f. How many hours the wife/partner will work?
    g. How much time to spend as a couple apart from the children?
    h. The number of children the family has/plans to have?
    i. When to praise or punish the children
    j. How much time to spend with the children?
    k. When to have social contacts with the in-law's, extended family members, etc.?
    l. When to have sexual relations?
    m. How to express oneself sexually?
    n. How to spend money?
    o. How and when to pursue personal interests?
    p. Who to pursue personal interests with?
    q. Whether or not to attend formal religious services outside of the family system?

r. Which religious services to attend?

Are all family members satisfied with the distribution of power within the family system? To what extent do family members want the power redistributed? Which family members do and do not want this power redistribution? Doe the family members currently holding the power appear to be willing to renegotiate it? Have there been any recent shifts in the family's power balance (e.g., An increase in a partner's level of academic achievement? Income? Formation of a new stepfamily? Child custody issues? Implications of immigration among the status of family members? Job loss? Physical debilitation? Bankruptcy? Foreclosure?, etc.). Are there *covert* sources of power in the family (e.g., the wife/partner is dismissed or evenly openly disrespected but actually holds the primary role in making family decisions; the expression of one family member as "sick" or "deviant"?, etc.).

In observing the communication within this family system:

1. Who openly shares his/her view and who comments on it?
2. Who speaks for whom?
3. Who speaks first?
4. Who speaks at the same time as someone else?
5. Who interrupts whom?
6. Who agrees with whom?
7. Who disagrees with whom?
8. Who does most of the talking?
9. Who decides who decides?
10. Whose ideas are usually adopted when the family system engages in decision-making?
11. Who seems to hold the ultimate authority for making decisions, regardless of who originated the ideas the family system is considering?

In determining the functionality of the power dynamics:

1. Is the family power structure stable, allowing it to carry out its maintenance functions in an orderly manner? Does the power base shift as members compete for power?
2. Does the power base reside with the Executive Subsystem (e.g., husband/wife) or within covert coalitions (e.g., mother/daughter, father/father-in-law, etc.)?
3. Are members of the family content with the distribution of power? If not, how do they express their dissatisfaction (e.g., overtly, covertly)?

VIII. AFFECT WITHIN THE FAMILY SYSTEM

[*Answer the following questions in the context of the family's cultural background.]*

What emotions are acceptable in the family and which ones are not (e.g., anger, sadness, fear, shame, hurt, relief, happiness, etc.)? Are certain emotions allowed by only certain family members (e.g., females in the family are allowed to express sadness and fear but not anger; males are allowed to show anger and happiness but not sadness or fear; the oldest child is encouraged to express fear, while the youngest is allowed to express anger, etc.)? To what extent are love, care, and affection expressed verbally to family members? By whom? To whom? To what extent are love, care, and affection expressed non-verbally to family members? By whom? To whom? To what extent are

loving and caring behaviors perceived and/or appreciated by family members? To what extent are individual family members satisfied or dissatisfied with the level of loving and caring messages received from members within the family system? To what extent do individual family members feel they would like to increase loving and caring messages to others or be the recipient of such messages? How flexible are individual members and the family system, as a whole, in making adjustments in this area? What are the tolerable limits for each family member? Is there evidence of a mood disorder that might be affecting the ability of family members to express emotions presently?

IX. GOALS WITHIN THE FAMILY SYSTEM

[*Answer the following questions in the context of the family's cultural background.]*

What are the expressed family goals (e.g., "We want to see all of our children graduate from college," "We want to retire by age 55," "Our home and yard are always the showcase of the community," etc.). What are the covert goals (e.g., "We want to appear to others like the perfect family," "We want to move up the social ladder in the community," etc.).

To what extent do clear goals guide the organization of the family system? To what extent are members aware of the overriding goals of the family? To what extent is there shared consensus among family members regarding major goals and the priorities assigned to these goals? To what extent is family conflict caused by the lack of consensus regarding primary goals of individual family members? How functional are commonly-held goals in meeting the needs of individual members and promoting wellbeing of the group as a whole? To what extent are the manifest troublesome interactional patterns related to the covert goals held by family member?

X. MYTHS WITHIN THE FAMILY SYSTEM

[Answer the following questions in the context of the family's cultural background.]

What are the shared cognitive perceptions that family members have about each other, the family system, and the world (e.g., "We are just victims of fate and there is nothing we can do about it," "The world is against us and we are powerless to change it," "People are born bad and my son is just bad – there's no changing that," "Only weak people show their emotions," "Don't talk about problems and they'll eventually work themselves out," etc.)?

Are there any family members that have been labeled as "different" or "deviant" (e.g., "S/he is just sick/bad/crazy/lazy/black sheep/dumb/clown/geek," etc.)? Do these labels cause family members to relate to the "different" family member on the basis of a single characteristic, overlooking the wider range of attributes, strengths, or feelings the family member possesses?

XI. ROLES WITHIN THE FAMILY SYSTEM

[Answer the following questions in the context of the family's cultural background.]

A. To what extent are role assignments made on the basis of gender rather than on factors such as abilities, interests, and the time available to the individual family member to perform the role?
B. How clearly-defined are roles in the family system? Are any of the children showing evidence of parentification?

C. Has role strain occurred due to a shift in the ordinal positions of the children into a new stepfamily/adopted family/foster family, creating a sense of loss for some family members?
D. How satisfied are the marital couple/partners with their prescribed role within the family system? To what extent is each member willing to consider adjustments when role dissatisfaction is a key factor in family problems?
E. How flexible is the entire family system in readjusting roles in response to everyday pressures and changing circumstances?
F. How adequately do spouses/partners perform their designated roles as spouses/partners and/or as parents?
G. To what extent do one or both partners receive messages from significant individuals outside of the nuclear family (e.g., parents, relatives, friends, etc.) regarding what their role definitions "ought" to be? What impact does this input have on the family system?
H. To what extent are pressures and stresses caused in the family system by role overload?

XII. COMMUNICATION STYLES WITHIN THE FAMILY SYSTEM

A. Are the verbal messages given to family members congruent?
B. Are the verbal messages congruent with nonverbal messages?
C. Are the verbal and nonverbal messages congruent with the context in which they are stated?
D. Is communication mystified or masked within the family system?
E. Are there patterns of communication that prevent the building of intimate relationships, such as:
    1. Shifting the subject
    2. Avoiding certain topics
    3. Asking excessive questions
    4. Sympathizing, excusing, or giving false reassurances
    5. Mind-reading, diagnosing, interpreting
    6. Dwelling on negative historical events in the relationship
    7. Under-responding to one another
    8. Failing to express one's opinion
    9. Verbally dominating interactions
    10. Speaking in a dichotomous manner (e.g., black/white, good/bad, right/wrong, etc.)
    11. Agreeing or disagreeing excessively
    12. Giving advice frequently
    13. Negatively evaluating, blaming, name-calling, or criticizing
    14. Directing, ordering, threatening, admonishing
    15. Using sarcasm, excessive kidding, or teasing

Do communication patterns consistently appear to enhance/validate or diminish/invalidate the self-esteem of individual family members? If so, whom and how?

XIII. FAMILY STRENGTHS

Identify strengths within the family system (e.g., willingness to talk about problems, willing to accept help from people outside of the family, commitment to talking through painful issues, expressing caring feelings for family members, attempts to observe and discover how the family

functions, willingness to make adjustments or changes that will benefit the family, ability to transcend the effects of racism, classism, sexism, homophobia, etc.

XIV. FAMILY LIFE CYCLE OF THE FAMILY SYSTEM

Assess the developmental stages in the family life cycle that this family system is currently addressing. Discuss the successes and present roadblocks to completing those tasks. Analyze how changes over the family's life span impacts each person in the family system and how each person is coping with the feelings associated with those developmental changes.

XV. SYNTHESIS

Construct the critical events that have occurred in this family's life cycle. Complete a multigenerational genogram, if further inter-generational data seems indicated. Place the family system in the context of its environment and discuss how issues of race, class, gender, sexual orientation, physical limitations, etc., have impacted the family's development. Look to see where problems have historically congregated for the family system. Does it seem to occur at transitional points in the family's life cycle? Does the family perceive itself to be empowered to change their lives for the better? Interpret the data and draw conclusions based upon the facts you have gathered and your professional interpretation of those facts.

XVI. RECOMMENDATIONS AND INTITIAL TREATMENT PLAN

List the recommendations you and the family have come to at the end of this assessment process. State the initial treatment plan and any referrals you and the family have decided upon.

_____ _____

Signature of the MSW and any credentials **Date**

AN EXAMPLE OF A COMPLETE FAMILY HISTORY AND ASSESSMENT

Client Name	**Peter Wood**
Case Number	**13-4217**
Date	**January 15, 2019**
Social Worker	**Barbara J. Nowak, LCSW, ACSW, CADC-III**

VIII. Presenting Problem

Peter Wood, a white 50-year-old married father of four, came to the Albany Treatment Center as a voluntary patient on October 1, 2018 to address his dependence on opioids and is the Identified Patient. He married his wife, Denise, a Puerto Rican 48 year old nurse practitioner at the local hospital, in 1991. The couple has four children: Amy, age 21; Jack, age 20; Christine, age 16, and David, age 14. The Wood family owns a one-story four-bedroom ranch home in a rural part of Lee County. Amy currently attends Georgia State University and lives off-campus with friends. Jack rents an efficiency apartment in Valdosta when he is in town.

Mr. Wood reports that he is anxious for his family to be involved in his treatment and recovery because he now sees how his addiction to opioids has negatively affected them. Mr. Wood initially came into treatment when his wife filed divorce papers and moved her and her children in with her parents in Leesburg. Mrs. Wood states that she is willing to be a part of her estranged husband's treatment but is unsure if it will change her mind about going through with divorce proceedings. His eldest daughter, Amy, has not spoken to her father since she left home to attend college two years ago because of his behavior when using opioids. Jack is an over-the-road truck driver and refuses to be involved in his father's treatment, telling his mother he does not believe his father has a "drug problem." Christina and David are willing to be involved in family therapy in order to help their father recover from opioid addiction.

IX. History of Presenting Problem

Mr. Wood states that he has been a self-employed over-the-road truck driver since 1993 and has financially provided well for his family. In 2015, his truck was hit by a drunk driver, causing him to veer off the interstate and crash into a concrete wall, breaking his back in two places and deflating one of his lungs. He was in a coma and placed in intensive care for seven weeks and then hospitalized for a total of three months. While in the hospital, he was prescribed a high dose of the opioid pain reliever Oxytocin by his surgeon to control his intense pain. Upon his discharge from the hospital, he continued with rehabilitation therapy and a prescription for Oxytocin for pain

management. As a result of the accident, Mr. Wood is paralyzed from the waist down and can no longer work as a truck driver.

In 2016, Mr. Wood reports that he fell into a deep depression and was prescribed the antidepressant, Wellbutrin, by his family physician. Mr. Wood acknowledges, and his wife verifies, that he began to have rapid shifts in his mood, "becoming tearful one minute and then angry and hostile the next," according to Mrs. Wood. Mr. Wood states that his pain level increased, despite the use of the medication, and he asked his surgeon for more Oxytocin. He states that he would ingest a months' supply of the Oxytocin within eight to ten days with little relief of his pain. Upon a review of his highly elevated liver profile, the surgeon stated that he was unable to provide Mr. Wood with a higher dose of Oxytocin and, in fact, changed his medication to Buprenorphine in an attempt to wean him off Oxytocin.

Mr. Wood reported that the Buprenorphine did not control his pain at all. It is then that he asked a former truck driver that he knew to supply him with a small amount of heroin to help him deal with the pain. The truck driver supplied Mr. Wood with ever-increasing amounts of heroin until he was arrested on drug trafficking charges in Ohio. Mr. Wood then stated he would tell his wife that he had a doctor's appointment so that she would drop him off and he would drive his electric wheelchair to Walmart where he would meet a man that sold him heroin. As his addiction increased, he would quickly spend his S.S.I. check and then began to sell items out of his family home to the local pawn shop, including his wife's heirloom jewelry, his children's game systems, the car they bought for his children, their flat screen televisions, and anything else of value. In September, Mrs. Wood took her children and left, filing for divorce.

X. General Health History

Until his accident, Mr. Wood states that he enjoyed good health. Since the accident, however, he has had multiple health issues, including pain throughout his back and shoulders, breathing difficulties, severe headaches, constant nausea, and insomnia. Despite being prescribed antidepressants by his family physician, he reports that his depression has deepened, especially after his wife and children left the family home. He acknowledges he thinks about suicide as a way to stop hurting his family and ending his own emotional and physical pain.

Mrs. Wood states that she does not drink alcohol or use licit or illicit drugs. She states that she has tried to support her husband since his accident "but I can't allow my children to suffer while they watch their father destroy himself." Mrs. Wood states that she does suffer from insomnia and has become more anxious over the past year as she

struggles to maintain her duties at the hospital, care for her children and their home, and hide her husband's addiction from family and friends. She states her biggest fear is that her husband will get arrested for buying drugs on the street, bringing shame to her children and herself.

Mrs. Wood states that her children are healthy, except for Christina, who suffers from chronic asthma. She reports that her youngest son, David, was diagnosed two years ago with Attention Deficit Disorder with Hyperactivity and is on a low dose of Adderall to help him concentrate in school.

XI. The Family System in Context

Until the truck accident, Mr. Wood describes his family as "the typical middle class American family." The accident, however, has thrust the family into financial peril. Three years after his accident, Mr. Wood has not received a financial settlement from the insurance company of the drunken driver who hit him. Currently, his only source of income is a small monthly check under SSI. His father died in 2001 and his mother died in 2003 so, as an only child, he reports he has no family support system.

With a master's degree in nursing, Mrs. Wood is employed at the hospital as a nurse practitioner and has always earned slightly more money than her husband. Because of their combined incomes, they were able to provide a comfortable life for themselves and their children. With her husband now unable to work and with mounting medical bills, the family's lifestyle has drastically changed. Mrs. Wood tearfully states that she believes the reason her two eldest children left home, beyond the stress caused by her husband's addiction, was to relieve the family of the financial burden of caring for them. She is grateful to her parents for their emotional and, recently, their financial support of her and her children.

Mrs. Wood and her children have now moved out the home and has temporarily moved in with her parents. Her parents moved from Puerto Rico to New York in 1972 but disliked the cold weather, the crime and the urban setting there. Her father worked as a skilled tradesman and her mother was employed as an elementary school teacher there. In 1981, the family moved to Leesburg when her father opened up a construction company. The business was so successful that her mother no longer had to work outside of the home, allowing her to volunteer at her children's school.

Mrs. Wood reports that she is very close to her parents and to her older brother and two older sisters. She acknowledges that her entire family has had to deal with discrimination from some people in the community who often assumed they are all

illegal immigrants or migrant farmworkers. There are patients in the hospital who ask for a different nurse because she is Puerto Rican. She states her children have been called racially derogatory names in school. While her she and her children are bilingual, English is their first language (although the second language for her parents). However, when she goes to parent-teacher conferences, her children's teachers will still sometimes condescendingly ask, "Do you speak English?"

While Mr. Wood "isn't into religion," Mrs. Wood states that her church, St. Teresa's Catholic Church in Albany, is a source of strength for her and her two youngest children. They attend the 12:30pm Spanish Mass each Sunday and are volunteer in the soup kitchen and thrift shop. She reports that she and her two youngest children pray each night together for strength and guidance from God in this stressful time.

XII. Outer Boundaries of the Family System

Prior to the accident, the family reports that their house was the center of activity for the neighborhood. They often had neighbors over for barbecues and family parties. The children enjoyed having their friends over to watch television, play video games, or just "hang out." Mrs. Wood had women from the church over to her house on Thursday evenings for a time of study and prayer, followed by coffee and potluck. The children enjoyed having their grandparents, uncles and aunts over during the holidays that are remembered as festive times.

After the accident, however, all of that changed, Mrs. Wood reports. As Mr. Wood became more and more addicted to the pain medicine, he became irritable, irrational and often incoherent. The family made up excuses to their friends and family members about why they weren't inviting them to the house anymore. The family became more and more isolated from others as time went on. Even among themselves, they didn't discuss the painful reality unfolding before their eyes. The oldest children began to pull away emotionally from the family, with Amy leaving for college in Atlanta and Jack moving out on his own.

XIII. Internal Boundaries and Subsystems

Prior to the accident, Mr. Wood states that he and his wife had a very close, loving relationship. He reports that they were attentive to one another's needs and had excellent communication with one another. When they did disagree, they would talk the situation through and generally come to a compromise that satisfied them both. Both Mr. and Mrs. Wood reports that they were a united parental unit, as well. They

did not argue or disagree in front of their children. When there was a problem with one of the children, they talked together in private about how to address and resolve it.

As Mr. Wood progressed further into his addiction, however, Mrs. Wood states that she came to rely on her older children more and more. Jack became responsible for handling the daily upkeep of the yard and house while Amy was placed in charge of watching her younger siblings – and her father – while Mrs. Wood was at work. She knows Jack resented having to take on the responsibilities because he became sullen at times and even started having trouble in school (e.g., coming to school late, skipping school altogether, a few fights with other students). He just barely made it through high school, took classes at Albany Technical College to become an over-the-road truck driver, and left home as soon as he could afford to. Not wanting to repeat the scene with her youngest two children, Mrs. Wood decided to leave her husband and move in with her parents. She is concerned that her youngest children, Christine and David, are not the outgoing, energetic teenagers they used to be. Christine stays in her room most of the time listening to music. David spends his free time playing his video games.

XIV. Family System Power Structure

Before the accident, both Mr. and Mrs. Wood worked outside of the home to support their family. They equally divided the work around the house, with Mrs. Wood taking on the responsibilities of managing the inside of the home and Mr. Wood addressing repairs and outside work that needed to be done. When it came to making decisions, the parents would talk together to decide which was the best route to take. When they did disagree, they usually were able to compromise and negotiate a solution that was acceptable to them both. Mr. Wood admits with a smile that sometimes he would "give in" to his wife, acknowledging that she was "usually right".

Since the accident, however, all that has changed. Mrs. Wood states that she is now forced to make decisions regarding the family on her own, along with the input of her parents or children. She states that her husband is now incapable most of the time of making rational decisions and really doesn't even seem interested in doing so, anyway. As the family bankruptcy due to the loss of her husband's income and the enormous medical bills incurred, Mrs. Wood is working with an attorney to, at least, try to save the family home.

XV. Affect Within the Family System

The stress of dealing with the addiction of Mr. Wood, the crumbling of the family unit, the financial burdens and day-to-day life has taken its toll on all of the family members.

What was once an active, outgoing and basically happy family has now become an isolated and fearful system. Mrs. Wood acknowledges that the family members really don't interact much with each other anymore and just focus on doing the things that will get them through each day. The parents see Amy as an angry young woman who wants nothing to do with the family. Jack is sullen and Mrs. Wood states she is afraid that he is "going down the wrong path." She is concerned that he, too, might be drinking or even taking some kind of medication to help him stay awake on the road and then help him sleep when he gets home. Christine has always been a little shy, but she has become even more withdrawn and quiet since the accident. David used to be the child that brought so much joy and laughter into the home. Now, Mrs. Wood reports, he has become anxious and his teachers even report that he might have attention deficit disorder with hyperactivity. Mrs. Wood says that, when she is alone and has time to think, she cries about what she and her children have lost and feels fear about what the future holds for them all.

XVI. Goals Within the Family System

Mr. Wood states that, if he had been asked four years ago what the goals of the family were, he would have said (1.) pay off the mortgage so the family would have some financial freedom, (2.) get all the children through college, and (3.) have enough money saved up to have a comfortable retirement where he and his wife could travel and do all of the things they wanted to do. Now, all he wants to do is get off heroin and see if he can save his marriage and family.

Mrs. Wood states that she sees the goals of the family is to get through this crisis the best they can. She hopes that her husband is able to get free of his drug addiction but is unsure that alone will save the marriage. She states that there is "just too much pain" for her to consider ever going back to him. She wants to finish raising her children and help them become self-sufficient. After that, she doesn't know what the future holds for her and prefers not to even think about it.

XVII. Myths Within the Family System

Mr. Wood states that he spends a lot of time thinking about why this accident happened to him. He says he has always been a good man who has always been willing to "give the shirt off my back" to someone in need. He says he believes that God is punishing him for something but he is not sure what. His feelings of shame and guilt have made him feel like the situation is hopeless and there is no way out. He tries to be a strong man and not show weakness in front of his wife and children, but most days he finds

himself crying and feeling like his family would be better off without him "messing up their lives."

Mrs. Wood believes that everything happens for a reason and that God must have a plan for her and her children in this situation. She sees the accident as being "fate" and there is nothing that they can do but pray and try to act in a way that would be pleasing to God.

The family members follow the rules of "Don't talk. Don't trust. Don't feel." Members are hesitant to discuss the depth of the problems within the family, either in sessions or (by report) with each other. Family members have a difficult time identifying their feelings and giving appropriate expression to them.

XVIII. Roles Within the Family System

The Wood family describes themselves as a "typical American family" prior to the accident. However, the family adopted a non-traditional family structure that worked well for them. While Mrs. Wood was raised to become a fulltime homemaker like her mother, she decided at a young age to obtain an excellent graduate education and become a professional nurse practitioner. Her husband has always been extremely proud of his wife's accomplishments and supported her by taking on more household responsibilities so that she would not be overwhelmed. Mrs. Wood acknowledges that her husband "changed plenty of diapers and got up in the middle of the night with a sick child just as much as I did." When his friends occasionally teased him about being a "househusband," he would say, "Yeah, I'm laughing too – all the way to the bank!" His friends had to admit that they admired how well the two of them worked at as a team.

All that has now changed. As his addiction progressed, Mr. Wood did less and less with the family and was absorbed in a world of craving the drug, seeking the drug, taking the drug, and figuring out how to get his next hit of the drug. He admits that this left very little time to devote to his physical recovery, his marriage, or to his children. All of that responsibility has now fallen on Mrs. Wood. She is grateful to have the help of her parents in raising her two children still at home. Her mother cooks dinner for them all and her father shuttles the children to school, to after-school activities and to church programs when Mrs. Wood is unable to do so. When she doesn't know what to do, Mrs. Wood confides in her parents and seeks their advice on what steps to take next. In some ways, she says, she feels like she is the child again and they are the parents of both her and her children.

XIX. Communication Styles Within the Family System

Mr. and Mrs. Wood both report that the family at one time enjoyed open and honest communication with one another. When they had a problem, they would discuss is with one another until they were able to reach some consensus. There were times, of course, that they would have to make a decision that one of their children didn't necessarily like but that was best for them. Christine reports that her parents were "strict but fair" and they knew, even when they didn't like the decision, that their parents loved them and wanted them to grow up to be "good people."

Mrs. Wood admits that there is very little communication that goes on between any of them now. Mrs. Wood reminds them to do well in school, get their homework done and complete their chores but has little energy to talk beyond that. Her children don't seem to want to talk much, either, and believes it is just too painful to open up the wounds that they are concealing from one another. Mr. Wood doesn't visit the children since they moved to his father-in-law's house and the children don't reach out to him, either, because they never know if he will be under the influence of drugs or not.

XX. Family Strengths

The Wood family is a unit dealing with the aftermath of a traumatic accident that has affected each member in different ways. Mr. Wood has faces the loss of his physical abilities, chronic pain and, now, the loss of his family due to his addiction to opioids. Yet, he is still willing to seek treatment even though his hope of creating a life worth living forth is battered. Mrs. Wood survived living with her husband's addiction and took the frightening step of leaving him to protect her children and keep her family together the best way she knew how. The children have had the sudden loss of their parental unit and the home life they knew but try to help their mother out the best way they can by doing what they are supposed to do and "staying out of her way," as David puts it. Mrs. Wood and her children hold on to their faith to get them through the day. They all rely on the support they receive from Mrs. Wood's parents as well as from their church. The family members believe in hard work, supporting one another, and doing their best in any situation. Mr. Wood comes with hope for achieving and maintaining chemical freedom and possibly restoring his family. Mrs. Wood, while apprehensive, is willing to support her estranged husband in his quest to develop a chemically free lifestyle.

XXI. Family Life Cycle of the Family System

The family has moved into the launching phase of the family life cycle but this developmental stage has been negatively impacted by the addiction of Mr. Wood. Amy had originally planned to go to Valdosta State University so she could remain close to home and visit as often as she could. Once Mr. Wood's addiction progressed, she decided to attend Georgia State University and get as far away from the family as possible. Similarly, Jack's grades plummeted following his father's accident and, as a result, he no longer wanted to go on to college and become a doctor. Instead, he took a job as an over-the-road truck driver and rarely comes home or calls the family.

At this stage in the family life cycle, attention is once again paid to the marital dyad. Mrs. Wood states that, if it had not been for the accident and her husband's subsequent addiction to opioids, she believes they would be in a good place in their relationship. They always had a loving, supportive marriage, she states, and she believes that their relationship would only have gotten stronger once their last child left home. Now, however, she sees little hope for the relationship.

XXII. Synthesis

This family finds itself in the aftermath of a traumatic accident that impacted Mr. Wood's ability to work and led to his addiction to opioids. These events severely challenged the ability of the Wood family to work as a cohesive family unit, interrupting their development progression through the family life cycle. As result, the family unit has disrupted, with Mr. Wood living alone and his wife and children living with her parents in Leesburg. While Mr. Wood is now willing to accept treatment for his addiction, his wife and family are minimally supportive, fearing that the treatment may not work and they will be disappointed and heartbroken once more.

XXIII. Recommendations and Initial Treatment Plan

1. Mr. Wood will successfully complete an inpatient treatment program for his addiction to opioids.
2. Mr. Wood will research halfway houses where he can continue his recovery from opioid addiction following discharge from the inpatient treatment program.
3. Mrs. Wood and her children will attend family recovery programming, including attendance at the educational series on "Addiction and the Family," along with individual and group counseling.
4. Mr. Wood will attend Narcotic Anonymous meetings weekly and obtain a sponsor.
5. Mrs. Wood will attend Alanon meetings for support in her recovery
6. The Wood children will attend Alateen meetings for support in their recovery.

Barbara J. Nowak, LCSW FL #6922, CADC-III *December 1, 2018*

Barbara J. Nowak, LCSW FL #6922, CADC-III Date

This Bio-Psycho-Social-Spiritual Assessment is based on a fictitious client. Any resemblance to an actual family is purely coincidental.

CASE/TREATMENT PLAN

CASE NAME: **CASE NUMBER:**

DATE:

Issue/Concern/Stressor:

_____

_____

_____

_____

Prioritize by dealing first with the most life threatening/or pressing needs; nature/level of severity of the problem(s); frequency; duration.

Client Strengths	***Client Needs***

GOALS:

Goal #1:

_____.

Objectives:

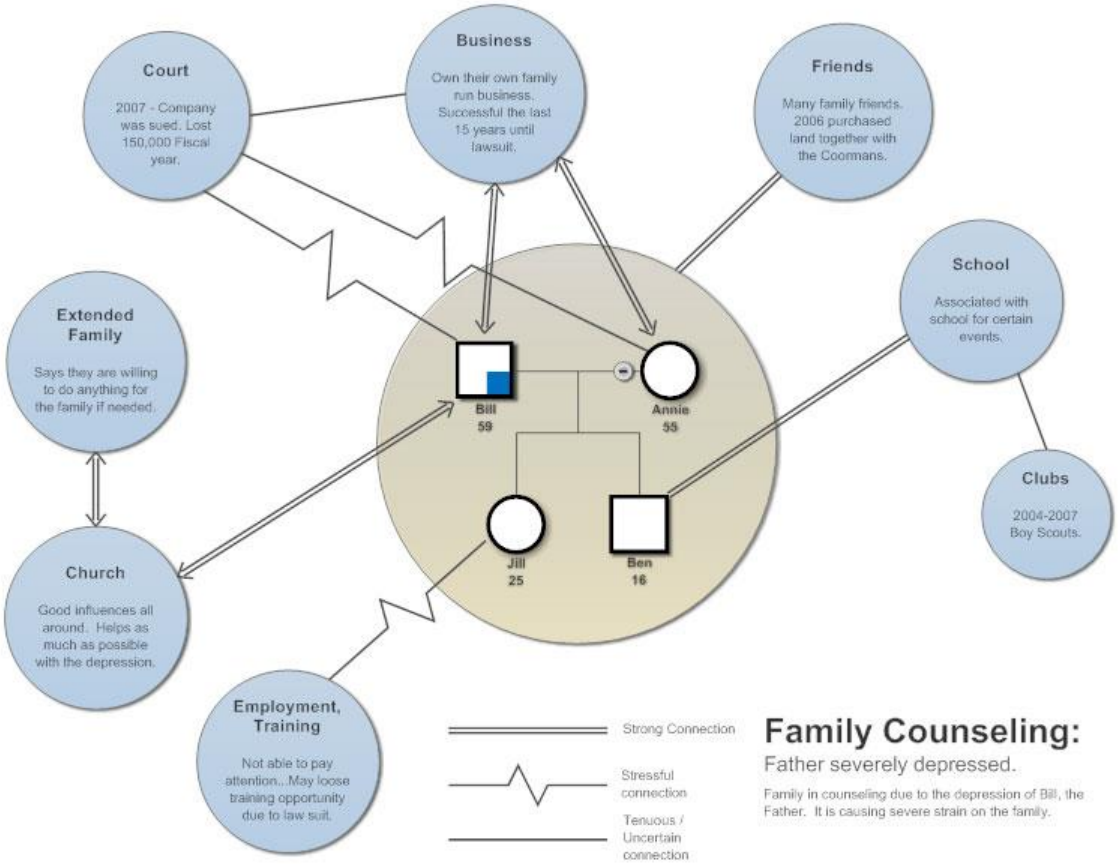
1. **_____.**
2. **_____.**
3. **_____.**
4. **_____.**
5. **_____.**

Goal #2:

Objectives:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

FAMILY ECO-MAP



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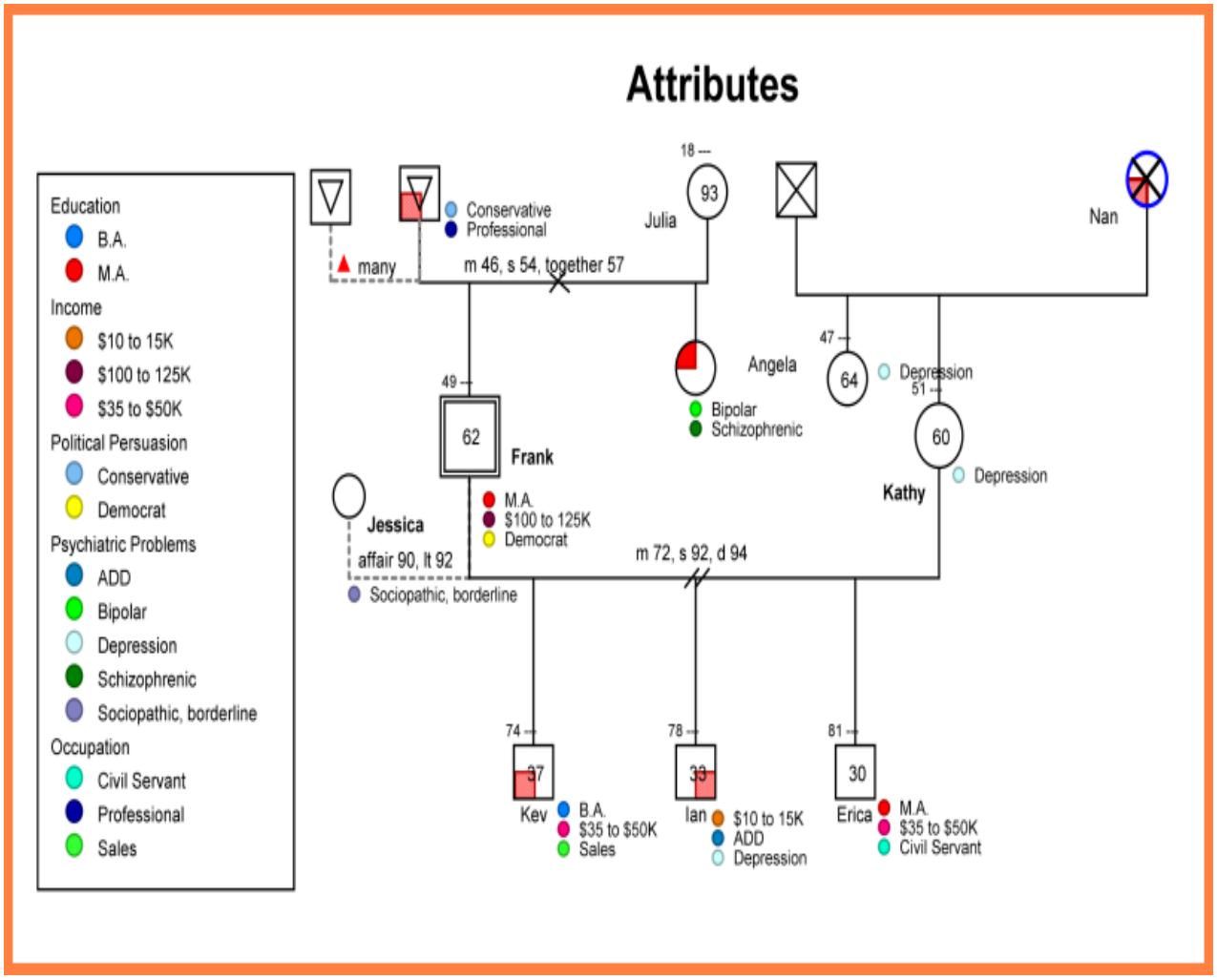

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EVIDENCE BASED INTERVENTION
(NAME OF INTERVENTION)

The Students' Case Manuals must contain a narrative, written in APA format, regarding the type of intervention utilized on each case.

Formulating the Method of Intervention

7. Research best practice in **peer reviewed social work journals** for the identified problem/issue/concern/stressor.
8. Choose an evidence-based best practice method which proves to be a good fit for the client with regard to client's culture, ethnicity, race etc. and include in written narrative.
9. Identify tool(s)/instruments that are to be utilized to further assess the targeted need/problem (briefly discuss what it measures and how it is utilized, including the name of the author, the meaning of all ratings, etc.)
10. Client's level of participation in the development of plan/intervention (remember to engage the client in the treatment planning process)
11. Identify specific intervention to be used
12. Identify that all parties (client, social worker, others associated with the intervention) understand the expectations respectively.

Implementation of Intervention

8. Describe how the intervention is implemented in accordance to research and social work standards. For example, the NASW *Code of* Ethics requires that researchers represent themselves with accuracy, maintain access to and utilize supervision, etc.)
9. Identify the specific theory on which the intervention is based.
10. Identify any barriers to intervention
11. Identify how the social worker and/or client might overcome the identified barriers
12. Discuss whether there was a need to modify the intervention? If so, why & how?
13. Level of progress anticipated in achieving intervention objectives
14. How the social worker would monitor the client's progress (i.e., home visits, direct observation of interactions, behavioral assessment etc.)

Summarize knowledge/information gained and identify possible implications for future practice.

Note: ANY MISSING INFORMATION WILL CONSTITUTE A ZERO for that particular area.

EXAMPLE

Formulating the Method of Intervention

In examining evidence-based practices for the treatment of clients with Substance Use Disorder, researchers support the use of such intervention methods as motivational interviewing, cognitive-behavioral therapy, couples therapy, structured family therapy, 12-step facilitation therapy, and psychopharmacology (Power, Nishimi, & Kizer, 2005). The most effective intervention for the family members would include the use of Cognitive Behavioral Therapy, as they possesses the required characteristics of average to above-average intelligence, are articulate, and are capable of insight.

The most commonly used instruments for assessing client irrational thought patterns include the Irrational Belief Test (IBT) (Jones, 1968) and the Rational Behavior Inventory (RBI) (Shorkey & Whiteman, 1977). Later, these scales were replaced with the Irrational Belief Scale (IBS) (Malouff & Schutte, 1986) which better separates cognition-related items from affective-related items.

Rational Emotive Behavior Therapy was introduced to the client as a method for addressing his substance use disorder. After fully explaining the theory and intervention methods to him, the family members were willing to incorporate it into their treatment plan. The Identified Client will attend the 8-week Rational Emotive Behavior Therapy group held every Wednesday evening from 6:30pm to 8:00pm in the Group Therapy room of the agency. The group members are men who are struggling to achieve chemical freedom and are willing to apply Rational Emotive Behavior Therapy to their recovery efforts. In the first session, the group members will be given the Irrational Belief Scale to complete and the scores will then be discussed. Group members will then be given a homework assignment entitled "Using the A-B-C Method" when they experience an event that triggers their chemical use. Group members will then examine their rational or irrational beliefs about the event, the emotions that followed those beliefs, and the behaviors that resulted from those thoughts and feelings.

The intervention will include (a.) the social worker who will refer the client into the group; (b.) the client who will successfully complete all 8 group sessions; and (c.) the group therapist who will lead the eight groups.

Family members will attend the two-day psychoeducational presentation on (1.) understanding chemical dependency, and (2.) understanding how the disease has impacted their family, as a whole, as well as how they have been individually impacted. The family will then attend weekly family therapy sessions utilizing the Structured Family Therapy. Structural Family therapy is a strengths-based, outcome-oriented treatment modality based on eco-systemic principles that emphasizes the interactions among family members rather than on individual psyches (Minuchin, 1974). The family is seen as the primary context in which humans develop themselves through interactions with family members. The family is seen as an adaptive structure that changes with the demands of the social environment. The family's structure consists of recurrent patterns of interaction that members develop over time as they accommodate to one another. The well-functioning family is seen as one

that can effectively handle stress and conflict as it responds to the developing needs of its members and the changing conditions of its environment. Therapy focuses on locating and mobilizing under-utilized strengths, helping the family outgrow constraining patterns of interactions that impede the effective utilization of its own resources.

Implementation of Intervention

The *NASW Code of Ethics* (1996) requires that social workers should strive to become and remain proficient in professional practice and the performance of professional functions by critically examining and keeping current with emerging knowledge relevant to social work practice. Additionally, social workers must base their practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics (Standard 4.01 (b)). Rational Emotive Behavioral Therapy has undergone rigorous empirical testing for validity and reliability of its instruments and its methodologies (Engels et al., 1993; Lyons & Woods, 1991).

Cognitive-Behavioral Theory is based on the idea that how we interpret situations will result in certain feelings that will lead to certain actions. In other words, thoughts determine feelings and behavior. From this theory, Albert Ellis (1977) developed the intervention method of Rational Emotive Behavior Therapy (REBT). This approach works to change a client's self-defeating beliefs and behaviors by challenging irrational, self-defeating and rigid thinking patterns. Ellis believed that through changing one's thinking to more rational thought patterns, the client could change unproductive feelings and self-defeating behaviors. This intervention method has been found to have success in application to individuals with substance use disorders (Ellis, 1977).

The Identified Client lost his driver's license recently due to a Driving While Intoxicated (DWI) charge and is unable to drive himself to the group sessions. Since the buses in town stop in the area of the agency at 7:00pm, this was seen as a problem to his enrollment in the group. However, when coming to see his social worker for a weekly meeting, he met his neighbor who is also enrolled in the group. This neighbor offered to give him a ride both to and from the group each week. With that obstacle resolved, the client is able to regularly attend the intervention.

Mr. Wood continued in the group sessions, it became clear that he was unable to maintain chemical freedom by through only group attendance. A modification was made to his treatment plan to include regular attendance at A.A. meetings in his neighborhood at least four times per week, weekly individual sessions with his social worker to discuss his relapse prevention plan, and daily Antabuse psychopharmacology intervention.

Upon modifying his treatment plan, Mr. Wood was able to successfully achieve and maintain chemical freedom throughout his involvement with the agency. The Identified Client's progress is monitored in his group sessions through his homework assignments which demonstrate the degree to which he successfully incorporates Rational Emotive Behavior Therapy techniques to his recovery efforts and the weekly scores on his Irrational

Belief Scale. These outcomes are recorded in a single system design progress chart that demonstrates the degree to which he successfully applies the intervention.

Rational Emotive Behavior Therapy has proven to be successful with men in recovery from a Substance Use Disorder. The research literature indicates that it can also be utilized successfully with adolescents (Gonzlez et al., 2004) and a group for adolescents is currently being formed to determine its success in application to youth with substance use disorders.

The family members attended the two-day psychoeducational classes at the beginning of the treatment process. As a result of the insights gained from those classes, Mrs. Wood agreed to attend Alanon but decided not to pursue couple's counseling. The family members attended one family therapy sessions before deciding that they did not want to pursue additional treatment for themselves or in conjunction with Mr. Wood. Mrs. Wood has continued on with divorce proceedings, despite her husband's success in achieving and maintaining chemical freedom. As a result, Mr. Wood has decided to enter into a long term residential treatment program in Florida. One of his former employers now lives in Florida, is highly supportive of his recovery, and is willing to act as his A.A. sponsor.

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PROGRESS NOTE
USING "S.O.A.P."

Client's Name:

Date	Type of Contact	Objective # Addressed	Progress

EXAMPLE OF PROGRESS NOTE
USING "S.O.A.P."

Client's Name: James Foster, Jr.

Date	Type of Contact	Goal # Addressed	Objective # Addressed	Progress
9/15/19	Individual Session	1	1	S: "I want to talk about how ashamed I am for how I treated my children when I was using drugs."
				O: Client tearful; looks down at lap and fidgets with buttons on shirt throughout the session
				A: Client demonstrates growth in recovery, taking responsibility for actions when actively using drugs. Demonstrates an understanding of how chemical use impacted family system, particularly the children.
				P: Completed goal #1, Objective #1. Will continue on with Goal #2, Objective #1 in next session.
				Barbara J. Nowak, LCSW 6922, CADC-III-------------------------

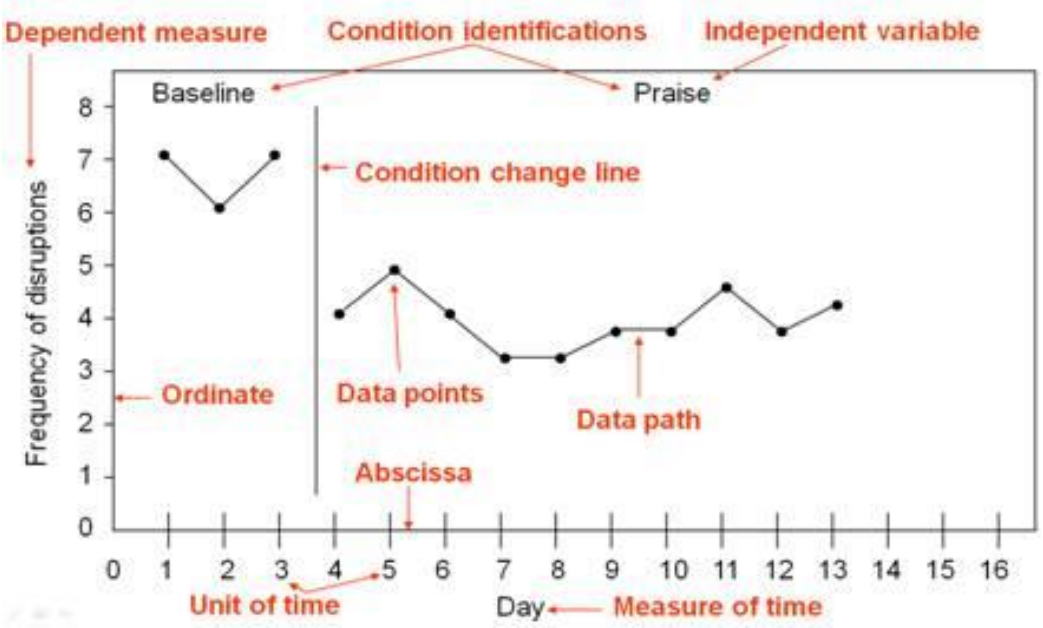
CLIENT EVALUATION
SINGLE SUBJECT DESIGN

"Single subject design" is used in social work practice when the social worker is attempting to change the behavior of an individual, family, or a small group of individuals and wishes to document that change. The social worker uses line graphs to show the effects of a particular intervention.

Suppose the social worker wished to determine the impact of praise on reducing the client's disruptive behavior over many days. First, she would need to establish a **baseline** of how frequently the disruptions occurred. She would measure how many disruptions occurred each day for several days. In the example below, the student was disruptive seven times on the first day, six times on the second day, and seven times on the third day. Note how the sequence of time is depicted on the x-axis (horizontal axis) and the dependent variable (outcome variable) is depicted on the y-axis (vertical axis).

Once a baseline of behavior has been established (when a consistent pattern emerges with at least three data points), the intervention begins. The social worker continues to plot the frequency of behavior while implementing the intervention of praise. In this example, you can see that the frequency of disruptions *decreased* once praise began. The design in this example is known as an A-B design. The baseline period is referred to as A and the intervention period is identified as B.

The student will complete a single subject evaluative design on the client chosen, using line graphs to show the effects of the intervention used in the case.



CLIENT DISCHARGE SUMMARY

A Discharge Summary is the synthesis of what has occurred during service provision. The Discharge Summary is an abbreviation of the demographics, issues identified, goals established, interventions made, empirical results reached, and any referrals or follow-up's made.

The Discharge Summary includes a summary of the client's course and progress in treatment, the client's status at the time of discharge, and any post-discharge plans made. The social worker would also state when an anticipated date of discharge to another are setting would occur, along with the plans made for that transfer, if appropriate. The Discharge Summary helps to ensure that the client's care is coordinated and that the client's termination is ethical and appropriate.

The Discharge Summary generally contains the following elements:

13. Date of Admission/Transfer
14. Date of Discharge/Transfer
15. Admitting Diagnosis/Assessment
16. Discharge Diagnosis/Assessment
17. Summary of Presenting Problem
18. Course and Progress of Treatment
19. Consultations, if any
20. Disposition (where the client is discharged to (e.g., home with outpatient support, daughter's house, halfway house, inpatient substance abuse center, ongoing family treatment, referral of family members to self-help groups, etc.)
21. Discharge Instructions
22. Recommendations
23. Follow-Up Information
24. Signature/Licensure of the Social Worker

DISCHARGE SUMMARY
Format

Date	
Client's Name	
Case Number	
Admission Date	
Termination Date	

Admitting Initial Diagnosis/Assessment
Discharge Diagnosis/Assessment
Summary of Presenting Problem
Course and Progress of Treatment
Recommendations
Follow Up Information
_____ _____ **[Social Worker's Signature/Licensure]** **[Date]**

DISCHARGE SUMMARY

[Adapted from http:www.notedesigner.com/guidelinestermination.html]

Date	August 12, 2019
Client's Name	James Bishop
Case Number	42-31778-8957
Admission Date	August 5, 2019
Termination Date	February 2, 2020

Admitting Initial Diagnosis/Assessment

303.90 Alcohol Use Disorder, Moderate, In a Controlled Environment

Discharge Diagnosis/Assessment

303.90 Alcohol Use Disorder, Moderate, In Early Remission

Summary of Presenting Problem

This 52-year-old African American married father of two teenage sons came to the Renewal Addictions Center following a DUI charge on Christmas Day. As part of his court orders, Mr. Bishop was required to complete a substance use assessment at this facility. While Mr. Bishop stated he had no alcohol use problem ("I only have a couple of beers on the weekend."), his wife, his two sons, and his business partner (who has been in alcohol recovery for 9 years) all stated that he drinks to the point of intoxication every day. Following a family intervention, the patient reluctantly agreed to come in to the 30-day inpatient treatment program to address his alcohol use. His wife, his sons and his business partner all agreed to support Mr. Bishop throughout the course of treatment.

Course and Progress of Treatment

Medical testing completed upon admission showed an extremely elevated liver profile, a high cholesterol count, and the onset of Type II diabetes. As Mr. Bishop progressed through inpatient treatment, his liver profile improved, as did his cholesterol count. By the second week of inpatient treatment, Mr. Bishop stated that he felt physically better but complained about sleep difficulties and alcohol cravings. Through the daily men's group meetings, daily 12-step meetings, and attendance at afternoon psychoeducational groups, the patient could articulate the medical model of alcohol addiction and developed a comprehensive relapse prevention plan to help him maintain chemical freedom upon discharge to the outpatient treatment program. Prior to discharge, the patient had made his first appointment with his Outpatient Counselor, had agreed to attend a men's recovery group once per week, had an AA sponsor, and had identified the 12 step meetings he would attend each week.

As a part of his treatment, his family attended the Saturday psycho-educational sessions to learn more about the disease of addiction and to identify how it had affected them as a family. While Mr. Bishop was involved in the inpatient program, Mrs. Bishop met with the Outpatient Family Counselor to begin codependency treatment. As part of her

recovery, she attends the women's codependent group one time per week. She attends three Alanon meetings per week and has obtained an Alanon sponsor. The patient's older son, David, attends a weekly adolescent group designed for children of parents with chemical dependency. He also attends an Alateen meeting on Saturday afternoons with a friend of his who also attends the meeting. The patient's youngest son, Ronald, is resistant to group therapy and involvement in support groups, but has developed a therapeutic relationship with his Outpatient Adolescent Counselor who sees once per week.

Recommendations

Mr. Bishop will continue with treatment on the outpatient basis, attending weekly men's group therapy meetings, meeting one time per week with his Outpatient Counselor, attending daily AA meetings, and speaking regularly with his AA Sponsor where he continues to complete his 12 steps.

Mrs. Bishop has formed a therapeutic relationships with her Outpatient Family Counselor who she will continue to see once per week. She will also continue to attend Outpatient Codependent Group Therapy once per week. When Mr. Bishop has progressed further into his outpatient recovery, the couple will attend couple counseling sessions with their counselors. David will continue with his weekly adolescent group therapy sessions and Ronald will continue to meet weekly with his Outpatient Adolescent Counselor.

Follow Up Information

As the family progresses in their recovery, the family will begin family therapy sessions and outpatient multi-family group to develop skills that will further the healthy development of the family system.

Barbara J. Nowak, LCSW 6922 *August 12, 2019*

_____ _____

[Social Worker's Signature/Licensure] **[Date]**