Free case study on psycho trauma report

Family, Father

Part 1 Traumagram

Information from traumagram and discussion about it with the client

- Family history for three generations of traumatized family members and mental illness
- Paternal Grandfather James b. 1925d. 1993
- James traumatized
- James died of liver problems
- Paternal Grandmother Mary b. 1929d. 2011
- Paternal Grandmother mentally ill (cruel at times, loving at times)
- Grandmother on father’s side traumatized grandfather and her children with verbal and psychological abuse
- Father Ricky b. 1995d. 2010
- Father traumatized
- Father became alcoholic in late teens
- Father mental illness (? does not know the type)
- Mother Louise b. 1955
- Louise traumatized by stepmother
- Mother traumatized children and husband
- Mother has mental illness
- Mother has always had medical problems
- Does not know if mother had addictions
- Does not know very much about grandparents especially on mothers side
- Family has many secrets about their past (grandparents and parents do not reveal information
- Mother’s side big mystery does not know her maternal grandmother,

grandfather or step grandmother. Only knows grandfather died of liver failure due to alcoholism, mother died young from a disease, step-mother was cruel to mother

- Brother Jessie b. 1973d. 2014 (died early in the year)
- Brother Jessie traumatized by parents
- Brother seemed to have deep depression
- Brother smoked marijuana every day for years
- Brother many physical ailments
- Brother self medicated with drugs from pharmacy for allergies and maybe other things
- Brother abusive
- Brother workaholic
- Sister Linda b. 1980
- Linda traumatized by parents
- Sister was estranged from client due to parents
- Sister seems good now but maybe problems with alcohol (another mystery)

- Sister has had bouts with depression
- Sister workaholic
- After death of father making contact with sister
- During childhood very close to brother but ended up with different values
- Mother and father did not love me and were very seldom kind to me
- Was not allowed to leave bedroom very often, until 17 years old and demanded to go out with local friends
- Loved maternal grandmother dearly but by the time she died she was

delusional and clearly crazy; awful to see her, painful

- Loved paternal grandfather dearly but he barely spoke, ever
- Parents relationship was terrible
- Father had many girl friends and spent all his money on women and alcohol

- Mother worked hard to pay bills
- Mother never satisfied, even with perfection

Part II

PSYCHOTRAUMATOLOGY EVALUATION – SAMPLE REPORT

IDENTIFYING INFORMATION:

Ms. C is a 42 year-old single, Caucasian, female. She presented herself for evaluation on February xx, March xx, April xx. She lives independently in an apartment she rents in City, Province/State. She has held a job for two years but may be eligible for the province's Disability Pension. She was self-referred after discussion with her general physician and her psychologist who runs her support group. She became extremely depressed and barely able to leave her apartment after the death of her brother early this year.

PAST HISTORY:

Ms. C could not answer many of the questions from her past history. Her family seemed to have many secrets. Therefore not all the facts contributing to her recent traumatic period are available. Her family on both the maternal and paternal side has a three generation history of alcoholism and mental illness. She is the only one in her family that has been involved in recovery and psychological mental health work. Ms. C and her brother and sister

received constant verbal and often physical abuse from their mother and father. Throughout her childhood she talks about remaining invisible in order to stay safe. She was called the bad seed, the bastard, etc. and not allowed to leave the house or yard except to go to school. In her teenage years she began having excruciating headaches and would not be able to leave her room from two to three days each week. She received a beating from her father (at her mother's urging) when she was 17 or 18 years old that damaged her face. She did not see a doctor and was not allowed to leave the house for about two weeks. She left home and did not see her parents or brothers or sisters again for seven years. She had several jobs and took some classes at different colleges. She had friends who were involved in smoking marijuana, using cocaine and LSD. She tried marijuana and LSD. She started using marijuana regularly to remain part of a group of people. She refuses to talk about her any history about her sexual activity. She has been using old prescriptions to purchase anti-depressants and pain pills at different pharmacies. She has been in AA for ten years and has not had a drink for almost ten years.

CHIEF COMPLAINT:

After her brother's death she has felt an overwhelming sense of guilt that she should have died and not her brother. She is having memories from the past that cause her to cry for several hours at a time. She shifts to times when she works seven days a week with little sleep that end in periods of crying fits. She says she has not tried to kill herself, because when she starts thinking about that she sits in one place not doing anything for hours or days until the feeling passes. She is in a support group for obsessive behaviors.

Her symptoms include depression, obsessive behavior, anxiety and deep feelings of guilt. Feelings of humiliation.

MEDICATION: Effexor, anti-depressant, from old prescription. 300 mg/day.

FAMILY HISTORY:

Her paternal grandmother descended in to worse and worse and worse fits of depression and violence before she died. Her mother, brother and sister also struggle (struggled) with depression. Her father was an alcoholic and slept with many women at their house or would not come home at night. Her sister and brother use (used) illegal drugs, mostly marijuana and alcohol. Her mother used combinations of prescription drugs to self-medicate.

PROBLEM LIST:

The client has Type I Trauma due to physical and mental abuse during childhood and young adulthood. Memories of extreme events were triggered when her brother died. She has agoraphobia, depression, and bipolar events.

Intrusive symptoms (B): flashes of past memories, nightmares with screaming, some sleep walking, feels guilty for death of brother and continually thinks about the past and how she could have ‘ saved him’

Avoidant symptoms (C): ability to leave her apartment and go to work has been decreasing, she does not answer phone or go out of house except to work, misses work often. Feels ostracized and like she is a bad person who must be kept apart from other people. Views herself as an observer not an actor in the world

Arousal symptoms (D): her supervisor at work has triggered feelings of rage

since the death of brother, which causes worry and increasing anxiety over fear of losing job. Easily irritated, easily frightened. Very jumpy.

Victim mythology: Wants to feel safe, feeling safe is her number one survival concern. Has been able to go to support group and finally gained courage to come for help. Has trouble going to work but once there work triggers workaholicism and she works extra hour and weekend to make up for past absences. Feels she needs to do extra to prove herself as good as the other workers.

Findings:

CAPS = borderline for PTSD

DES = 22 not a significant level of disassociation

DRS = 50 some identity confusion

GCS = 89

LEC = 12/17

PCL = reacting as PTSD

SCL-45 = 120 (more than moderate strees)

Trauma Treatment Diagnostic Algorithm:

SCL-45 > 100, DRS > DES Must work to stabilize condition before beginning trauma therapy. Medication needs to be appropriate and stabilized.

Assessing and Responding to Suicidal Intent

Mental Status:

Axis I: depression, agoraphobia, PTSD

Axis II: no, (possible bipolarism symptoms, must be monitored)

Axis III: high blood pressure, overweight, poor nutrition, stomach problems

(ulcer possible)

Axis IV: poor relationships, rage, self-harm ideation

Axis V. GAF 60

70 (highest in last 3 months)

Criteria for recovery:

The client needs to have the correct medication prescribed and she needs to follow the instructions for taking the pills. She is not doing well on Effexor, so dose may be too low. may need mild sleeping aid, venlafaxine and quetapine might be a good treatment. She needs medicine for her stomach. Keeping a journal and practicing mindfulness exercises.

TREATMENT PLAN:

Arousal Reduction: learn full body scan, visualization of her safe place, learn grounding exercises

Trauma Work: Cognitive Processing Therapy, Behavior change rehearsal (for problems at work)

Focal Psychotherapy: Client needs to understand that she can set boundaries in her relationships, and she must do so. The trauma needs to be repaired, perhaps with cognitive restructuring to help her understand reality of safety.