Case History Paper: Martha

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Abstract

This case history paper presents a biopsychosocial assessment of “Martha,” a fictional client seen in weekly outpatient therapy over a three-month period. Martha reports a history of significant trauma, complicated family relationships, increased alcohol use, and recent medical stressors that appear to impact mood stability and functioning. Current clinical concerns include episodic symptoms consistent with mania, impaired judgment, interpersonal conflict, and treatment refusal related to a serious medical diagnosis. This paper provides an assessment summary, DSM-5-TR diagnostic impressions with rationale, risk and prognostic factors, ethical and cultural considerations, and a treatment plan with goals and interventions.

Client Background (Biopsychosocial Summary)

"Martha" is a fictional adult client who participates in weekly 60-minute therapy sessions. She has been attending therapy for approximately three months and has gradually increased openness regarding childhood and adult stressors. Martha reports multiple significant losses and traumas, including her mother's death by suicide during Martha's adolescence, strained family relationships, and a sexual assault in early adulthood. Martha describes a complicated relationship with her children, including ongoing conflict and emotional distance. She reports being remarried and identifies her current relationship as supportive.

Martha reports living with stable housing and financial security. She describes frequent travel and access to resources, but her relationships and mood symptoms remain significant barriers to emotional stability. Martha reports increased alcohol use (4–5 nights per week) and interpersonal conflict related to impulsive decisions and shifting narratives about family finances.

Presenting Concerns and Current Functioning

Martha initially sought counseling to improve relationships with her children. Over time, additional concerns emerged, including mood instability, episodes of elevated energy and activity, increased irritability, impulsive spending, and interpersonal conflict. Martha has demonstrated patterns of loud, pressured communication, heightened emotional reactivity, and behavior that appears inconsistent with her typical functioning.

Martha also reports a recent diagnosis of advanced-stage lung cancer. She describes completing one treatment and states she does not plan to continue treatment. She reports refusing to use prescribed oxygen consistently. Martha denies current suicidal intent or self-harm intent;

however, she expresses strong fatalistic beliefs and limited willingness to engage with medical care planning.

Risk and Prognostic Factors

Risk factors:

- Family history of suicide and depression
- Trauma history (loss, assault)
- Increased alcohol use
- Possible mood disorder with impaired judgment during elevated mood states
- Serious medical diagnosis and treatment refusal
- Strained family relationships and conflict

Protective factors:

- Ongoing engagement in therapy
- Current supportive marital relationship
- Stable housing and access to resources
- Denies suicidal intent and expresses desire for dignity and autonomy
- Willingness to discuss involvement of spouse in care planning

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DSM-5-TR Diagnostic Impressions and Rationale

Primary Diagnostic Impression (Provisional): Bipolar I Disorder, current episode manic (DSM-5-TR)

Clinical rationale: Martha reports and demonstrates episodic periods of elevated energy, increased goal-directed activity, impulsive decisions (e.g., major purchases without planning),

irritability, and interpersonal disruption. The behavior described suggests episodes that involve impaired judgment and functional consequences. In sessions, Martha has also presented with increased intensity and loud/pressured communication. Based on these features, Bipolar I Disorder (current episode manic) is a reasonable provisional diagnostic impression pending full confirmation of episode duration, symptom count, and ruling out substance/medical causes.

Additional Clinical Consideration: Alcohol Use Disorder (severity to be assessed)

Clinical rationale: Martha reports drinking 4–5 nights per week with clear relational impact and escalating conflict. Further assessment is needed to determine tolerance, loss of control, unsuccessful attempts to cut down, and functional impairment for diagnostic severity.

Rule-Out/Diagnostic Considerations (require further assessment):

Mood Disorder Due to Another Medical Condition (rule out)

Substance/Medication-Induced Bipolar and Related Disorder (rule out)

Clinical rationale: Martha's advanced medical diagnosis and treatment decisions, combined with increased alcohol use, warrant careful assessment to determine whether mood symptoms are primarily attributable to a bipolar spectrum disorder versus medical/substance-related factors. A coordinated medical and psychiatric evaluation would be needed to clarify causality.

Note: Ongoing assessment should verify symptom duration, sleep changes, distractibility, pressured speech, and functional impairment across settings to confirm DSM-5-TR criteria.

Ethical and Cultural Considerations

Ethically, this case requires careful attention to self-determination, informed consent, and clinical responsibility. Martha expresses strong preferences regarding medical treatment refusal and a desire to "die with dignity." The clinician must respect autonomy while also assessing decision-

making capacity, particularly if mood symptoms or substance use may impair judgment. It is essential to avoid imposing personal beliefs, maintain a nonjudgmental stance, and ensure Martha understands options and consequences.

Confidentiality, appropriate documentation, and clear boundaries are critical due to family conflict and the potential for involving family members in sessions. If Martha consents, involving her spouse may support coordinated decision-making and improve communication. The clinician should also screen routinely for suicidal ideation and safety concerns given the family history of suicide, trauma history, and serious illness.

Treatment Plan (Goals and Interventions)

Immediate Priorities

1. Comprehensive psychiatric evaluation to clarify mood diagnosis, rule out medical/substance contributors, and determine need for medication support.
2. Risk monitoring and safety planning, including routine screening for suicidal ideation, hopelessness, and impaired judgment.
3. Reduce barriers to coordinated care by supporting appropriate collaboration (with consent) between medical providers and behavioral health supports.

Clinical Goals and Interventions

Goal 1: Improve emotional regulation and reduce interpersonal conflict.

- Interventions: psychoeducation on mood symptoms; coping skills (grounding, paced breathing); communication skills; session structure for de-escalation.

Goal 2: Reduce alcohol-related impairment and improve coping.

- Interventions: brief motivational interviewing; identify triggers; harm-reduction or reduction plan; referral to substance use assessment if indicated.

Goal 3: Support informed decision-making and coping with medical stress.

- Interventions: values-based counseling; explore fears and beliefs about treatment; support autonomy while assessing capacity; referral to medical social work/palliative support resources as appropriate.

Goal 4: Strengthen family relationships and support systems (as appropriate and safe).

- Interventions: family session with spouse (with consent); boundary-setting; relational repair strategies; clarify roles and expectations.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.; DSM-5-TR).