Clinical Report: Michelle Nguyễn

Assessment, Treatment, and Therapeutic Processes

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School of Psychology

Master in Clinical Psychology

Child Clinical Psychology

Kingswood, New South Wales, September 2025

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Assessment Process

Client: Michelle Nguyễn

Provisional Psychologist: Kiran Nath

Supervising Psychologist: Dr. John Smith

Date of Assessment: Friday, 5th of September, 2025

Time of Assessment: 4:40 PM

Duration of Assessment: 53 minutes, 40 seconds

Format of Assessment: Telehealth via Zoom

Referer of Assessment: Rebecca Wise, School Counsellor, Kingswood Park High School

1.1 Presenting Problems and Reason for Referral

Michelle was referred for psychological assessment due to persistent anxiety symptoms, declining academic performance, and increasing family conflict. The school counsellor reported verbal altercations with peers, classroom disruptions, and incomplete homework. Michelle attended the assessment stating her parents "forced" her to come, though she acknowledged wanting her voice to be heard within her family system. The referral letter indicated that Michelle feels she is "letting everyone down," suggesting internalized pressure and shame regarding multiple role expectations.

1.2 Home and Family Environment

Michelle lives with her mother, stepfather, and 13-year-old brother in what she describes as a highly conflictual environment. The family system reflects complex dynamics shaped by multiple transitions including parental divorce when Michelle was eight years old due to her biological father's substance use, her mother's subsequent remarriage, and ongoing acculturation tensions between Vietnamese heritage values and Australian contemporary norms. Michelle's biological father is currently in rehabilitation for alcohol and drug use, with no current contact maintained.

Michelle experiences her stepfather as controlling and authoritarian, reporting that "whatever he says, that's what goes" in family decisions. Her mother's role has become peripheral, consistently redirecting Michelle's concerns to the stepfather rather than providing direct maternal support. This family structure creates a double bind where Michelle cannot access maternal support while feeling persistently invalidated by paternal authority. The family's Vietnamese cultural background emphasizes collective harmony, academic achievement, and hierarchical respect, values that create tension with Michelle's developmental need for autonomy and identity formation within Australian adolescent culture.

The clinical significance of these family dynamics extends beyond typical adolescent-parent conflict. Michelle's statement "I feel like I'm letting everyone down" reflects internalized shame stemming from her inability to meet competing cultural expectations while maintaining authentic self-expression. The family system lacks secure attachment relationships, with Michelle reporting emotional distance from both biological and stepfather figures, stating "I don't really mind not having a father" while simultaneously expressing distress about the lack of parental understanding and support.

1.3 Educational and Occupational Functioning

Michelle demonstrates significant functional splitting between academic struggle and occupational success. At school, she reports inability to understand increasingly complex material, particularly since beginning high school. She experiences teachers as dismissive, stating they "just circle it back to me" when she seeks help. The school environment has become increasingly hostile due to persistent bullying from what Michelle describes as "popular girls" who ostracize her while mocking her introversion and academic difficulties. She reports being boycotted by classmates following conflicts with these students, leaving her with only a small group of supportive friends.

Conversely, Michelle thrives in her part-time position as a cook at a fast-food restaurant, a role she has maintained for two years. She receives consistent praise from her supervisor and maintains positive peer relationships in this environment. She explicitly stated that work "feels really great compared to school" and provides crucial self-esteem and financial independence from her stepfather. This functional discrepancy suggests that Michelle's difficulties are context-specific rather than pervasive, indicating environmental factors significantly impact her functioning rather than global capability deficits.

From a cultural perspective, Vietnamese families typically prioritize academic achievement as the primary pathway to success and family honor as per Nguyen & Benet-Martínez (2012). Michelle's academic

struggles represent not just personal failure but perceived family shame, intensifying pressure and anxiety. Her parents' inability to recognize her occupational competence reflects rigid cultural values that may not accommodate alternative definitions of success within the Australian context.

1.4 Substance Usage

Michelle disclosed daily alcohol consumption consisting of two beers after school, beginning at age 14. Initial use was motivated by peer acceptance attempts following bullying experiences, but has evolved to serve anxiety management and emotional regulation functions. She reports alcohol makes her anxiety "vanish" and enables her to "say whatever I wanted," indicating both anxiolytic and disinhibiting effects. This pattern suggests developing psychological dependence, though physical dependence markers were not formally assessed during this initial interview.

The epigenetic vulnerability through paternal substance use history significantly elevates Michelle's risk profile for substance use disorder development as per Merikangas et al. (1998). Her alcohol use occurs within a complex trauma context including witnessed parental conflict during early childhood, effective paternal abandonment, and current family dysfunction. Michelle's concealment strategies, including using mints and careful timing to avoid detection, demonstrate both awareness of parental disapproval and entrenchment of use patterns. She reports experiencing hangovers that affect morning academic performance, creating a cyclical pattern where substance use interferes with the very domain causing distress.

1.5 Relational and Social Functioning

Michelle's romantic relationship with Adrian, also 16 years old, reflects broader attachment patterns characterized by approach-avoidance conflict. Their relationship history of initial connection, six-month breakup, reconciliation, and current "break" initiated by Adrian parallels her inconsistent early attachment experiences. Adrian's unilateral decision to pause the relationship reportedly due to academic pressures triggers abandonment concerns while Michelle's statement about lacking "sense of connection" suggests defensive deactivation of attachment needs.

The hidden nature of this relationship from parents reflects both normative adolescent privacy needs and specific cultural tensions around Vietnamese parental expectations regarding adolescent romantic relationships. Michelle's values around physical intimacy, stating it was "never in my family to have sex before marriage," indicate partial internalization of traditional values despite rejecting other parental expectations. This selective adoption of cultural values suggests active identity negotiation rather than wholesale acceptance or rejection of either cultural framework.

Peer relationships remain limited to a small group of friends whose parents Michelle describes as "way more progressive" than her own. These friends provide crucial support, including covering for Michelle when she wants to socialize by telling her parents they are having "group study sessions." Michelle also enjoys activities with these friends including chess, Monopoly, and basketball, which provide stress relief and normalizing adolescent experiences.

1.6 Symptomatology of Psychopathology

Michelle presents with pervasive anxiety across multiple domains including academic performance, peer relationships, family interactions, and identity formation. Her anxiety manifests somatically through sleep disturbance and concentration difficulties, and behaviorally through alcohol use and social withdrawal. The anxiety appears both reactive to environmental stressors and internalized as persistent worry about meeting others' expectations.

Sleep patterns reveal severe disruption with Michelle reporting 3 to 5 hours of sleep nightly, with bedtimes between 2:00 and 4:00 AM. She engages in prolonged phone use and ruminates about interpersonal conflicts, particularly after parental arguments. While Michelle denied current depression, her presentation suggests subsyndromal depressive features including anhedonia evidenced by lost interest in previously enjoyed reading, social withdrawal beyond her small friend group, and persistent negative self-concept.

Eating behaviors indicate body image concerns with controlled diet to avoid weight gain. Michelle reported being bullied for acne and fears additional bullying if she gains weight. While not meeting criteria for an eating disorder, these concerns warrant monitoring given their interaction with anxiety and self-esteem issues.

1.7 Risk Assessment

Michelle denied current suicidal ideation, self-harm behaviors, or homicidal ideation during the assessment. Protective factors include future orientation, work satisfaction, supportive friend network, and demonstrated help-seeking capacity despite ambivalence. Risk factors include daily alcohol use, significant family conflict, social isolation at school, academic failure, and paternal substance use history. Current risk appears low to moderate, requiring ongoing monitoring particularly given the accumulation of stressors and limited coping strategies beyond alcohol use.

2

Treatment Process

2.1 Clinical Impression

Michelle provisionally presents with Adjustment Disorder with mixed anxiety and depressed mood (F43.23) in the context of significant family dysfunction and acculturation stress. Her difficulties reflect systemic family problems rather than individual pathology, indicating family-based intervention as the primary treatment approach. Differential considerations include monitoring for potential Alcohol Use Disorder development and Social Anxiety Disorder features.

2.2 Evidence-Based Treatment

The following intervention plan draws from the California Evidence-Based Clearinghouse for Child Welfare (CEBC) registry and follows the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework as per Aaron et al. (2010).

Table 2.1: *Five-Session Intervention Plan Using Brief Strategic Family Therapy*

Session	Participants	Objectives	Key Activities	Rationale
2	Michelle (30 min), then parents (30 min)	Complete assessment; Provide psychoeducation; Establish alliance	Administer DASS-21 and Acculturative Stress Scale; Psychoeducation on anxiety-alcohol connection; Introduce BSFT framework to parents	Following BSFT joining phase, builds alliance while gathering baseline data and reducing blame through education
3	Full family	Identify interaction patterns; Map family structure	Conduct enactment exercise observing family discussion; Create family genogram with immigration history; Identify repetitive problematic sequences	Direct observation provides richer data than reports; Understanding patterns precedes change attempts
4	Michelle and parents	Restructure communication; Address cultural gaps	Practice adapted I-statements for hierarchical context; Develop cultural compromise contracts; Role-play validation before limit-setting	Targets specific interactions while respecting cultural values and preserving parental authority
5	Michelle (20 min), family (40 min)	Consolidate changes; Address substance use; Safety planning	Develop anxiety management strategies; Collaborative problem-solving exercise; Create family safety plan; Schedule maintenance sessions	Ensures changes transfer beyond therapy while addressing risk factors within family context

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Table 2.1 – *Continued from previous page*

Session	Participants	Objectives	Key Activities	Rationale
6	Full family	Review progress; Adjust interventions; Plan sustainment	Review contract compliance; Adjust agreements based on outcomes; Develop long-term maintenance plan	Promotes sustained change and prevents relapse to previous patterns

3

Therapeutic Process

3.1 Cultural Compromise Contract

The Cultural Compromise Contract represents a structured negotiation exercise where family members develop written agreements honoring both Vietnamese cultural values and Australian adolescent developmental needs. This concrete, visual tool transforms abstract cultural conflicts into tangible, manageable agreements.

The activity's primary objective involves creating specific, measurable agreements that balance Michelle's autonomy needs with parental values, thereby reducing daily conflicts while preserving family harmony and cultural identity. This approach addresses the core tension identified during assessment, specifically the competing cultural expectations creating impossible binds for Michelle. Rather than forcing choice between cultures, this intervention validates both perspectives simultaneously.

The theoretical rationale draws from research on bicultural competence demonstrating that youth who successfully integrate both cultures show better psychological adjustment than those forced to choose between cultural frameworks as per Nguyen & Benet-Martínez (2012). The written format appeals to Vietnamese emphasis on formal agreements while the negotiation process reflects Australian democratic values, creating a paradoxical intervention satisfying both cultural frameworks simultaneously.

Implementation begins with a ten-minute introduction explaining that both Vietnamese values of family harmony, respect, and academic achievement and Australian values of independence, self-expression, and peer relationships contain wisdom. The therapist frames this as a "both/and" rather than "either/or" situation. During the subsequent fifteen-minute values clarification phase, each family member lists their top three values regarding the issue being negotiated. Parents might prioritize safety, reputation, and academic focus, while Michelle might emphasize trust, social connection, and independence.

The proposal development phase requires each party to write specific proposals over ten minutes. For instance, regarding social outings, Michelle might propose going out with friends Friday nights until 11:00 PM, while parents might propose completing homework first, returning by 9:00 PM, and calling when arriving and leaving locations. The fifteen-minute negotiation phase utilizes the therapist as cultural mediator to find middle ground, perhaps agreeing to Friday nights until 10:00 PM if homework is completed, with 11:00 PM permitted once monthly for special events, and text updates every two hours.

The final ten minutes involve writing a formal contract specifying agreements, duration for trial period, review date, natural consequences for violations, and rewards for compliance. This document becomes a living agreement that can evolve as trust builds and responsibility is demonstrated.

The developmental appropriateness for a 16-year-old involves providing scaffolded independence through freedom within boundaries that can expand over time. The concrete nature suits adolescent cognitive development by making abstract concepts tangible and negotiable. Cultural adaptation respects Vietnamese preference for clear hierarchies and explicit agreements while the negotiation process honors Australian egalitarian values. The parents maintain authority as contract signatories while Michelle gains voice in creating terms, with the therapist serving as an educated intermediary respecting both cultural frameworks.

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Reflection Process

4.1 Areas of Strength

During this initial assessment, I successfully established rapport with Michelle despite her stated reluctance to attend therapy. My opening approach acknowledging she had not seen a psychologist before and explaining confidentiality in accessible terms helped reduce initial resistance and established a foundation of transparency. I demonstrated cultural sensitivity by allowing Michelle to share her perspective on family dynamics without immediately pathologizing Vietnamese parenting styles, recognizing these as acculturation tensions rather than dysfunction requiring correction.

4.2 Areas of Professional Development

Reflecting on this session, I recognize several areas requiring development in my clinical practice. I could have explored Michelle's strengths more systematically throughout the assessment. While she mentioned work success, I did not fully investigate what specific skills or qualities contribute to this achievement, representing a missed opportunity for strength-based intervention planning that could build self-efficacy and hope.

My exploration of protective factors was insufficient for comprehensive risk assessment. I should have asked more about her friendship network dynamics, specific coping strategies beyond alcohol use, and cultural strengths within her family system that might serve as resources for intervention. When Michelle mentioned friends with "progressive" parents, I could have explored these alternative family models as potential sources of support or mentorship.

I notice I did not adequately assess Michelle's readiness for change or explore her own goals beyond wanting to be "heard" by her family. Questions exploring what specific changes she would like to see and what she might be willing to do differently could have elicited more collaborative treatment planning and increased engagement. Additionally, I could have been more curious about her experience as a Vietnamese-Australian teenager navigating dual cultural identities, exploring sources of pride and connection rather than focusing primarily on conflicts.

The risk assessment, while covering immediate safety concerns, could have explored protective factors more thoroughly to provide a more balanced clinical picture. I also recognize that my closing felt somewhat rushed, and I could have spent more time ensuring Michelle felt heard and validating her courage in attending despite her reluctance and ambivalence about therapy.

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Appendices

ASSESSMENT NOTES

Session Date: 5/9/25, 4:30pm, Telehealth

HOME AND ENVIRONMENT DOMAIN

Lives with mother, stepfather, younger brother age 13. Reports "always having arguments" regarding school, clothes, going out, boyfriend. Stepfather "controls everything" with mother deferring decisions to him. Biological father has alcohol and drug history, currently in rehabilitation with no contact. Parents divorced when Michelle was 8-9 years old, witnessed significant parental fights. Vietnamese family described as "conservative" with clash against Australian culture. Michelle feels unable to be herself, states she is "letting everyone down." Reports no safe space at home, prefers being outside home.

EDUCATION AND EMPLOYMENT DOMAIN

Attends Kingswood Park High School with significant academic struggles. Cannot understand material, experiences teachers as "not helpful." Bullied by "popular girls" through verbal harassment and ostracizing. Maintains small friend group but anxious about friendship stability. Works part-time as cook at fast food restaurant for 2 years. Reports being "really good at it" with praise from boss. Met boyfriend Adrian at work. Enjoys work and feels competent there.

ACTIVITIES AND PEER RELATIONS

Spends time at friends' houses where she experiences "freedom" with supportive parents. Enjoys chess, Monopoly, and basketball with friends. Previously enjoyed reading but now feels "too much reading already." Friends help cover for her by saying "group study" to parents. Avoids most peers due to bullying. Reports being boycotted by classmates after conflicts.

ALCOHOL AND DRUGS DOMAIN

Started alcohol use at age 14 initially due to peer pressure. Currently consuming 2 beers daily after school. Reports "anxiety vanished" when drinking and helps her "say what I want." Hides use from parents using mints and careful timing. Experiences hangovers affecting morning classes. Father's substance use history noted as risk factor.

RELATIONSHIPS AND SEXUALITY

Boyfriend Adrian age 16, met at work. On and off relationship, currently ”on break” initiated by him stating he doesn’t ”have time.” Relationship hidden from parents. No sexual activity reported, states ”not before marriage” aligning with family values. Worried relationship might end permanently.

MENTAL HEALTH SCREENING

Anxiety: ”worried all the time” about school, appearance, peers. Sleep: 2-3am bedtime, 7am wake resulting in 3-5 hours sleep. Stays up on phone, ruminating about fights. Worse after parent arguments when sleeps only 3 hours. Eating: Controls diet, doesn’t want to ”get fat.” Already bullied for acne, has weight concerns. Denied suicidal ideation, self-harm, or homicidal ideation. Denied current depression but low mood evident in presentation.

RISK ASSESSMENT

Protective factors identified: Work success, friend support, future-oriented thinking. Risk factors identified: Daily alcohol use, family conflict, social isolation, academic failure, paternal substance use history. Current risk assessed as low to moderate. Denied current suicidal ideation or self-harm behaviors.