

What is a Psychosocial Assessment?

As a social worker, one of the most important genres of writing you will use in order to convey information about a particular client will be the psychosocial assessment. A **psychosocial assessment** is the social worker's summary as to the problems to be solved. The social worker considers a variety of factors, which may include the physical/psychiatric illness and its impact, results derived from psychological tests, legal status, descriptions of the problem(s), existing assets and resources, the prognosis or prediction of outcome, and the plan designed to resolve the problem(s).

Your **psychosocial assessment** should:

- Communicate pertinent information about a client to colleagues for case planning and referral purposes.
- Establish in writing an account of "**where the client is at**" at a particular moment in time during service provision; the psychosocial assessment account offers baseline information about the client when he or she enters an agency for service.
- Offer the social worker an opportunity to reflect on, refine thinking, and raise questions about the client and his or her situation – to digest information about and impressions about the client through the process of **writing about it**.

Parts of a Psychosocial Assessment

A psychosocial assessment is divided into **three** different sections, which contain different sub-headings:

- **Basic Information**
 1. Identifying Information
 2. Referral
 3. Presenting Problem
 4. Sources of Data
 5. General Description of Client
- **Background and Current Functioning**
 1. Family Composition and Background
 2. Educational Background
 3. Employment and Vocational Skills
 4. Religious/Spiritual Involvement
 5. Physical Functioning, Health Conditions, and Medical Background
 6. Psychological and Psychiatric Functioning and Background
 7. Social, Community, and Recreational Activities
 8. Basic Life Necessities
 9. Legal Concerns
 10. Other Environmental or Psychosocial Factors
 11. Client Strengths, Capacities, and Resources
- **Impressions, Assessment, and Recommendations**
 1. Clinical Summary, Impressions, and Assessment
 2. Goals and Recommendations for Work with Client

In order to learn how to incorporate all of these different sections into your finished psychosocial assessment, please refer to the Infosheets for each particular section.

Identifying information

The **identifying information**, which is included under the “**basic information**” section of your psychosocial assessment, should include the following:

- Client name
- Gender
- Date of birth and age
- Marital status
- Race, ethnicity, and nationality (if not born in the U.S.)
- Language spoken
- Income (socioeconomic status)
- Neighborhood where client lives (general profile of community)
- Living arrangements (with whom does the client live?)

Example:

“María de los Angeles Arrieta, a 37-year-old single woman from Jalapa, Mexico, has been living in Jamaica, New York for the last ten years. She describes herself as a “hard worker,” and she describes how she has held the same position as a paralegal assistant for the last three years, after earning a promotion. Her income, depending on end-of-year bonuses, varies between \$45,000 and \$55,000 a year.”

What kind of information should be included in the referral section of the psychosocial assessment?

The **referral**, which is included under the “**basic information**” section of your psychosocial assessment, should include the following:

- Source (who referred the client to agency)
- Nature of request (what type of assistance is being sought?)

Example:

“Mr. Solomon first sought help after hearing about the agency’s services from his sister-in-law. Even though Mr. Solomon cannot quite describe the source of his problems, he believes his ongoing sadness and depression are beginning to affect his work, which worries him and has prompted several episodes of extreme anxiety. He believes a more serious, committed form of assistance is necessary in order to ensure his success at work.”

Presenting the Problem

In the “presenting the problem” section of your psychosocial assessment you should:

- Describe the problem for which the client came (or was referred) for help.
 - Include client’s definition of problem/need and expectations of service.
 - Include a brief history of the presenting problem:
 - Length of duration of the problem
 - Prior attempts to resolve the problem
 - Previous involvement with social agencies for assistance with the problem
 - If client is in crisis or considered “high risk” (e.g., in danger: of being abused, using violence against someone else, suicidal, decompensating, relapsing to drug use), describe and offer brief assessment of the risk

Example:

“Hal Solomon is a 32-year old entrepreneur whose presenting problem is a sense of unworthiness over earning more than a million dollars each years in the past 10 years of his work career. He says that the amount of money is considerably out of keeping with the degree of energy used, and that compared to people who “real work,” it seems completely wrong for him to earn so much money.

Mr. Solomon came to the interview on time, wore dress slacks and a polo shirt, is deeply tanned, and says that he is 6’1” and weighs 165 pounds. He runs 5 miles a day and works out at the gym at least an hour every day. He wore no rings or other jewelry, but he did have on a gold Rolex watch. Initially, he moved around a great deal in his chair and his fingers continually tapped on the arm of his chair. After 5 minutes, he slumped back in his chair, and, from time to time, wiped tears from his eyes as he discussed the impact his career has had on his former marriage, family life, and on issues of intimacy. He comes to treatment for help in resolving problems of continued feelings of unworthiness, depression, and guilt that have lasted a duration of more than 2 years and which began with his divorce several years ago.”

From Glicklen, M.D. (2005) *Improving the effectiveness of the helping professions: An evidence based approach to practice*. Thousand Oaks, CA: Sage.

How should you refer to your sources of data in your psychosocial assessment?

In order to ensure accuracy in your psychosocial assessment, you should:

- Identify all the types of information used to write this assessment:
 - Interviews
 - Observations
 - Written materials (e.g., agency records)
 - Consultations with collateral contacts
 - Records from this or referring agency
 - Diagnostic test results (e.g., psychiatric, educational, psychological, vocational, medical)
- Describe client involvement in data collection process
 - Who was present during interview/s and observations?
 - How many times were interviews conducted, colleagues consulted, etc?
 - Over what period of time was the information gathered?

Example:

“Mr. Solomon came in for a series of weekly, one-hour long interviews, beginning at the end of September, and lasting until the second week of December. During this time period, he was referred to a psychiatrist, who diagnosed him with chronic depression in late October. As this was the first time Mr. Solomon had consulted with a psychiatric expert, or with any kind of social work agency, this is the full extent of diagnostic reports available.”

What should you include as part the general description of your client?

Your **general description of the client** should include the following items:

- Client's appearance, attitude, affect, and interpersonal style during the interview/s
 - Mention any apparent problems with memory, thinking, speech, or client's sense of reality
 - Note any signs or mention of anxiety, depression, or other mood states, if they are present
 - Indicate how the client related to you during the interview/s

Example:

"Throughout our interviews, Mr. Solomon continuously expressed concern about his job and his professionalism. Despite these concerns, he always arrived on time for the interviews, which were scheduled after his regular work hours. Thus, he arrived wearing suit and tie to all of these interviews. A few times during our conversations, he would pause; he commented several times that he was having difficulty expressing his feelings and anxiety to a relative stranger. Despite these concerns, however, after a few meetings, he seemed much more at ease, even engaging me in casual topics of conversation, even though at the beginning of his sessions he refused to talk about anything other than his anxiety."

Family composition and background

The **family composition and background** section should mention:

- Nuclear family members and significant relationships; list members, ages, marriage dates, deaths, divorces. Describe relationships-focus on marital and parental strengths and difficulties, if relevant.
- Family of origin (family with whom one grew up); list members, ages, where they live, deaths, divorces. Describe all of these relationships.
- History of relevant substance abuse, legal problems, and/or psychiatric problems among family members.

Example:

“Marie is the mother of two teenage children. Oliver, age 12, lives at home while Michael, age 17, is currently in a boot camp in Mount Allen. She states she and Oliver get along well and that he is doing well in school. She sees Michael every other weekend and is hopeful that the boot camp experience will help him in the long run.”

From Summers, Nancy. *Fundamentals of Case Management*, 2nd Edition, Thomson, Brooks/Cole, Belmont, Ca. 2006; p. 248.

Educational background

The **educational background** section should mention:

- School history and current status. This could include:
 - Highest level of education.
 - Degree/s earned.
 - Special school/educational talents, challenges, goals.

Example:

“Mr. Solomon became an entrepreneur in the computer field after his sophomore year at Stanford University. he has not returned to finish his degree and says that his lack of formal education makes him feel insecure about his intellectual abilities. however, he reads a great deal and has tried to make up for his lack of formal education by reading books recommended by people he respects.”

From Glicken, M.D. (2005) *Improving the effectiveness of the helping professions: An evidence based approach to practice*. Thousand Oaks, CA: Sage.

What kind of information is included under the “employment and vocational skills” section of your psychosocial assessment?

The educational background section should mention:

- Occupation, work history, and current status (e.g., employed, unemployed, full-time, part-time).
- Special training/skills.

Example:

“María de los Angeles Arrieta has been working as a paralegal assistant in Manhattan, New York for the last ten years. She completed her AA degree eight years ago, and her workplace has offered several training seminars which she completed with enthusiasm, according to her description.”

Religious and spiritual involvement

The religious and spiritual involvement section should mention:

- Level of involvement with and support from religious community and/or spiritual practices and beliefs.

Example:

“Marie describes herself as a ‘serious Catholic.’ She attends Sunday mass every week, along with her two small children. She regularly attends other weekly, social gatherings organized by her church.”

Physical functioning, health conditions, and medical background

The **physical functioning, health conditions and medical background** section should mention:

- Physical development, general health, disabilities, and current functioning.
- History of disease, accidents, genetic predispositions, and prescription medication.

Example:

“Simon Kowalsky is in general good health, although he complains sometimes about headaches and general tiredness. He has consulted with his general physician in regards to this condition, who seems to believe it is stress related. He is currently managing this condition through non-prescription medication, such as aspirin. His family, in particular on his father’s side, has a history of heart disease, which contributes to Mr. Kowalsky’s uneasiness concerning his stress levels.”

What kind of information is included under the “psychological and psychiatric functioning and background” section of your psychosocial assessment?

The psychological and psychiatric functioning and background section should mention:

- History of mental health/psychiatric problems, prescription medication, addictions (e.g., alcohol and other drug use).
- History of physical, mental, and/or sexual abuse or neglect.

Example:

“[Mr. Solomon] reports... depression or anxiety in his life, which occurred about the time he decided to marry. He believes the cause of his depression was the conflict with his parents over the marriage. He says that he is healthy, although he sometimes feels easily fatigued.... He was on a tranquilizer several years ago because of anxiety and depression during the divorce but cannot remember the name of the medication. He says that it made him sleepy and that he discontinued its use because it interfered with his work.”

From Glicklen, M.D. (2005) *Improving the effectiveness of the helping professions: An evidence based approach to practice*. Thousand Oaks, CA: Sage.

Social, community, and recreational activities

The **social, community, and recreational activities** section should mention:

- Social functioning, (are there any significant friendships, interpersonal relationships, support network?)
- Use of community organizations or resources (e.g., as client, member, volunteer)?
- Hobbies/leisure involvement.

Example:

“Bill states that he has a number of friends and sings in his church choir. Last summer he joined a local baseball team and intends to this summer as well. He likes sports and goes to games with friends.”

From Summers, Nancy. *Fundamentals of Case Management*, 2nd Edition, Thomson, Brooks/Cole, Belmont, Ca. 2006; p. 248.

What kind of information is included under the “basic life necessities” section of your psychosocial assessment?

The **basic life necessities** section should mention:

- How is client functioning with respect to basic life necessities-food, housing, employment?
- What entitlements does the client receive? What assistance does client require?

Example:

“Mr. Solomon has held his current job for over 5 years, and he describes his income as ‘more than enough.’ He describes a feeling of accomplishment regarding the ownership of his own apartment.”

What kind of information is included under the “legal concerns” section of your psychosocial assessment?

The **legal concerns** section should include:

- Immigrant status, housing, marital issues, domestic violence, parole/probation, DWI's?

Example:

“During the first few meetings, Ms. Arrieta described her worries regarding an ex-boyfriend who she described as “abusive.” During her three-month relationship with this man, Ms. Arrieta had been concerned with his temper, and his verbal, violent threats. After ending the relationship, she had received a few phone calls from him, and at the beginning of our sessions, she had considered calling the police. After a few sessions, however, she had decided against calling the police, as she heard from a friend that her ex-boyfriend had moved out of the state.”

What kind of information is included under the “other environmental or psychosocial factors” section of your psychosocial assessment?

The **other environmental or psychosocial factors** section should include:

- Military service, sexuality issues, etc.

Example:

“During several of our interviews, Mr. Olvera commented on the military service he completed in his home country, Mexico, as a source of great concern; it was during this service that he first began to struggle with his sexuality, feeling that his peers in the volunteer army would shun him or “reject him” if they knew he was gay. Even though he never actually revealed his sexuality to any of his friends in his home country, the anxiety provoked by these experiences still “follows” him, as he himself reported during several of our sessions.”

What kind of information is included under the “client strengths, capacities, and resources” section of your psychosocial assessment?

The **client strengths, capacities, and resources** section should address:

- How does the client cope? What are his/her strengths and problem-solving capacities? What are his/her limitations to deal with the current problem/s?

Example:

“While [Mr. Solomon] complains of depression and fatigue, he continues to do well in his work, exercises daily, and has widely invested his large income for the future. He is an avid reader and has tried to use available literature to understand and resolve many of his problems, sometimes effectively.”

From Glicken, M.D. (2005) *Improving the effectiveness of the helping professions: An evidence based approach to practice*. Thousand Oaks, CA: Sage.

Clinical summary, impressions, and assessment

The **clinical summary, impressions, and assessment** section should:

- First give a brief, 3-5 sentence summary of what you have already written:
 - Identify the primary problem, need, or concern the client is dealing with and contributing factors.
 - Also, describe the sense of urgency the client has with the problem/s.
 - Identify secondary problems, needs, or concerns if these are raised.
- Summarize how the client appeared during the interview/s.
 - Give an overview of client's mood, signs of anxiety or depression, problems with memory, speech, sense of reality, judgment, attitude toward their situation/difficulty.
 - Indicate how the client related to you. Your impressions give important clues to where the client is right now and how the client is handling the problem emotionally and cognitively.
- Note the client's expectations of service.
- Note your assessment of the client's motivation for change and likely use of service.

Example:

"Mr. Solomon is a 32-year old divorced Jewish entrepreneur who seeks help for feelings of guilt and depression over the large amount of money he has made in a career that he describes as "frivolous." He describes ongoing feelings of isolation and loneliness and is concerned over his inability to trust others. The onset of these feelings seems to have coincided with the death of his parents and the divorce from his wife as a result of her infidelity. All three events took place within months of one another. [...]

Mr. Solomon has many positive behaviors that should be particularly helpful in his treatment. He is successful at work; he is introspective and feels concern over his current emotional state; and he has some insights into the origins of his problems with his parents, siblings, and former wife. He appears to be highly motivated to change. Although he suffers from a steady degree of depression, he is still able to work at a successful level. He longs for more intimacy and wants to form the types of caring relationships that have been so elusive in his life. He values education and has made a conscious effort to improve his general level of knowledge in an attempt to make up for an early withdrawal from college."

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Goals and recommendations for work with client

The **goals and recommendations for work with client** section should:

- Identify goals for work with client.
- Recommendations for service and resources
 - Modality (what type of treatment).
 - Length of time (how many sessions? Long term, short term?)
- Next steps.

Example:

“Given Mr. Kowalsky’s problems with social anxiety, which is causing problems at work, long-term therapy is suggested. Mr. Kowalsky has agreed to find a therapist using his health-insurance, and has agreed to a minimum of three months therapy once he finds a suitable provider. After this initial three months, Mr. Kowalsky has agreed to reconvene with me, and consider further options, such as psychiatric treatment. In the meantime, he has agreed to keep me regularly updated on his stress levels by meeting with me once every two weeks.”

Why is content of clinical documentation important?

The material contained within a report:

- Communicates pertinent information about a client to colleagues for case planning and referral purposes.
- Establishes in writing an account of “where client is at” at a particular moment in time during service provision; the psychosocial assessment account offers baseline information about the client when he or she enters the agency for service.
- Offers the social worker an opportunity to reflect on, refine thinking, and raise questions about client and his or her situation-to digest information about and impressions about the client through the process of writing about it.

Objective facts and subjective impressions

What are objective facts?

These include:

- What is actually said by the client, other people connected to the client (e.g., family members), and/or colleagues involved with the case; this can include what the client thinks or feels, or what the client's impressions are about his or her own situation
- Communicates pertinent information about a client to colleagues for case
- Communicates pertinent information about a client to colleagues for case planning and referral purposes.
- Establishes in writing an account of "where client is at" at a particular moment in time during service provision; the psychosocial assessment account offers baseline information about the client when he or she enters the agency for service.
- Offers the social worker an opportunity to reflect on, refine thinking, and raise questions about client and his or her situation-to digest information about and impressions about the client through the process of writing about it.

What are subjective impressions?

These include:

- Social worker's insights, beliefs, hunches, guesses, inferences, speculations about the client and his or her situation (e.g., presenting problem) based on the objective material presented by (or about) the client.
- These are statements that the social worker makes about what he or she believes are underlying or latent meanings or motivations of the client's remarks, actions, patterns of behavior, experiences, interaction, and feelings.

How do we differentiate between objective facts and subjective impressions?

We do this by:

- 1) **"Making Attributions"** – clarify who said, thought, believed, felt, wrote, or did what?
- 2) **"Framing Claims"** – being explicit in how we write our statements about whether the statement is an objective fact or a subjective impression.

Statements of objective fact can be framed without qualification:

Examples:

- *The client smiled as he spoke about his older son.*
- *The client explained that she didn't want to hurt her mother's feelings.*
- *The client reported that she felt embarrassed when she fell out of her wheelchair.*
- *The client didn't finish high school because she reportedly felt she had to stay home and take care of her younger siblings.*

Statements of subjective impression must be framed with qualification (and evidence):

Examples:

- *The client seemed happy as he spoke about his older son because he was smiling.*
- *The worker sensed that the client didn't want to hurt her mother's feelings because the client said she kept "forgetting" to tell the mother that she was moving out of the house.*
- *Although the client did not say it, she appeared to be embarrassed about falling out of the wheelchair; when she arrived at the agency she seemed flustered and out of sorts.*
- *The client didn't finish high school; this might have occurred because the client stated that she had much childcare responsibility for her younger siblings.*

Tentative Phrases

What is “tentative language” in a psychosocial assessment?

Phrases that tell the reader that the writer is going to make a claim that is based on inference, interpretation, suggestion, hypothesis-ways to move beyond what the client has said, to what the social worker “reads” from the case material to shed light on the client’s underlying meaning and motivation.

Examples of tentative phrases:

It appears that	It seems that
It may be the case that	The social worker wonders whether
It points to	It suggests that
One might speculate that	There is a hint of
One is struck by	It is worth wondering if
She might be	Perhaps...
It leads one to question whether	It is like that
It is unlikely that	

Inference: The act or process of deriving logical conclusions from premises known or assumed to be true; the act of reasoning from factual knowledge or evidence.

Interpretation: A representation of the meaning or significance of something; the act or process of explaining the meaning of something.

Suggestion: The sequential process by which one thought or mental image leads to another by association.

Hypothesis: A tentative insight or explanation for an observation or phenomenon that can be tested by further investigation; a provisional conjecture.

Coverage: Does the report contain enough useful clinical information? That is, is there enough material in relevant sections of the report that:

- relates to,
- provides some context for, and
- may shed light on the presenting problem?

Does the report contain a balance of information presented-including

- client strengths and difficulties
- objective facts and subjective impressions
- material from multiple data sources, if available?

Prioritizing: Is information presented in a way which highlights the key clinical issues for this client?

This requires that YOU decide which:

- Issues are of primary and secondary importance.
- Section/s should receive the most weight in a report

Decisions about which issues and sections should be highlighted should flow from what is the most relevant, important, or urgent issues for the client, given his/her situation and presenting problem.

How to HIGHLIGHT and give PRIORITY:

- **Present more material** about the issue/area of client's life than you write for other issues/areas.
- **Present it first** in a paragraph or section
- **Explicitly state** that is most important

Details: Is there enough specific information and examples to give context to clinical issues? Content of report should offer detail, illustration, and examples.

What do we mean by “informational accuracy” in a psychosocial assessment?

- Since your report may be read by colleagues (and when requested, clients) **“getting the story right”** is critical.
- When thinking about accuracy, we need to ask ourselves:
 - **“Is the report material is written out faithfully – meaning, as true to how it was presented by client, colleague, record, as possible?”**
 - **“Does the prose accurately convey what client (or other data source) said, did, thought, felt, or believed to the extent that it was presented?”**
- If not, **what are the errors and in what ways do these mislead?**

Organization in Psychosocial Assessments

It is **not** appropriate to record everything the client (or other data source) said, thought, felt, evidenced since he or she was known to your agency, otherwise all one would have to do is turn on a video-recorder and the “record” would be the tape.

We sift or filter what we write and sequence it within logical sections in order to be **EFFICIENT AND COMPREHENSIBLE**, e.g. the reader can “cut to the chase” quickly. Everything should be pertinent – NOT MORE and NOT LESS – and whatever appears should be placed in its proper section.

Avoid reports of “clinically irrelevant” information and extraneous words that don’t add to meaning:

Examples:

- Client **really** is having a hard time. (“Really is an extraneous word)
- Client **wanted to go to the program today but had to wait for the bus, so she was 5 minutes late.** (The information in this sentence is unimportant – being 5 minutes late because of a late bus is not ‘remarkable’ – or anything that needs to be reported. It is uneventful in most of our lives.)

Yet, if you wrote:

- Client **wanted to go to the program today but had to wait for the bus, so she was 5 minutes late. She said she was so anxious about being late that she toppled out of her wheelchair when the bus left her off. She was sent to the nurse as soon as she arrived at program.** (The information here makes the late bus arrival ‘remarkable’ and clinically important. It shows us something striking, perhaps extreme about the client’s reaction to getting to the program on time.)
- Client **said she was proud of her son when he brought home the positive report card last week, she was pleased, and it made her happy.** (The three descriptions of client’s reaction to her son’s report card are similar enough; only one is needed).
- In the mornings, the client attends a job workshop where she like has to develop a few skills – **an example of this is that she is developing her skills at** how to look for a job. (“Like” is an extraneous word. The phrase “an example...” does not add anything to the sentence – it contains extra words that are not needed.)

Make “**mental footnotes**” of material that may not be clinically significant at the moment, but you may want to remember it for the future.

