SAMPLE PSYCHOTHERAPY SOAP NOTE

ONCOLOGY PSYCHOTHERAPY — STAGE IV CANCER, EXISTENTIAL DISTRESS

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Miriam L. Osei

DOB
07/28/1956

AGE / SEX
69 / Female

CREDENTIALS
PhD, Licensed Clinical Psychologist (CA License PSY-24881)

SESSION DURATION
50 minutes

DATE OF SERVICE
05/09/2026

PROVIDER
Dr. Yolanda Carter, PhD — Clinical Psychology / Oncology Psychotherapy

MRN / PATIENT ID
ADIME-2026-0614

VISIT TYPE
Individual Psychotherapy — Follow-up Session, Inpatient Oncology

CARE SETTING
Inpatient Oncology Unit — Hospital Day 7; Cycle 3 carboplatin/paclitaxel, platinum-resistant stage IV ovarian cancer

CC CHIEF COMPLAINT

2 PRIMARY PSYCHOTHERAPY CONCERN

> *'I don't know how much time I have left. I'm scared. I've been trying to be strong for Abena but I'm tired of pretending.'*

Mrs. Osei was referred for inpatient oncology psychotherapy by Dr. Priya Kapoor (Medical Oncology) after nursing staff reported she was 'crying alone at night and refusing visitors.' This is Session 3 of a brief inpatient psychotherapy engagement. A secondary concern was raised today for the first time: 'I need to make sure my grandchildren remember me. I need to leave something behind.' This opens an avenue for legacy work, a core oncology psychotherapy intervention for end-of-life preparation.

S SUBJECTIVE

3 PATIENT-REPORTED SYMPTOMS & HISTORY

3a CURRENT SYMPTOMS

- **Anxiety / death anxiety:** Dominant presenting concern. 'I think about dying every day now. Not like before when it was abstract — now it feels close.' Wakes at 2–3 AM with intrusive thoughts about what dying will feel like. Not panic attacks (no tachycardia, no breathing difficulty) — anticipatory and death anxiety, a normative and primary clinical concern in advanced cancer.

- **Depression:** PHQ-9 not formally administered today (too fatigued). Clinical impression: moderate depressive features. Anhedonia partially intact (still shows pleasure discussing her daughter and grandchildren). Tearfulness frequent but not continuous. Hopelessness: 'I know this cancer isn't going to go away... I know my body.' Not demoralized in the helplessness sense — she retains agency over how she approaches this.
- **Fatigue:** Profound — 'The chemo has taken everything. I sleep 18 hours a day.'
- **Nausea:** Significantly improved from Day 1–2 (1/10 today vs 8/10 at peak). Ate ~30% of her breakfast tray.
- **Appetite:** Slowly improving with antiemetic optimization. Drank 6 oz vanilla Ensure Plus during the session.

3b ONSET, COURSE & FUNCTIONAL IMPACT

- **History:** Diagnosed with ovarian cancer January 2024 (16 months ago). Completed first-line carboplatin/paclitaxel ×6 cycles (2024) with partial response, then bevacizumab maintenance. Recurrence confirmed January 2026 — platinum-resistant. Psychotherapy referral came at this admission (May 2026).
- **First mental health support:** No formal support prior to this admission — 'In my family, in my culture, you don't talk about these things. You pray and you keep going.' This session marks a significant shift — she is actively choosing to speak about her fears for the first time.
- **Functional impact:** Profoundly limited. Bedbound due to chemotherapy fatigue and weakness. Cannot cook, clean, or care for herself. Cannot travel (canceled a planned April 2026 trip to Ghana due to disease progression). Primary source of meaning and identity: family and faith.

3c STRESSORS, TREATMENT PROGRESS & SAFETY

- **Stressors:** (1) Disease progression — platinum-resistant ovarian cancer with peritoneal carcinomatosis; she understands the serious prognosis. (2) Witnessing Abena's distress — 'I am the one dying but I am also worried about her' (a 'double grief'). (3) Unfinished business — the grandchildren legacy concern raised today. (4) Nausea, weight loss, and physical deterioration — 18% weight loss since January. (5) Cultural context — Ghanaian/Christian background; she processes illness through faith ('God has a plan') and cultural stoicism.
- **Treatment progress:** Session 1 — established therapeutic relationship; spoke mostly about her daughter; cried briefly; allowed herself to be heard. Session 2 — began discussing her fears (pain, being a burden, losing control). Session 3 (today) — first disclosure of the grandchildren legacy concern; she is ready for legacy and meaning-making work.
- **Safety:** No SI, HI, or self-harm. C-SSRS not administered (fatigue; rapport-based assessment): no ideation. 'I am not going to hurt myself. I am fighting to stay as long as I can.' A direct protective statement.

ROS BEHAVIORAL HEALTH REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Depression / anhedonia / hopelessness:** POSITIVE — moderate depressive features; anhedonia partially present; hopelessness regarding prognosis but does NOT generalize (retains hope for meaningful time and being remembered)
- **Anxiety / death anxiety:** POSITIVE — primary presenting concern; death anxiety normative in advanced cancer and the core therapeutic target; no panic disorder; no phobia
- **Sleep disturbance / nightmares:** POSITIVE — early morning awakening (2–3 AM) with intrusive thoughts about dying; no trauma-related nightmares; no PTSD features
- **Appetite / weight change:** POSITIVE — profound weight loss (18%); appetite improving slightly with antiemetic optimization; eating ~30% of meals today (up from <10% on admission)

- **Irritability / anger:** MILD POSITIVE — occasional frustration at the situation, not people. 'I am angry that this is happening. I did everything right.' Existential anger, not interpersonal aggression
- **Hallucinations / paranoia / delusions:** NEGATIVE — reality testing fully intact; no perceptual disturbances; no distorted illness beliefs
- **Substance use:** NEGATIVE — no alcohol, tobacco, or other substance use; never a smoker
- **Trauma symptoms / PTSD:** NEGATIVE — no PTSD symptoms; hospitalization is frightening but not re-experienced; no hypervigilance or avoidance beyond illness-appropriate concerns
- **Suicidal ideation / self-harm:** NEGATIVE — directly assessed; no ideation; strong desire to live; protective factors: daughter, grandchildren, faith, active treatment pursuit
- **Concentration / executive function:** MILD POSITIVE — chemotherapy-related cognitive slowing ('chemo brain'); difficulty completing sentences at times; expected and transient

O OBJECTIVE / MENTAL STATUS EXAMINATION

5 MSE

APPEARANCE

Lying in hospital bed, HOB at 30°. Hospital gown, neat. Appears ~stated age of 69 but visibly thin — temporal wasting visible. Hair thinning (taxane effect). IV access right arm in use. Alert and tracking from the beginning.

BEHAVIOR

Cooperative and engaged. Eye contact consistent and direct — an improvement from Session 1 (downward gaze much of the time). Psychomotor mildly slowed secondary to fatigue. No agitation. Held her rosary throughout the session.

SPEECH

Rate mildly slowed due to fatigue. Volume soft but not whispering. Fluency intact. Articulation clear. Coherence fully intact. Spontaneity improved from Session 1 — she initiates topics today without prompting.

MOOD

'Scared. But I feel a little better today — it helps to talk.' Dysphoric but with genuine moments of warmth and humor. Self-deprecating comment about appetite: 'Can you believe I actually finished an Ensure? I hate it but I finished it.'

AFFECT

Range broader than prior sessions — able to access humor, warmth (grandchildren), and sorrow (prognosis) within the same session. Reactivity present and appropriate. Congruent throughout.

THOUGHT PROCESS

LINEAR and goal-directed. No tangentiality, loose associations, or disorganization. Moves naturally between topics with appropriate transitions.

THOUGHT CONTENT

No SI (directly assessed). No HI, delusions, or paranoia. Primary content: death anxiety, legacy concern (grandchildren), grief about physical decline, concern for daughter's grief, and faith as a coping resource. All reality-based and clinically appropriate.

PERCEPTION

No hallucinations, illusions, dissociation, or depersonalization.

COGNITION

Alert and oriented ×4. Attention sustained throughout the 50-minute session. Memory intact for current and prior session content (recalled Sessions 1–2 accurately). Processing speed mildly slowed (pauses mid-sentence — fatigue and chemo-brain).

INSIGHT

GOOD — understands her diagnosis, its gravity, and the role of psychological support. 'I think I've been carrying all of this alone for too long.'

JUDGMENT

INTACT — making thoughtful, informed decisions about

her care and family relationships. Pursues active treatment while beginning to prepare for end-of-life.

SAFETY

No acute safety concerns. No SI. See risk assessment section.

RA RISK ASSESSMENT

7 RISK LEVEL

- **Suicidal ideation:** ABSENT. Direct assessment via rapport-based interview (C-SSRS not formally administered due to fatigue): 'I am not going to hurt myself. I am fighting to stay as long as I can.' Reflects active therapeutic engagement with life. No passive death wish distinct from illness-appropriate acceptance of prognosis.
- **Means access:** None beyond what is present in the hospital room (IV medications hospital-controlled). No prior suicide attempts or self-harm history.
- **Self-harm / homicidal ideation:** Absent.
- **Demoralization:** Present but NOT hopelessness in the Snaith sense — she retains a sense of personal agency and meaning-making even with an incurable illness. This distinction matters: demoralization in advanced cancer responds to meaning-making interventions (which we are providing), while major depression may require pharmacologic treatment.
- **Overall risk level:** LOW. Protective factors: strong daughter relationship (Abena present daily), active religious faith, grandchildren as primary legacy concern, desire to live as long as possible and remain conscious and present, and active treatment pursuit.
- **Monitoring:** Weekly while inpatient. After discharge home, establish outpatient oncology psychotherapy link at MD Anderson (coordinating with oncology transfer).

IN INTERVENTIONS PROVIDED

8 PSYCHOTHERAPY INTERVENTIONS THIS SESSION

1. **Meaning-Centered Psychotherapy (MCP) — primary modality today:** Introduced the concept of 'legacy' explicitly for the first time. Asked: 'What do you want your grandchildren to know about you?' She became tearful — 'That I was strong. That I loved them. That I always put my family first.' Collaborated on concrete legacy activities achievable within her functional limits: (a) voice recordings or letters to each grandchild (ages 8, 11, 14); (b) a 'memory box' with photos and small personal items; (c) recording a Ghanaian folk story from her childhood ('My mother told me this story. I want them to hear it in my voice.'). She became visibly animated describing the folk story — the highest level of spontaneous engagement observed in 3 sessions.
2. **Supportive psychotherapy — validation and presence:** Validated the depth and legitimacy of her death anxiety without pathologizing it: 'Being afraid of dying when you have a serious illness is one of the most human experiences there is… It means you love life.' She responded: 'I needed someone to say that.'
3. **Cognitive reframing — daughter's grief:** Gently explored the burden she feels about Abena's grief. Offered reframe: 'Abena's tears are not your burden — they are her love for you.' She sat with this silently, then: 'I hadn't thought of it that way.' A brief but genuine cognitive shift.

4. **Existential work — death anxiety:** Introduced brief mindfulness-based present-moment focus for anticipatory anxiety. Practiced together: 3 breath cycles, focus on what is here now ('Right now, I am in this room. I am talking to someone. I drank my Ensure. I thought of my grandchildren.'). Completed 3 cycles without distress; will build on this in Session 4.
5. **Care coordination:** Notified Angela Torres, RDN, that the patient consumed 6 oz Ensure Plus during the session (positive nutrition update). Notified Dr. Kapoor (oncology) that psychological distress is improving and legacy work has begun — relevant to goals-of-care discussions if they arise.

RI RESPONSE TO INTERVENTION

9 PATIENT RESPONSE

- **Engagement:** Best session engagement across 3 sessions. She initiated topics, showed emotion, laughed briefly, and ended with a request: 'Can you come back tomorrow?'
- **Legacy work:** Highly responsive. The folk-story idea was her own and generated the highest positive affect of any session — a meaningful therapeutic breakthrough she can begin from her hospital bed (recording on a smartphone; Abena to facilitate).
- **Death anxiety intervention:** Validated the anxiety without eliminating it (co-existence with anxiety while maintaining meaning is the goal). At the end: 'I am still scared. But I feel less alone with it.' This is the therapeutic target.
- **Cognitive reframe:** The daughter's-tears reframe was received and integrated. She repeated it in her own words: 'Her love. Not my burden.'
- **Mindfulness:** Completed 3 breath cycles without distress or disengagement — good initial response.
- **Nutrition:** Drank 6 oz Ensure Plus during the session without prompting — an indirect indicator of improved comfort and engagement.

A ASSESSMENT

10 PSYCHOTHERAPY CLINICAL INTERPRETATION

- **Primary diagnosis:** Adjustment disorder with mixed anxiety and depressed mood (F43.23) — acute, in the context of advanced platinum-resistant ovarian cancer. Secondary: existential distress and death anxiety appropriate to prognosis (a normative crisis requiring therapeutic support, not a diagnosable disorder per se).
- **Current status:** IMPROVING. Across 3 sessions: increasing engagement, decreasing guardedness, increasing spontaneous positive affect, and first engagement with legacy and meaning-making work — a positive therapeutic response.
- **Clinical interpretation:** Mrs. Osei is in an existential crisis that is both psychologically appropriate (life-threatening illness) and therapeutically addressable. She is not in a major depressive episode — anhedonia is partial, reactivity preserved, and capacity for joy and humor intact (attenuated by fatigue). Primary needs: (1) a safe space to be afraid without protecting others; (2) meaning-making and legacy work leveraging her cultural and familial identity; (3) tools for managing anticipatory death anxiety without suppressing it. All three in progress.

- **Medical necessity:** Continued oncology psychotherapy is medically necessary — psychological distress in advanced cancer directly impacts treatment tolerance, adherence, and quality of life; untreated existential distress is associated with worse palliative outcomes.

P PLAN

11 ONGOING PSYCHOTHERAPY MANAGEMENT

1. **Legacy work (primary focus):** Session 4 — facilitate the first voice recording for grandchildren. Abena to bring a smartphone tomorrow. Provide simple prompts: 'Tell them about the folk story.' 'Tell them what you love about being their grandmother.' Achievable from a hospital bed with minimal physical effort.
2. **Meaning-Centered Psychotherapy:** Continue the MCP framework for remaining inpatient sessions (estimated 3–4 more before discharge). Introduce Viktor Frankl's concept of 'choosing our response' adapted to her context: 'You cannot choose that you have cancer. You can choose what you do with the time you have.'
3. **Death anxiety management:** Expand mindfulness to 5 cycles in Session 4. Introduce simple cognitive grounding for the nighttime 3 AM intrusions.
4. **Coordination with palliative care:** Recommend Dr. Kapoor initiate a formal palliative care consultation if not already in place. Psychotherapy and palliative care work synergistically; psychotherapy is not a substitute for palliative symptom management.
5. **Outpatient transition:** Coordinate with the MD Anderson transfer (05/22/2026 consultation) — identify an MD Anderson psycho-oncology service for continuation. Goal: establish outpatient psychotherapy continuity before discharge.
6. **Caregiver support:** Abena should be offered her own support session separately — she has been exclusively supporting her mother and has her own grief. Will coordinate with Dr. Park, LCSW (social work).

F FOLLOW-UP

12 REASSESSMENT PLAN

Next session 05/10/2026 (tomorrow, inpatient — daily while admitted). Focus: facilitate the first voice-recording legacy activity; continue death anxiety work; PHQ-9 adapted when clinically feasible. Discharge planning: establish MD Anderson psycho-oncology continuity before hospital discharge (estimated 05/12–05/14/2026).

TIME DOCUMENTATION & BILLING

TOTAL TIME
50 minutes

COUNSELING / COORDINATION TIME
10 minutes (coordination with oncology, nutrition, social work)

CPT / E/M CODE(S)
90837 — Psychotherapy, individual, 53+ minutes

BASIS FOR BILLING
Time-based individual psychotherapy

PRIMARY ICD-10 CODE
F43.23 — Adjustment disorder with mixed anxiety and depressed mood

SECONDARY ICD-10 CODE(S)
C56.9 — Malignant neoplasm of unspecified ovary; E43 — Severe protein-calorie malnutrition

PROVIDER SIGN-OFF

CLINICAL PSYCHOLOGIST	CREDENTIALS	SPECIALTY	DATE	TIME
Yolanda Carter, PhD	PhD, Lic. Clinical Psychologist (PSY-24881)	Oncology Psychotherapy	05/09/2026	2:50 PM