Journal Article

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Abstract

The theoretical eclectic model presented discusses a thorough and comprehensive assessment using a bio-psycho-social-spiritual model with the primary theoretical approach of Cognitive Behavior Therapy (CBT). From the literature review presented conclusions are drawn about exposure therapy being the most effective form of treatment for PTSD and CBT as the most effective approach. Protocols for treatment are established for a case study of a complicated case of PTSD where the patient experienced three traumatic events on the same night; a car accident, a stillbirth, and the threat of losing her own life as a result of the stillbirth. Careful development of empirically-based treatment protocols is presented with a new treatment approach called The Phenomenon of Hope which uses spirituality and hope resulting in significant reduction of symptoms of PTSD.

*Keywords:* PTSD, Cognitive Behavior Therapy, Exposure Therapy, car accidents, stillbirth, Phenomenon of Hope, Treatments

Journal Article of Post-Traumatic Stress Disorder

**Introduction of Theoretical Eclectic Model**

This journal article discusses the importance and value of a theoretical model that is eclectic, integrating various models that collaborate in conducting a comprehensive and ethical assessment. The theoretical integration of various models of psychotherapy is considered among best practices because it draws several empirically supported models and evidence-based practices according to the needs, diversities, and complexities of each client individually (Corey 2009, p. 448-449). The clinician needs to be aware of any biases that may interfere with the diagnosis and treatment in order to prevent any unethical issues interfering with an objective assessment and treatment (Corey 2009, p.25). Therefore, the responsible integration of various theoretical models ensures the client will have an appropriate and ethical treatment.

The primary theoretical orientation this clinician has selected is Cognitive-Behavior Therapy (CBT) based on empirical evidence indicating that CBT is found to be effective in significantly reducing symptoms as well as achieving sustained remission when treating post-traumatic stress disorder and other disorders such as depressive and anxiety disorders (Basco, Glickman, Weatherford, & Ryser, 2000). CBT is also used in combination with other techniques and approaches when appropriate such as Developmentally Based Psychotherapy, Client-Centered therapy, and Psychodynamic approaches. The selection of this eclectic approach will vary according to the needs of the client and the symptom presentation to ensure an ethical and objective treatment format that will help the client achieve his or her counseling goals.

The elements that comprise the comprehensive assessment as part of this theoretical eclectic model include a bio-psycho-social-spiritual assessment, case conceptualization, DSM-5 diagnosis, measurable treatment planning, empirically based treatment, aftercare planning, and outcomes assessment which will be further explained in the following sections.

**Personal Model of Ethical and Effective Bio-Psycho-Social-Spiritual Assessment**

In order to conduct a responsible assessment it is important to consider a holistic view of the client’s needs and functioning, by obtaining knowledge and understanding of the primary dimensions of the individual which are biological/physical, psychological/emotional, social/cultural and spiritual (Corey 2009, p.8). Consequently, this evaluation will lead to carefully select the various models, techniques and strategies that would encompass the personal theoretical eclectic model of treatment.

The therapist has the responsibility to understand the dynamics of symptom presentation and its interactions with the signs observed by the therapist during the diagnostic interview in order prevent a misdiagnosis (Nussbaum 2013, p.4). To ensure the ethical assessment, diagnosis and treatment of a client it is vital to conduct a comprehensive Bio-Psycho-Social-Spiritual-Assessment.

The selection of the diagnostic model is important because it contributes to the the systematical assessment preventing any misdiagnosis that may put the client’s health and treatment at risk (Foa, Keane, & Friedman 2000, p. 23, 74). A significant factor contributing to a successful diagnostic exam is the therapeutic alliance with the client since it determines the client’s engagement, the amount and quality of data provided, and it sets the tone for the therapeutic process that will follow (Nussbaum 2013, p. 13-20).

This therapist has selected a semi-structured diagnostic interview technique due to being considered the “gold standard technique for diagnosing psychiatric disorders”(Wisco, Marx, & Keane, 2012). Through this form of interview, the clinician is able to obtain relevant information needed to determine an accurate diagnosis as well as reducing the number of diagnosis attributed (Nussbaum 2013, p. 39). This form of interview allows the patient to identify and express his or her symptoms and reactions openly facilitating the clinician’s adequate gathering of information to determine if there is additional clinical or medical situations that may need attention (Nussbaum 2013, p. 33-39). Using severity ratings, screening tools, the Socratic method and the free expression of the client provides insight into other areas that may need clinical attention (Nussbaum 2013, p.33-39)

**Biological Assessment**

A medical examination is important in the assessment process to rule out any medical conditions with symptoms similar to those of other conditions that may interfere or be interpreted as the current symptom or cognitive processes of a mental health condition such as in cases of hypothyroidism, diabetes, Parkinson’s disease, cancer and other conditions that cause depression, anxiety and other symptoms that need to be differentiated. When there is presence or suspicion of other medical conditions, the clinician has the ethical responsibility to refer to appropriate medical personnel with the corresponding referral and consents for coordination of treatment so that the patient receives appropriate medical attention (Whiston 2016, p.140-142).

Evidence-based recommendations indicate the need to rule out physiological or biological implications that may interfere with an accurate diagnosis and treatment such as in the case of PTSD as well as other disorders that experience physiological symptoms as part of the mental disorder criteria, this process is called “focused therapeutic intervention” (Kudler, 2007). Not identifying or ruling out physiological factors may be controversial at the moment of determining appropriate medication needs for such cases as PTSD (Levi, 2013). It is important to consider the referral to a psychiatrist to evaluate the need for medication evaluation when the severity of symptoms is such that it interferes with the patient’s daily functioning.

Once the patient’s health condition has been clarified through the assessment, the clinician can focus on addressing the presenting issues associated with the actual mental health disorder presentation in order to begin to develop a treatment plan.

**Psychological Assessment**

The psychological assessment is vital to provide a comprehensive evaluation of the mental status of the client and is the first step into gaining insight about the client’s mental and emotional state. This first step is important to establish a provisional diagnosis which can later be confirmed or corrected with the use of appropriate assessment measures. During the psychological assessments preliminary battery of tests or screening tools are important in order to obtain information about the current symptomatology. It is also important to consider the psychological developmental profile of the client’s emotional and affective regulation patterns (Greenspan 1997, p.3-6).

Through the use of the following assessment measures the clinician can determine and define the present condition and pathological domains; it is the beginning point to assess the client’s psychological state (APA 2013, p.733-737). The DSM-5 provides different assessment measures that help the clinician through the diagnostic process and psychological assessment. Level 1 cross-cutting measures reveal what needs immediate attention. The WHODAS is the World Health Organization Disability Assessment that helps assess the client’s current level of functioning in areas such as self care, social life, understanding and communicating, getting around in the community, getting along with people, and daily living activities (household chores, school, work) which is important to determine the client’s level of impairment (APA 2013, p. 734).

When the client has indicated a particular interest, experience or issue that he/she/they wants to address in counseling such as a traumatic experience, anger, sleep, or personality; the clinician can include a Disorder Specific Measure provided in the DSM-5 to assess the current level of disturbance in the specific category. A critical assessment in this process is the the Mental Status Examination which provides information about the client’s current state of mind assessing the quality of the mental condition and evaluating his or her current cognitive processes (Sommers-Flanagan & Sommers-Flanagan 2014, p.250-251). Through this examination it is vital to conduct a risk assessment that explores ideation for suicide or homicide always seeking to ensure that no harm is at risk whether to the client or others.

**Social Assessment**

Conducting a social assessment is important to identify any factors that may influence the client’s current emotional state such as cultural, ethnic, and family background, as well as other social considerations (Whiston, 2016, p.9). The DSM-5 provides social and cultural considerations in the assessment process through the *Cultural Formulation Interview* section that outlines a thorough assessment (APA 2013, p.749). Psychosocial and cultural stressors can interfere with the symptom presentation and can also be addressed to promote wellness and health to the client through the exploration of his or her support system which can strengthen the client’s resilience and competencies (APA 2013, p. 750). The knowledge and understanding of cultural variations through a thorough assessment may help the clinician to avoid misdiagnosing (APA 2013, p. 750). The exploration of family of origin considerations and background also contribute to obtain insight into the client’s emotional state, therefore it is important to asses it carefully and with unconditional positive regard.

In all cases and especially with clients that have been exposed to trauma, it is important to assess the patient’s social environment and support considering that evidence indicate that positive social support contributes to symptom reduction whereas negative social support contributes to the development of trauma symptoms (Tarrier, 2010).

**Spiritual Assessment**

Conducting a through spiritual assessment aids in identifying and assessing the individual’s spiritual assets. The role of spirituality has been supported by evidence indicating that it contributes to the survival, coping and recovery of trauma survivors where spiritually coping strategies and mechanisms help individuals develop a healthier sense of self leading to higher resilience (Drumm et al., 2013). Therefore, the importance of conducting a thorough spiritual assessment. Patients hospitalized with chronic conditions have reported that spirituality is the most important factor for them to cope and continue with their lives (Hodge, 2005).

The clinician needs to assess the current spiritual strengths and limitations of the client in order to implement scripture and other spiritual elements into the treatment plan to help him or her access hope and motivate them to their own recovery. Some of the questions to explore the client’s spiritual assets are: Who or what is the source of the client’s spirituality; What is the client’s spiritual background, what are your spiritual practices, what is the client’s perspective on hope (Saguil & Phelps, 2012). The clinician should always be respectful of the client’s spiritual beliefs and never impose his or her own beliefs on the client but know what are the client’s spiritual beliefs and goals to strengthen the client’s resilience levels through spirituality. Obtaining the client’s consent to address spiritual issues is important to help them address it as another source of hope, healing, resiliency and growth (Saguil & Phelps, 2012).

**Case Conceptualization**

The development of a case conceptualization is equally important in the assessment process prior to the beginning of treatment as it helps the clinician understand the client’s presenting issues and determines the therapeutic course of action. This section contains the therapist’s clinical opinion about the client’s presenting issues, signs and symptoms leading to the determination of diagnosis and the proposed course of action in terms of treatment. After the clinician has completed the diagnostic interview he or she will write in a narrative format about the clinical presentation that is drawn from the data provided by the client which can be organized in various formats such as themes, symptoms, etc. (Berman 2015, p.6-7). This process of case conceptualization helps the therapist to provide an explanatory framework with possible hypothesis for the problem at hand (Kuyken, Padesky, & Dudley 2014, p.27). This process incorporates the strengths of the client in order to provide motivation towards treatment and influence positive treatment outcomes.

**DSM-5 Diagnosis**

After all the corresponding information has been gathered and assessed, the clinician has the responsibility to evaluate that information in light of the dimensions provided by the DSM-5 to determine an accurate diagnosis. The DSM-5 is the guide to diagnose mental health disorders by providing clinical dimensions, timeframe, onset, and specific criteria for the symptomatology (APA 2013, p.5). It provides a framework guide for treatment recommendations to address the client’s mental health needs (APA 2013, p. 5). It also provides information about differential diagnosis that prevents incurring in risks of misdiagnosing. The DSM-5 provides all relevant information such as: diagnostic criteria to identify signs and symptoms, behaviors, cognitive functioning, personality traits, physical signs, and comorbid possibilities to be differentiated (APA 2013, p. 5-6). The clinician is responsible to obtain appropriate clinical training and experience in using the DSM-5 to conduct an accurate and ethical assessment and diagnosis (APA 2013, p. 5-6).

The DSM-5 provides assessment measures to aid in the assessment and diagnostic process through cross-cutting measures level 1 and level 2; in addition to other disorder specific clinical assessments according to the condition and need. If the clinician is observing some incongruences; psychological tests may provide additional information to fill in the gaps, especially when a client is experiencing difficulty identifying or expressing his or her symptoms; either because of interference from the symptoms, illiteracy, emotional dysregulation or other factors interfering with an adequate quantity of information that may serve for the diagnostic purposes.

**Measurable Treatment Planning**

This section discusses measurable treatment planning. Once a diagnosis is established then a treatment plan can be developed to address the diagnostic features and issues associated to the presenting problem. The treatment plan should be developed in a collaborative effort and process between the clinician and the client where the client is an active participant.

The treatment plan begins with the initial intake and should include a list of the problems to be addressed in therapy. The details such as therapeutic interventions to be considered or used, what and how it is going to be done throughout the treatment and who will do those tasks, whether the client or the therapist are included in the treatment plan (Perkinson 2007, p.75). It is fundamental that the treatment plan be measurable, that goals and objectives are stated in a positive presentation and that the interventions are specific, indicating what the therapist will do or attempt to help the client achieve the therapeutic goals and objectives (Perkinson 2007, p.76-77). Throughout the therapeutic process the treatment plan needs to be reviewed frequently in order to assess the client’s progress and consider any new problems that may arise through the course of therapy that may require an amendment to the treatment plan.

**Empirically Based Treatment**

After the clinician and counselee have determined the diagnosis and problems to be treated, it is crucial to follow a responsible treatment protocol by researching those treatment interventions that are supported by research, empirically based and are the standard of care in the mental health field. The interventions, strategies and models selected for treatment need to be established from significant findings stating that there is evidence suggesting the efficacy of such intervention in order to be included in the treatment plan. The data obtained from research indicate which treatments work and how, as well as efficacy rates, and which treatments are not supported (Chambless, 2015). Complications or limitations found in the research are also carefully evaluated in order to avoid putting the client’s mental and emotional health at risk by using a treatment that has no evidence of efficacy (Chambless, 2015).

The use of empirically based treatments provide the clinician and the client the reassurance and accuracy of using a treatment that is current, relevant, and trustworthy, increasing the client’s motivation and confidence about entering treatment (Hollon, 2015).

A well designed empirically based treatment plan helps improve the quality of the client’s mental health because it is comprehensive at considering comorbidities or factors affecting the presenting problems; or diagnosis. It is important for the clinician to ensure that the selected interventions are within the clinicians’ scope of practice in order to prevent any unethical treatment.

**Aftercare Planning**

The following discussion covers the aftercare planning of the theoretical eclectic model. The aftercare planning process helps the client prepare in transition to managing his or her life without the constant care of psychotherapy (Nurjannah, Mills, Usher, & Park, 2013). During the aftercare planning stage of treatment, the clinician has already observed, measured and recorded the client’s progress. At this time the clinician should begin the process of termination and preparation of after care plan. The clinician should evaluate the percentage of therapeutic goals obtained by the client in order to prepare the client for termination and plan for a sustained remission of the diagnosis. The clinician should discuss and review with the client the importance of relapse prevention and life after the termination of therapy. The importance of aftercare planning with the patient is to ensure sustained remission at a long-term. The clinician will discuss and teach the client strategies to prevent relapse or regression as it is important to prepare and establish an action plan so that the client learns to manage future triggers (Corey 2009). It is important to terminate therapy leaving the client with the assurance that the therapist’s door is open in case future needs or situations arise. The client should be motivated to feel welcomed and comfortable to return to therapy even if it is for a consultation, a booster session, or just a one-time session to discuss sustained remission or process any situations that the client may wish.

**Outcomes Assessment**

This section discusses the importance of outcomes assessment. One way of measuring treatment outcomes is to re-administer the same assessment measures that were administered at the beginning of treatment as a post-test treatment measure (Whiston 2016, p. 334). The change in scores will indicate which levels of symptomatology have improved and at what levels they are currently present. Outcomes measures allow the clients to have a way of measuring their progress in a tangible manner letting the patient know how much of the counseling goals have been achieved, which in turn is encouraging in the process towards termination of therapy. Other ways of assessing outcome are through the client’s self-report, another mental status examination and compare it with the initial examination, and the clinicians’ observations.

**Literature Review on Effective Treatments for Post-Traumatic Stress Disorder**

The purpose of this section is to present the findings from a literature review of empirically based studies on effective treatments for Post-Traumatic Stress Disorder. Post-Traumatic Stress Disorder (PTSD) is a complex disorder characterized by the direct or indirect exposure to an event that causes or threatens the individual with death, serious injury or any form of violence (APA 2013, p. 271-274). The signs and symptoms emerging from that exposure include several categorical presentations in the areas of intrusive symptoms, avoidance, negative alterations, and marked alterations of arousal (APA 2013, p.271-272).

**PTSD, Psychotherapy and CBT**

It is estimated that approximately 8-9% of individuals are affected by Posttraumatic stress disorder (PTSD) at some point in their lives (Cukor, Olden, Lee, & Difede, 2010). In a meta-analysis where 26 studies with 44 treatment conditions was investigated for PTSD treatment; treatment recommendations and practice guidelines identify that the most effective form of treatment for PTSD is psychotherapy indicating several approaches as significantly effective, Cognitive Behavior Therapy has demonstrated the strongest evidence support (Cukor et al., 2010). Exposure therapy is the only treatment that research has consistently provided enough evidence supporting it as the best treatment (Cukor et al., 2010). Other modalities with a lesser degree of efficacy than CBT, but effective enough through research are Eye movement desensitization and reprocessing (EMDR), stress management/relaxation, CBT Groups, and two pharmacology agents approved by the FDA: sertraline and paroxetine (Cukor et al., 2010).

A different research indicates that Cognitive Behavioral Therapy (CBT) is considered the best and most recommended treatment modality for PTSD consistently across the mental health field (Trusz, Wagner, Russo, Love, & Zatzick, 2011). In a study were CBT was researched to assess and determine any possible barriers to care and client’s readiness for CBT in early acute care PTSD interventions; two independent groups of 59 and 106 participants in the sample were interviewed (Trusz et al., 2011). Research found that additional investigation is needed to determine a more accurate assessment for barriers and readiness. The qualitative content data analysis of clinicians logs and field notes were useful in to observe efficacy (Trusz et al., 2011). Limitations of this study include inability to test predictive validity of the readiness assessment, no independent measures were present, and the patient’s perspective on barriers were not assessed in a comprehensive manner (Trusz et al., 2011).

CBT has demonstrated to be highly effective in developing post-traumatic growth and in reducing symptoms of PTSD in trauma survivors of motor-vehicle accidents (Zoellner, Rabe, Karl, & Maercker, 2011). After being treated with CBT in a randomized control trial; 40 trauma survivors experienced and developed a new and/or increased appreciation for life, improved intimate relationship with others and positive psychological and spiritual change (Zoellner et al., 2011). The only limitations of this study are that the sample was conducted only with survivors of motor-vehicle accidents in Germany and it may not necessarily be the same result with other populations or cultural backgrounds (Zoellner et al., 2011).

**Cognitive Behavior Writing Therapy**

Cognitive Behavior Writing Therapy has demonstrated potential effectiveness in a study with children ages 8-18 where children write/type the story of trauma in a storyline describing their thoughts, feelings, and behaviors associated or after the traumatic event (Van der Oord, Lucassen, Van Emmerik, & Emmelkamp, 2010). Using pre-test, post-test, and follow-up, the symptoms of PTSD were measured indicating potential effectiveness even though the limitation is that is not a controlled trial (Van der Oord et al., 2010).

**Breathing Biofeedback and Exposure Therapy**

Breathing Biofeedback has demonstrated that it can complement Trauma-Focused CBT exposure treatment with positive and effective results. A randomized study was conducted with nine patients in an outpatient clinic of the Academic Medical Center in The Netherlands and were treated with breathing biofeedback through a device that helped them with breathing regulation measuring biological responses from the exercise and providing feedback (Rosaura Polak, Witteveen, Denys, & Olff, 2015). The results demonstrate that breathing biofeedback hastens clinical improvement with symptom reduction and is effective when used in combination to exposure therapy in CBT. The limitation of this study is that the size of the sample is small.

**Metacognitive Therapy**

The use of metacognitive therapy (MCT) has been researched to determine its effectiveness in reducing symptoms of PTSD. The main purpose of MCT is to elicit specific thinking processes under specific adaptive control in order to reduce the individual’s preoccupation with danger and traumatic related thoughts (Wells & Colbear, 2012). The sample of this study included 20 participants chosen between the ages of 18 and 65 and assigned to two treatment groups; one to MCT and the other to delayed treatment control group. The results of this study indicate that MCT demonstrated to be highly effective and efficient in reducing symptoms of PTSD, depression and anxiety. This study had two limitations; one being a small sample and the second not having an objective way of measuring treatment compliance ((Wells & Colbear, 2012).

**CBT and Childbirth PTSD**

The effectiveness of CBT treatment has been studied among women with PTSD after giving birth. Two case studies were conducted among women who were diagnosed with PTSD after giving birth. The effectiveness of CBT demonstrated to be significant in both cases and no limitations were openly identified in the research. Evidence indicate that PTSD can occur with the same likelihood as post-natal depression and unfortunately it is usually overlooked or misdiagnosed. The percentage of women who suffer from PTSD after giving birth is between 1% and 2%, therefore it is important to bring awareness about this fact in order to provide the necessary therapeutic attention (Ayers, McKenzie-McHarg, & Eagle, 2007).

Women who have experienced a traumatic childbirth also experience symptoms of PTSD as other individuals who have experienced other traumatic events (James, 2015). A review of qualitative data on nine cases, indicate that CBT can be used in women with PTSD symptoms resulting from traumatic childbirth and is as effective as with other non-postnatal cases. The only limitation of this study is that the sample studied is small and a replication of the study with a larger sample may provide additional data specifically to post-natal PTSD symptom effects (James, 2015).

**Exposure Treatments**

Goncalvez, Pedrozo, Silva, Figueira, and Ventura (2012) report that Exposure treatment is considered to be the first-line form of treatment for PTSD. A systematic review of various published articles with quantitative review of literature was conducted using a sample of seven studies with treatments of child abuse related to complex PTSD to investigate the efficacy of Virtual Reality Exposure Therapy (VRET). The study indicates that VRET has the same level of efficacy as traditional exposure treatment (Gonçalves, Pedrozo, Coutinho, Figueira, & Ventura, 2012). This form of treatment is recommended for patients who have demonstrated resistance to traditional exposure therapy. However, although a variety of CBT treatments are shown to be effective in treating Complex PTSD, there is not enough evidence to sustain the same results due to the limitation of high dropout rates and lack of follow up data (Gonçalves et al., 2012).

A short term treatment named Narrative Exposure Therapy (NET) has been researched through 18 randomized control trials among 950 patients diagnosed with Complex PTSD (Jongedijk, 2014). One of the major strengths of the study is that the sample has included a population that is culturally diverse because it was conducted in several different countries; Asia, Europe, and Africa. The use of NET has resulted in being recommended as “the most evidence-based trauma treatment” (Jongedijk, 2014) for its efficacy in treating multiple trauma experiences and complex trauma. No limitations have been openly identified in this study (Jongedijk, 2014).

**Pharmacological Enhancers and Exposure Therapy**

Exposure therapy consistently is being demonstrated through a wide variety of research as the first-line treatment for PTSD due to its efficacy (de Kleine, Rothbaum, & van Minnen, 2013). However, basic research also indicates that through the use of pharmacological agents, patients’ learning and memory process is enhanced during exposure therapy (de Kleine et al., 2013). A clinical data review evaluated the efficacy of four pharmacological enhancers, MDMA, hydrocortisone, propranolol, and D-cycloserine (de Kleine et al., 2013). Results demonstrated that the use pharmacology enhances learning and memory process during exposure therapy among patients diagnosed with PTSD (de Kleine et al., 2013). There are three limitations to this study: participants were not able to be completely blind to treatment conditions, participants in the MDMA group received more exposure sessions than placebo, and psychotherapy was not delivered in the standard manner (de Kleine et al., 2013).

**The Phenomenon of Hope**

Due to the complexities that treating Complex PTSD involve; an approach based on Individual Therapy via the Phenomenon of Hope for Treating Chronic and Complex PTSD (Levi, 2013) indicate that if therapists focus on elements beyond the limits of the traumatic event; using the integration a various approaches and adding the phenomenon of hope variable; it results in greater efficacy, confidence and control (Levi, 2013). Evidence indicate that this form of treatment is valuable in treating Complex PTSD, therefore the need for a combination of CBT and psychodynamic therapies in a short term therapeutic approach has been identified as most effective (Levi, 2013). This model of the phenomenon of hope is integrated into the treatment through a five stage model in combination with techniques between CBT and Psychodynamic (Levi, 2013). The limitation in this study is that there is not enough research studying the phenomenon of hope and therefore there is a need for further research with appropriate questionnaires (Levi, 2013).

**Conclusion**

In conclusion this literature review reveals that the most effective evidence-based treatments for PTSD are Cognitive Behavior Therapy modalities such as individual psychotherapy, exposure treatment modalities, and the combination of exposure treatment with pharmacological agents. The phenomenon of hope is also indicating evidence that it helps the client reduce symptoms of PTSD and being valuable in treating specifically Complex PTSD.

| **Study** | **Sample** | **Methods** | **Findings** | **Limitations** |
| --- | --- | --- | --- | --- |
| Evidenced-Based Treatments for PTSD | 26 studies | Meta-Analysis | * Exposure Treatment is a powerful tool * Novel treatments indicating efficacy   Are: Couples therapy, IPT, VRT, and pharmacology prazosin. | - participants were excluded due to comorbidities and other syndromes present |
| Assessing Barriers to Care and Readiness for CBT in Early Acute Care PTSD Interventions | Trauma Survivors from 2 studies  Study I (n=59)  Study II (n=106) | Qualitative Content Analysis of clinicians logs and field notes | Additional investigation is needed specifically for acute care | * Inability to test predictive validity of the readiness assessment * No independent measures * The patient’s perspective on barriers were not assessed comprehensively |
| PTSD Growth as Outcome of CBT | 40 German survivors of severe motor-vehicle Accidents | Randomized control trial of CBT | * CBT helped develop Post-Traumatic Growth with openness and Optimism * CBT was highly effective in reducing PTSD symptoms | * Only Traumatized individuals from motor vehicles * May not be applicable/generalized to other populations |
| Effectiveness of CBT Writing Therapy | 23 Children  Ages 8-18  In a community Mental Health Clinic | Pre-Test  Post-Test &  Follow-up | Potentially effective | * Not a controlled study |
| Breathing Biofeedback as an Adjunct to Exposure in CBT | 9 Patients with Chronic PTSD in an Outpatient Clinic | Randomized | Breathing Biofeedback hastens clinical improvement and effective when used to complement Exposure Therapy in CBT | Small Sample Size |
| Using Metacognitive Therapy to Treat PTSD | 20 Participants ages 18-65 with chronic PTSD | Random assignment to MCT or Delayed Treatment Control | Significant Reductions in symptoms of PTSD, Depression, and Anxiety  Reduces preoccupation with danger and traumatic events | * Small sample size * Absence of study measurements of treatment compliance |
| CBT for Post-natal PTSD | 2 women with post-natal PTSD and their CBT treatment | 2 Case Studies | CBT is effective in treating postnatal PTSD |  |
| Efficacy of Virtual Reality Exposure Therapy in treating PTSD |  | Systematic Review of Published Articles | VRET is as efficacious as traditional exposure therapy |  |
| Established First-Line Treatments for Complex PTSD | 7 Studies with treatments of Child Abuse related complex PTSD | Quantitative Review of Literature | Variety of CBT treatments are effective, but there is not enough evidence to sustain results with Complex PTSD | Lack of follow up data  High dropout rates reported among participants. |
| Individual Therapy via the Phenomenon of Hope for Treating Chronic and Complex PTSD | 1 survivor of combat | Case Study of combat-related PTSD trauma | Valuable in treating Chronic PTSD |  |
| Narrative exposure therapy: an evidence-based treatment for multiple and complex trauma | 950 patients diagnosed with PTSD | 18 Randomized Control Trials | Recommended as the most evidence-based trauma treatment | No limitations openly identified |
| Pharmacological enhancement of exposure-based treatment in PTSD: a qualitative review | 4 pharmacological enhancers: MDMA, hydrocortisone, propranolol, D-cycloserine | Clinical Data Review | -Pharmacology enhances learning and memory process during exposure therapy.  - no conclusion about which enhancer was most effective. | - participants were not able to be completely blind to treatment conditions  - Participants in the MDMA group received more exposure sessions than placebo  - psychotherapy was not delivered in the standard manner |
| Women’s experiences of symptoms of posttraumatic stress disorder (PTSD) after traumatic childbirth: a review and critical appraisal | 9 studies | Review of Qualitative Data Collection | Women who experience traumatic childbirth experience the same PTSD symptoms as patients who suffer other traumatic events.  CBT can be used in women with PTSD symptoms resulting from traumatic childbirth. | Small sample |

**Case Study**

The following presentation is a case study about a client with a complicated case of Posttraumatic Stress Disorder where the nature of her situation is discussed along with her background information, the DSM-5 assessment, treatment plan, empirically based treatment recommendations and aftercare plan.

Mrs. Maria Perez is a 32 year old Hispanic female, married who came to counseling referred by her obstetrician presenting issues of extreme irritability, nightmares, fear, aversion and avoidance to see or have contact with babies. Mrs. Perez reports her symptoms began after she had a car accident and consequently having a stillbirth the same night of the accident. The clinician proceeded to use a semi-structured interview format to conduct an initial comprehensive assessment to determine the cause for the presenting problem, establish a diagnosis, and develop the appropriate treatment plan (see Appendix A for complete description of intake report).

The therapist utilized the Bio-Psycho-Social-Spiritual assessment model to gather the corresponding data to ensure an accurate diagnosis and case conceptualization. The client cooperated in the interview process by providing sufficient and adequate amount of information in all areas of the assessment (see Appendix B for bio-psycho-social-spiritual evaluation). Considering that Mrs. Perez was referred by her obstetrician, a thorough biological assessment was conducted due to the nature of the activating event triggering her symptoms and possible risk contributing factors.

During the examination process and assessment of the psychological aspects, the clinician completed a mental status exam to determine the client’s current state of mind (See Figure B2 in Appendix B for Mrs. Perez mental status exam). Mrs. Perez level of functioning was assessed along with her symptoms with all of the DSM assessment surveys provided by the American Psychiatric Association: cross-cutting symptom measures level 1 and 2, disorders specific, disability, and personality measures. Mrs. Perez social, home, and cultural background were assessed during the social assessment using the DSM assessment surveys as well.

After completing the diagnostic assessment and interview, the clinician proceeded to write a case conceptualization about Mrs. Perez’s case with the results of the assessment and the observations from the initial interview in order to establish and clarify the diagnostic impressions (see Appendix C for the clinician’s case conceptualization report). During the examination process, the clinician ruled out the diagnosis of major depressive disorder and anxiety, establishing posttraumatic stress disorder as the diagnosis that met all criteria presented by the patient’s reports.

A treatment plan was developed with the collaboration and active participation of the client where she indicated her counseling goals. Mrs. Perez reported her interest in overcoming the traumatic experience of having a car accident and experiencing the stillbirth of her first baby on the night of the accident and as a result of it. She also reports her desire to overcome her extreme irritability as well as decrease the symptoms of PTSD. Mrs. Perez wants to learn new coping strategies and increase her level of functioning. One aspect that the client reported was one of her primary concerns for coming to therapy is that she wants to overcome her aversion and avoidance to see babies indicating she wants to decrease her fear of being pregnant again and losing a baby. Mrs. Perez reports overcoming the aversion for babies will help her meet her baby niece and establish a relationship with her. She also reports that she would like to drive again without fear. Mrs. Perez reports she would like to prepare emotionally and psychologically to plan another pregnancy (see Appendix D for Mrs. Perez treatment plan).

The clinician selected CBT along with other treatment modalities to help Mrs. Perez meet her counseling goals. The therapeutic process begins with providing the client with psychoeducational information about the nature of the disorder and evidence-based treatment modalities in order to educate and normalize client’s feelings and reactions about the trauma (Gabbard 2014, p.484-487). Using metacognitive therapy, the client is instructed about the normalcy of symptoms after experiencing a traumatic event (Wells & Colbear, 2012). The client is taught and guided through a series of calming techniques using relaxation and breathing biofeedback techniques (Rosaura Polak et al., 2015).

The following sessions include a referral to a psychiatrist for an evaluation of psychotropic medication needs to determine the use of pharmacological agents as adjunct therapy to exposure therapy (de Kleine et al., 2013). Throughout the therapeutic process, Mrs. Perez was guided through exposure therapy, narrative exposure therapy, and other exposure modalities to reduce the aversion and avoidance associated to the traumatic event (Jongedijk, 2014). Cognitive processing therapy was used to teach Mrs. Perez about identifying and changing maladaptive thoughts associated to the traumatic event in order to restructure those cognitions (Jongsma 2013 & Gabbard 2014, p.484). The phenomenon of hope model was implemented along with bible verses that talk about fear, anxiety and trusting God. Consequently, Mrs. Perez reported feeling significant progress in her feelings of irritability and fear and began to drive at least to the gym and her job.

After four weeks of using metacognitive therapy (Wells & Colbear, 2012) Mrs. Perez began to exhibit and report progress about her symptoms of PTSD indicating that she began to experience less flashbacks and was able to watch babies on TV without feeling like relieving the night of the stillbirth; although she reports had not been able to see her sister’s baby yet. The therapist continued to used exposure therapy gradually in combination with CBT techniques (Gabbard 2014, p. 483) along with narrative exposure therapy (Jongedijk, 2014) and other CBT techniques. Mrs. Perez reported gradual, but consistent progress every week. When Mrs. Perez reported she felt ready and positive about planning for a new pregnancy and no active symptoms of PTSD; the clinician began to prepare the client for termination with relapse prevention by developing an aftercare plan.

Mrs. Perez was notified that termination did not mean she could not return to counseling if she felt the need for it or if she wanted to process an isolated issue. She was told that the doors of the counseling office were open and available for her in case she needed it. The clinician and Mrs. Perez agreed on establishing a preventive plan for processing emotions once she gets pregnant again to process emotions associated with the progress of that pregnancy as a preventive measure. A chart of the proposed evidence-based treatment protocol is included in Appendix E.

**Conclusion**

This paper presented a personal, responsible eclectic theoretical model for treatment with a thorough explanation of the assessment process and a case study of a complicated experience of posttraumatic stress disorder. The discussion highlights CBT, Psychotherapy, and various modalities of exposure treatment as the most effective treatments for PTSD. The discovery of the Phenomenon of Hope Model has strengthened the importance of faith and spirituality for the treatment of PTSD resulting in significant symptom reduction.

The theoretical approaches, empirically-based treatment, and treatment protocols are vital for the responsible and ethical treatment in the mental health field. It is a privilege to serve clients in the counseling office and with that privilege comes the responsibility to continue research and training to provide the best quality of care so that counselees can experience healing, hope, and restoration.

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**Appendix A: Intake Report**

**Intake Report**

**\*\*CONFIDENTIAL\*\***

**NAME**: Maria Perez **DOB:** 3/26/1984 **AGE:** 32

**SSN: 123-45-6789 SEX:** Female

**DATE OF INTAKE:** 3/28, 2016 **DATE OF REPORT:** April 15, 2016

**INTERVIEWER:** Zoricelis Davila, MA, LMHC, LPC-S

1. **Identifying Information and Reason for Referral**
2. **Clinical name**: Maria Perez
3. **Age**: 32
4. **Sex**: female
5. **Racial/Ethnic information**: Hispanic
6. **Marital Status**: Married
7. **Referral source** (and telephone number when possible): Dr. Jane Motley, Obstetrician-Gynecologist, Fort Worth, TX. 817-919-1234
8. **Reason for referral** (why has the client been sent to you (e.g., consultation, clinical intake, counseling). Counseling
9. **Presenting complaint** (use a quote from the client to describe the complaint).

The client began to report the following statements when asked about her reasons to come to counseling: “I can’t stand myself; I can’t get those images out of my head; I can’t stand anybody, I cant’ see babies, I can’t hold babies; I keep having nightmares about that night; I haven’t been able to sleep more than 3 hours since that night; I’m always vigilant, irritable, not trusting anybody; I can’t concentrate, I’m crying all the time and fearful all the time; I’m afraid of getting pregnant again and I’m afraid of not being able to get pregnant; I’m afraid of losing my baby again; I don’t want to think about it but I can’t get the image out of my mind; My ObGyn thinks I’m traumatized by what happened to me and my baby, but I can’t stop feeling the sensation of pushing a cold dead baby.” Client reports that her ObGyn referred her to counseling due to experiencing signs of trauma after having a car accident, experiencing the stillbirth of her first child and almost losing her own life, all on the same night six months ago prior to the date of this intake. Client reports that although she is not currently trusting her ObGyn, she wants to “get over this” so that she can continue with her life.

1. **Behavioral Observations (include Mental Status Exam)**

Client presented herself to the session groomed with appropriate hygiene, but with no other evidence of additional grooming details as evidenced by no make up and casual/house attire. Client’s eye contact shifted from appropriate to avoidant and mistrustful, her body posture was tense as evidenced by seating on the edge of the couch. Client’s affect was appropriate to full range of emotions, her affect exhibited sadness and anxiety at time. Client exhibited significant sadness as evidenced by uncontrollable crying despite observable efforts from client to attempt to control the sobbing but unable to accomplish it reporting “I’m sorry I don’t know why sometimes I can’t stop myself from crying. I feel so many emotions I don’t know what to feel anymore, what is normal or what is not. I feel afraid, and sad, and angry and I don’t know why!”

Client’s thought content appeared to be within normal limits as evidenced by no apparent presence of compulsions, obsessions, nor paranoid ideation reported or observed. Client’ reports no suicidal ideation or homicidal ideation. Client’s exhibits no evidence of hallucinations or delusions. She does exhibit thoughts of rumination associated with the experience of stillbirth and almost loosing her life.

Client exhibited courtesy and was cooperative with the clinician. Client’s quality of speech was normal and appropriate. Client’s verbal responsiveness to questioning was appropriate with adequate provision of data and information.

1. **History of the Presenting Problem**

Client reports her presenting problem is not being able to stop all the images that come to her mind about the night of the accident where she lost her child. Client reports can’t control her irritability, anger, fear and crying. Client reports she cannot see or hold babies anymore. Client reports has not been able to sleep more than three or four hours a night since the night of the accident. Client reports is always vigilant and cannot concentrate. Client reports “I’m crying all the time and fearful all the time; I’m afraid of getting pregnant again and I’m afraid of not being able to get pregnant; I’m afraid of losing a baby again; I don’t want to think about it but I can’t get the image out of my head.” Client reports now she is making so many mistakes on her job tasks that her supervisor reprimanded her, she is not cooking, cleaning, nor going out anymore. Client reports is having constant arguments with her husband and does not want to be sexually intimate with him for fear of getting pregnant. Client also indicated that they have not had sex in the six months after the loss of the child.

Client reports in November 2015, one week before thanksgiving day, she experienced the loss of her first child by stillbirth at 23 weeks of pregnancy. Client reports she had been experiencing some spotting of blood during her pregnancy and that every time she told her obstetrician, she told her it was normal and not to worry about it. The client began to have contractions at 23 weeks of her pregnancy and noticed it was not normal so she decided to go to the hospital and contact her doctor. Client reports on the way to the hospital a white truck ran a red-light and impacted them. Client reports their car span several times and ended impacting other cars. Client reports all she can remember was the chaos of cars hitting, her world spinning around her and her baby because her contractions and the pain increased.

Client reports she cannot get out of her mind the images and flashbacks of the ambulance, people yelling, the doctors around her, and her pain. Client reports she was screaming “My baby! I don’t want to loose my baby! He is not supposed to be born yet! Save my baby!”

Client reports in the middle of the chaos of having doctors and nurses all around her she suddenly felt cold. Client reports the doctors told her she had to begin the delivery process and push the baby through. Client reports she heard she had lost so much blood they needed to give her blood transfusions. Client reports during the delivery her life was in danger due to complications and that she was told the baby was already dead but that she needed to push and deliver him. She reports when the doctor came to her and put the dead baby in her arms she looked at him, feeling him cold and with no color. Client reports at that moment she lost consciousness.

Client reports the hospital gave her a “Memory Box” with pictures of the baby and other items. She reports since that event she has not been able to sleep. Client reports has flashbacks of the whole incident from beginning to end daily. Client reports has the same nightmare about dead babies every night. She also reports avoids going to the “baby’s room” in her house, but has not allowed her husband to change it as he suggested. Client reports she avoids watching TV because she does not want to look at babies, commercials with babies or anything that has to do with babies. She reports cannot see babies around her and cannot hold babies. She also reports her younger sister who was pregnant at the same time she was had a baby girl a month prior to the appointment and she has not been able to visit her sister to meet her niece because she does not want to see babies. Client reports seeing babies remind her of her dead baby.

Client reports sometimes she wants to remember details about that night, but there are some things she can’t’ remember. At the same time, she also reports does not want to remember. Client reports “I cannot trust anyone” indicating she knew something was wrong and no one believed her. Client reports feeling guilty because she could have done something to prevent the loss of her first child. She reports does not feel the same, feeling constantly unhappy and dissatisfied with life and everyone around her. Client reports the worse is feeling so angry and irritable with everyone. She also reports being hypervigilant and not being able to concentrate.

Client reports she has never felt this way before and that she does not want to continue to feel this way ever again, but is afraid she may never recover from this experience. Client denied any previous history of depression, anxiety, or any other mental health disorder.

1. **Past Treatment (Psychiatric) History and Family Treatment (Psychiatric) History.**

Client reports no history of psychiatric conditions or treatment in her life or her family’s. Client reports her family is healthy and no one has ever had medical or psychiatric problems.

1. **Relevant Medical History**

Client reports no history of medical illnesses except for the complications she experienced during her pregnancy and stillbirth. She reports had never had a hospitalization before the incident where she lost her child by stillbirth. Client reports her doctor told her she was having hypertension but that if she followed a healthy diet, rested, and walked it would not be a problem. Client reports her doctor told her that the car accident caused her blood pressure to be elevated and that led to the following complications at the time of delivering the baby.

Client reports her current health status is normal and that her blood pressure is normal as well. Client reports her doctor told her “Your body is back to normal and you can begin to plan for a future pregnancy.” Client reports when she heard that, she began to cry and told her doctor all her fears, feelings, and reactions and that is when her doctor suggested counseling. Client reports has not been prescribed with any medications.

The client’s primary care physician is Dr. Juan Vargas, (817) 230-0908 and her obstetrician is Dr. Jane Motley, 817-919-1234. She has a follow-up appointment with Dr. Motley to monitor her symptoms after she has at least six counseling sessions, the appointment is scheduled for May 20, 2016. Client reports Dr. Motley indicated that when the client decides to plan a pregnancy, she can conduct an examination with blood tests to ensure she continues in good health in preparation for a future pregnancy.

1. **Development History**

Client reports a normal developmental history with no complications or abnormalities during her developmental stages. Client reports she has always excelled in school and work, has been friendly and outgoing.

1. **Social and Family History**

Client reports she had an outstanding childhood because her family is very close and united. She reports she grew up in a Christian family with both her parents and one sister 3 years younger than her. Client reports her parents are loving and supportive and that for her; family is always first.

Client reports she has worked as an assistant for a seminary professor at Southwestern Baptist Theological Seminary for 10 years since she graduated college. She reports no military history, no aggression/violence history, no alcohol/drug history, and no legal history. Client reports she has always been obedient, following instructions, obeying her parents and authority, and never having problems with anyone.

Client reports met her husband Jose while working at the seminary when he was studying a Master of Arts in Divinity because he wanted to be a pastor. Client reports they have been married for seven years. She reports prior to her husband she only had one boyfriend in her first year of college, but he was not a committed Christian and she decided to end the relationship and wait on God to bring her a husband. Client reports was never sexually active until she married her husband. Client reports her and her husband had not been able to have children before so when they learned she was pregnant they were both very happy. However, she reports being distraught by the loss of their first child in such a traumatic way.

Client reports she grew up in a Christian home and she accepted Christ as her Savior when she was 15 years old. She reports has always gone to church, but has not served as her parents taught her to serve the Lord. Client reports has kept her sexual purity because she learned to obey God in every way. Client reports likes to help at church and likes participating in the children’s ministry; but does not feel she has abilities to serve in that area because she feels inadequate. Client reports since the loss of her baby, she has not entered the children’s department because it hurts her too much to see children and not have her own. Client reports sometimes feels that God may have been punishing her for not serving as she should or for doubting her abilities to serve in the children’s ministry.

Client reports has a strong support system in her family, church, and friends. She reports her church friends have reach out to her and her family has been present and making sure she is doing well; but she reports cannot overcome the experience and reports she may never recover.

1. **Current Situation & Functioning**
2. A description of typical daily activities.

Client reports she wakes up at 6:00 am go to the Gym and come home and get ready for work from Monday through Friday; although she has missed days of work at least once a week. She reports when she comes home she tries to prepare dinner, but sometimes she doesn’t feel like it so her husband cooks or buys dinner. She reports spend time with her husband having supper, and talking. She reports they used to clean the kitchen together and later watching a movie or a TV show and go to bed at 10:00pm after watching the news; but now she just goes to bed around 9:00pm and does not like watching TV. On Wednesdays, client reports she and her husband go to bible study. Client reports Fridays used to be her and her husband’s date night, but she has not felt like it since the night of accident.

1. Self-perceived strengths and weaknesses

Client reports her strength is her desire to recover because she considers herself to be a strong self-sufficient person; however, she reports her weakness is that this loss and accident has made her feel insecure, afraid, angry and that she thinks she may never recover from this experience.

1. Ability to complete normal activities of daily living (ADLs)

Client reports since the night of the accident where she had the stillbirth; she has not gone to the gym with the same frequency she used to go. Client reports is difficult for her to go to work because she does not want to face anybody and have people who don’t know about the stillbirth to ask her “How is the baby?” Client reports goes to work late and has missed days of work at least once a week. Client reports is making constant mistakes on the job and that her boss has communicated his concern about her absences and poor concentration. Client reports is not driving because is afraid of having an accident; therefore, her husband drives her to work and her mother drives her to run errands when her husband is not able to drive her. Client reports she tries to function as much as she can but daily activities are hard to do because she does not feel like doing anything.

1. General Assessment of coping skills

Client reports she used to have good coping skills, but feeling so overwhelmed that she thinks her coping skills are somewhat limited to going to the Gym sometimes to try to feel better. She reports her devotional in the morning and praying is what keeps her going despite her feelings and reactions.

1. **Diagnostic Impressions (this section should include a discussion of diagnostic issues and at least a provisional Axis 5).**
2. Brief discussion of diagnostic issues.

Client meets criteria for Posttraumatic Stress Disorder by meeting criterion A, directly experiencing a traumatic event and exposure to a threatened death as evidenced by client reports having a car accident and later having a stillbirth that threatened her life and losing the life of her first child by stillbirth. Client meets criterion B as evidenced by the presence of client reports of having recurrent involuntary, and intrusive memories of the accident and the loss of her baby. Client also reports experiencing distressing dreams of dead babies, associated with the loss of her baby by stillbirth. Client reports having constant flashbacks and reliving the night of the accident and labor. Client reports cannot see babies because she feels distressed and reminds her of the traumatic experience of delivering a dead and cold baby. Client meets criterion C as evidenced by the presence of avoidance of seeing or carrying babies and avoidance of driving. Client meets criterion D as evidenced by the presence of negative alterations associated to the traumatic event such as client’s reports of not being able to remember some details of the traumatic event, persistent thoughts of “I cannot trust anyone,” persistent feelings of anger, fear, and guilt. Client also reports of thinking she is the one to blame for the loss of her baby. Client reports inability to feel happiness or satisfaction. Client meets criterion E as evidenced by client’s reports of constant irritability, hypervigilance, problems with concentration and sleep disturbance. Client reports has experienced these symptoms for six months with onset immediately after the traumatic event occurred.

The clinician ruled out Major Depressive Disorder due to not meeting full criteria and her symptoms of diminished interest in activities, irritability, and sleep disturbance are associated to the posttraumatic stress disorder criteria when considered all the symptoms in light of the events. The client’s crying outbursts are associated with normal grief and bereavement feelings typical of the loss of a child and not the presence of a mental disorder of clinical depression.

1. DSM-5 Diagnosis

PROVISIONAL

F43.10 Post-Traumatic Stress Disorder

1. **Case Formulation and Treatment Plan:**

Client’s emotional and psychological state appears to be normal up to the moment where she experienced the car accident on her way to the hospital due to early contractions at 23 weeks of pregnancy. The chaos of two intense events occurring simultaneously; the accident and the premature delivery resulting in stillbirth deregulated the client’s emotional stability by not being able to process and begin to cope with the experience. Client is exhibiting signs of normal grief and bereavement due to the loss of her fist child by the tragic event of stillbirth. The client has experience a good quality of life having good and healthy experiences as a child in her home background, social, school, and spiritual background. These experiences along with a healthy sense of coping have contributed to her difficulty processing, adapting, accepting and coping with the event to such an extent that the client is experiencing severe aversion and avoidance to driving and babies. The client experiences significant fear to plan a pregnancy to the point she is not having sexual intimacy with her husband for fear of getting pregnant. The client has developed aversion for all babies including her newborn niece.

The client’s strong support system in her family and church help her in her efforts to cope; however, the impact of experiencing two traumatic events on the same night and almost losing her life is beyond her current capacity to cope.

The following techniques will be used in the development of the Treatment Plan:

Cognitive Behavior Therapy

* 1. Exposure Therapy
  2. Virtual Reality Exposure Therapy
  3. Cognitive Processing Therapy
  4. Metacognitive Therapy
  5. The Phenomenon of Hope
  6. Socratic questioning
  7. Challenging and changing maladaptive cognitions for positive ideas

Person Centered Therapy

1. Unconditional positive regard
2. Empathy
3. Congruence

Please see Treatment Plan Chart attached, following this report.

Zoricelis Davila

Zoricelis Davila, MA, LMHC, LPC-S

Bilingual Psychotherapist

**Appendix B: Bio-Psycho-Social-Spiritual Evaluation**

**Biological**

Mrs. Perez’ biological evaluation indicates that she met all her developmental stages without any difficulties or complications. Prior to the stillbirth she reports had never experience a hospitalization or any medical complications. Mrs. Perez reports that obstetrician indicated to her that it is typical for many women to experience blood-spotting in their first pregnancy; but are able to complete their term without risks to the baby. Client reports the complications during the delivery were provoked by high blood pressure but that she had never experienced it before that night. After the stillbirth, her obstetrician conducted several tests to ensure that her health was not at risk and had given her the release to go back to work. The client also indicated that her body was ready to conceive again.

**Psychological**

During the psychological evaluation, Mrs. Perez exhibited tension, sadness, sobbing uncontrollably at times, with full awareness and good insight about her situation and emotional impact of the traumatic event. The clinician conducted a mental status examination that reflected no suicidal ideation, no homicidal ideation, no hallucinations or delusions. Mrs. Perez was seating on the edge of the couch and her eye contact shifted at times from normal to avoidant. Mrs. Perez level of distress was observable as evidenced by her uncontrollable, sobbing, her apologizing for crying, and also indicating “I can’t get those images out of my head” while shaking and touching her head with her hands. No other major observations resulted from the psychological evaluation, her current presentations and reports are associated to the traumatic event of having and accident, later giving birth to a dead baby, and her life being at risk during the process.

**Social**

Through the inquiring about Mrs. Perez social background, she openly described she had a wonderful family, friends, and church. She indicated her Hispanic heritage nurtures family first and are always supportive of each other in every circumstance. Mrs. Perez indicated a healthy social development with a strong support system in her family, her friends, and her church. Mrs. Perez reported her relationship with her husband was healthy and strong and that throughout this critical moment he has been understanding, loving and supportive. Mrs. Perez has reported stability in her job for the past seven years.

**Spiritual**

Mrs. Perez spiritual life appears to be strong as reported by her indications of growing up in a Christian family, committing to sexual purity since her adolescence, accepting Christ as her savior at the age of 15, and continuing to be committed to her church. Mrs. Perez reports how she learned to obey God in everyway and she has committed her life to serving God to the point that she chose to work at Southwestern Baptist Theological Seminary to be surrounded by Christian people. The only concern Mrs. Perez report is that she feels inadequate to serve in the children’s ministry department although is the area that she enjoys. During the evaluation, Mrs. Perez exhibited feelings of spiritual guilt and a sudden-distorted view of God as evidenced by her remark of thinking God was punishing her with the stillbirth for not serving as she should and even doubting her abilities. Mrs. Perez indicated she chose a Christian counselor because she wants to overcome this experience from a Christian perspective using scripture as well as the other psychological approaches.

**Figure B2 Appendix B: Mental Status Exam (MSE)**

MENTAL STATUS EXAM (MSE)

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name (First, MI, Last):  Maria Perez | | Client No.:  2098 | |
| NOTE: Record level of severity next to abnormal findings. 1= Mild, 2= Moderate, 3= Severe, X= Normal Finding | | | |
| **General Observations** | | | |
| **Appearance** | Well Groomed **2**  Unkempt  Disheveled  Stated Age  Younger  Older | | |
| **Build** | Average  Thin  Overweight | | |
| **Eye Contact** | Average  Hostile  Mistrustful  Withdrawn  Preoccupied  Demanding | | |
| **Activity** | Average  Agitated  Slowed | | |
| **Speech** | Clear  Slurred  Rapid  Pressured  Perseveration  Clang | | |
| **Thought Content** | | | |
| **Delusions**  None reported | Grandiose  Persecutory  Somatic  Bizarre  Nihilistic  Religious | | |
| **Other**  None reported | Autistic  Obsessional  Guarded  Phobic  Guilty 3  Ideas of Reference  Preoccupied 2  Other: | | |
| **Self-Abusive**  None reported | Suicidal (assess lethality if present):  Intent  Plan  Self-mutilation | | |
| **Aggressive**  None reported | Aggressiveness (assess lethality if present):  Intent  Plan | | |
| **Perception** | | | |
| **Hallucinations**  None reported | Auditory  Visual  Olfactory  Gustatory  Tactile | | |
| **Other**  None reported | Illusions  Depersonalization  Derealization | | |
| **Thought Process** | | | |
| Logical  Concrete  Incoherent  Circumstantial  Tangential  Loose  Racing  Blocked  Flight of Ideas | | | |
| **Mood** | | | |
| Euthymic  Euphoric  Anxious  Angry  Irritable  Depressed | | | |
| **Affect** | | | |
| Full  Constricted  Flat  Inappropriate  Labile | | | |
| **Behavior** | | | |
| Cooperative  Resistant  Agitated  Impulsive  Over-Sedated  Assaultive  Aggressive  Hyperactive  Restless  Loss of Interests  Anhedonia  Withdrawn  Dystonia  Tardive Dyskinesia | | | |
| **Cognition** | | | |
| **Impairment of:**  None reported | Orientation  Memory  Attention/Concentration  Ability to Abstract | | |
| **Intelligence Estimate** | MR  Borderline  Average  Above Average | | |
| **Insight/Judgment** (If more space is needed, use reverse side.) | | | |
| Good Insight. | | | |
| **Elaboration of Positive Mental Findings**  (If more space is needed, use reverse side.) | | | |
|  | | | |
| **Provider Signature/Credentials**  **Zoricelis Davila, MA, LMHC, LPC-S** | | | **Date:**  **4/15/2016** |

**Appendix C: Case Conceptualization**

Mrs. Perez is a 32 year old Hispanic female, married with no children, and Christian. She came to the intake session exhibiting high levels of emotionality, uncontrollable sobbing, and touching her head reporting “I can’t get those images out of my head.” Her primary complaints are flashbacks, nightmares, aversion for babies, extreme irritability, hypervigilance, poor concentration, inability to trust others, and fear of loosing a baby “again.” Through the examination, she exhibited nervousness, tension, and observable distress.

Mrs. Perez has developed normally all her life with no medical conditions or complications up until the night of the stillbirth where as a result of the car accident her blood pressure was elevated and her life was at risk. During the delivery process, she lost a significant amount of blood and the baby died in her womb. Mrs. Perez reports the experience of delivering a dead cold body is something she will never forget. Mrs. Perez described her body being cold and having to push the baby through knowing the baby was dead, distraught her.

Mrs. Perez acknowledges her family, husband, and church as her primary support system is strong and she loves them; but she is experiencing difficulty processing the experience even with the support of her family. She also reports God and spirituality are vital in her life, but admitting feels guilty for not serving God as she thinks he wants and thinks her loosing her baby may be a form of punishment from God. This report from the client exhibits, a sudden-distorted view of God that was triggered by the inappropriate guilt of feeling inadequate to serve in the children’s department and by the grief experience for the loss of the baby.

Mrs. Perez has developed such an aversion for babies that she has not visited her younger sister who was pregnant at the same time she was and delivered a baby girl. The client reports cannot see her niece, cannot see or hold babies, and cannot see babies not even on TV. The second aversion Mrs. Perez has developed is in relation to driving. Mrs. Perez has not driven a vehicle since the night of the accident. A major issue in the symptom presentation of Mrs. Perez is her constant flashbacks where she reports are such that she feels distressed for not having a moment of rest where the images are out of her head. Mrs. Perez functioning is impaired in the occupational, personal, emotional, sexual, and social areas. She reports has not been able to concentrate, has not allowed her husband to be sexually intimate with her, has not seen her sister or met her baby niece, and has withdrawn socially.

Mrs. Perez is exhibiting significant levels of grief and bereavement associated to loosing her first child by stillbirth at 23 weeks of pregnancy. Her grief has been complicated by the fact that while on the way to the hospital because she was experiencing premature contractions, her and her husband had a severe car accident. Her reactions, symptoms, and reports are consistent of those meeting the criteria for Posttraumatic stress disorder. Her treatment plan has been developed using an eclectic theoretical model with the primary approach being cognitive behavior therapy in combination with person centered therapy. The primary therapy to be used in the treatment is evidence-based supported exposure therapy with other exposure modalities.

Appendix D: Treatment Plan Chart

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Problem or Concern** | **Measurable**  **Treatment Goal** | **Treatment Interventions** | **Expected # of Sessions to Reach Goal** | **Measurable Means of Evaluating and Monitoring Progress toward Goal** | **Aftercare**  **Plan Follow-up** |
| Symptoms of PTSD, irritability, flashbacks, nightmares, and difficulty sleeping among others | Reduce the severity, frequency, and amount of symptoms by increasing the level of relaxation | -Psychoeducation  - breathing biofeedback  -calming techniques  -Relaxation Techniques  -Metacognitive therapy  -unconditional positive regard | 6 | * Complete daily mood log * Complete a symptoms chart to track progress | * Continue to monitor her symptoms weekly |
| Aversion for Babies   * Inability to meet her baby niece * Inability to watch babies on TV * Inability to carry babies | Increase the level of comfort, affection, approval and sympathy for babies | * Narrative Exposure Therapy * Virtual Exposure Therapy * Gradual In-vivo Exposure * Cognitive restructuring * CPT * empathy | 8 | -no longer avoids babies  -is able to visit her sister to meet her niece  - is able to carry her niece  - is able to watch babies on TV | -continue to practice positive self-talk about the real meaning of seeing or carrying a baby  -continue to develop and establish a healthy, loving, and comfortable relationship with her baby niece |
| Avoidance to Drive | - Gradually Increase driving  - Be able to drive without fear in her everyday life | -gradual exposure  -virtual reality exposure  - in vivo exposure  -cognitive restructuring  -CPT | 8 | Increase gradually her driving distance at least one mile per week until is able to drive to any place without fear | -Continue to practice positive self-talk and correcting any negative cognitions that may arise at the moment of driving  - practice relaxation techniques before driving.  - Continue to drive normally in her everyday life |
| Fear of Getting Pregnant | - Reduce the level of fear  - Increase the level of assurance, calmness and ease about getting pregnant | -phenomenon of hope  - use of scripture verses  - cognitive restructuring  -CPT | 10 | Client’s self-report of readiness to plan for a new pregnancy without apprehension | Continue once a month maintenance/follow-up sessions during the term of the new pregnancy to process and maintain emotional stability associated with new pregnancy |

**Appendix E: Proposed Evidence-Based Protocol**

|  |  |
| --- | --- |
| *Sessions* | *Treatment Interventions* |
| Session One | * Assessment * Establish a therapeutic alliance using unconditional positive regard * Conceptualization of Case |
| Session Two | * Treatment Plan Preparation * Provide psychoeducational information about PTSD * Using Metacognitive therapy educate the client about the normalcy of the symptoms and reactions of experiencing a traumatic event. |
| Session Three | * Teach the client calming techniques such as breathing/relaxation and breathing biofeedback * Begin the process of guiding the client with gentleness and unconditional positive regard into the recollection of the traumatic event in order to identify facts and cognitive/emotional reactions associated to the traumatic incident. * Practice calming techniques throughout the session * Homework: Practice calming techniques throughout the week |
| Session Four | * Continue to guide client into the recollection of the traumatic event in order to identify impacts resulting from the traumatic events and feelings associated * Assess the client’s need for pharmacological therapy referral/evaluation for the possible use of pharmacological enhancements as adjunct therapy to exposure therapy. |
| Session Five | * Using cognitive processing therapy ask the client to write a description of the meaning of the traumatic event * Homework: Journal about the meaning and feelings associated to the traumatic event. * Continue to practice calming techniques |
| Session Six | * Teach the client the association between thoughts/beliefs, emotions, and behaviors associated to the traumatic event * Begin the process of Narrative Exposure Therapy |
| Session Seven to Nine | -Continue the Process of Narrative Exposure Therapy  -Using CBT explore the client’s schemas, beliefs, and self-talk associated to the traumatic event  -Review counseling progress towards counseling goals |
| Session Ten to Thirteen | -Use Exposure Therapy, gradually guiding to in-vivo exposure therapy  -Teach the client to keep a daily mood log to record her automatic thoughts, feelings, and reactions.  -Homework: Assign the client to keep a daily mood log to record her automatic thoughts, feelings, and reactions.  -Assign the client to gradually drive one mile every day; and gradually increase one additional mile everyday. |
| Session Fourteen | -Teach and Identify any maladaptive cognitions and teach thought replacement into positive/healthy realistic thinking  -Review counseling progress towards counseling goals and treatment plan |
| Session Fifteen | -Direct the client into constructing a fear, aversion, and avoidance hierarchy of the stimuli related to the traumatic event.  -Begin to teach and practice the Phenomenon of Hope Model  -Homework: Assign the client to find, read, and place in different places around her house, purse, and desk at her job; Bible verses that talk about fear, anxiety, and trusting God. |
| Session Sixteen to Twenty | -Using Virtual Reality Exposure Therapy, Writing Therapy, and Exposure Therapy, address the aversion and avoidance for babies |
| Session Twenty-one to Twenty-four | -Evaluate the client’s current use of coping strategies, teach additional coping strategies for the client to access; develop a “coping card” with additional coping strategies the client can use. |
| Session Twenty-five – Twenty-seven | -Review progress towards counseling goals  -Begin relapse prevention stage  -Discuss and establish aftercare plan and follow-up sessions once new pregnancy is confirmed.  -Evaluate Therapy process and progress  -Set a follow-up booster session |

**375/400**

**I enjoyed reading your paper Zori and appreciate all of the time, energy, research, and wisdom you put into it! Outside of the minor issues I pointed out in my comments, this is very well done!**