Elizabeth Mulligan, PhD
Intervention Work Sample

Contextual Statement: I have chosen to present the intervention case of Mr. Z, a 68-year-old, single Vietnam era veteran who was originally referred to the Geriatric Mental Health Clinic by his VA Primary Care Provider after he called the Patient Call Center requesting anger management services. At our initial session, it was clear that his treatment needs extended beyond anger management. From a period of December 2011-August 2013, I followed the veteran for 38 sessions of individual therapy, an 8-session coping with bereavement group, and a 6-session cognitive behavioral therapy for insomnia group. I started working with this veteran during my fellowship year and continued after I transitioned to my staff psychologist position. Extensive information about the veteran's psychiatric and psychosocial history is provided in the initial assessment below.

One primary goal of therapy was for the veteran to gain a better understanding of how multiple traumatic events, including physical abuse perpetrated by his father during childhood and combat-related experiences in Vietnam, affected his life/how he views himself and the world. Interventions initially focused on teaching the veteran healthy coping skills (e.g., behavioral activation, relaxation, anger management) and encouraging him to practice them on a regular basis. These interventions served two purposes: (1) to help the veteran gain confidence in the potential benefits of therapy given his initial ambivalence; and (2) to provide him with self-care skills he could draw on when serving as the primary caregiver for his brother with Parkinson's disease and when engaging in trauma-focused therapy. Materials from Cognitive Processing Therapy (CPT; Karlin et al., 2010; Resick, Monson, & Chard, 2008) were used flexibly throughout trauma-focused therapy, including psychoeducational information (e.g., PTSD as a disorder of non-recovery; costs of avoidance; role of thoughts in keeping a person stuck), a conversation about the potential for symptoms to increase initially in this type of work, a written impact statement and trauma accounts, Socratic questioning, and discussions of themes including trust, control, and esteem. For example, the veteran was able to identify important similarities between his childhood, his time in Vietnam, and even his time as a caregiver including a sense of not being in control and of not being able to protect the people he cares about. The veteran also benefitted from considering a lifespan developmental perspective of his PTSD given his drive to understand why he was experiencing more intrusive thoughts later in life (e.g., retirement given that prior long work hours and heavy alcohol use were forms of avoidance; caregiving triggering his sense of loss of control). During this work, I found him to be insightful, self-reflective, and quite resilient.

Unfortunately, just as we began making good progress with trauma-focused therapy, the veteran's brother Q passed away from complications related to his Parkinson's disease. The veteran lived with his brother and served as his primary caregiver. Their relationship was very close. They often worked together to stay away from their father during their childhood and Mr. Z identified Q as the one person he could trust. Our focus shifted to grief following this loss, although we often reflected on how several themes from the veteran's trauma-focused work regarding trust, control, and guilt also carried over to this death. Eventually the veteran joined an 8-session coping with bereavement group I was offering in the clinic. In both individual and group sessions, our work was informed by the Dual Process Model of Coping with Bereavement (Stroebe & Schut, 2010), with interventions focused on (1) helping the veteran to accept the reality of his brother's death; (2) experiencing the pain of grief, while also giving himself breaks from this pain at times; (3) gently challenging his tendency to blame himself for this death; and (4) adjusting to life without his brother, including reflecting on his values and ways of carrying on his brother's legacy (e.g., by continuing to volunteer at the VA).

The veteran's willingness to participate in the bereavement group represented a change, as he was initially ambivalent about his level of comfort with other veterans given his difficulties with trust and his belief

that he may not deserve treatment as much as others. Fortunately, he was more open to other groups after having a positive experience in this group. He specifically requested to participate in a Cognitive Behavioral Therapy for Insomnia (CBT-I; Karlin et al., 2013) group given ongoing difficulties with sleep onset and maintenance. I have been facilitating this group in the Geriatric Mental Health Clinic several times per year since receiving certification in this intervention through the VA's current evidence-based psychotherapy dissemination efforts. It focuses heavily on psychoeducational information about sleep as a rationale for interventions including stimulus control, sleep restriction, sleep hygiene, and cognitive strategies (e.g., cognitive restructuring, scheduled worry time). Throughout both the bereavement group and the CBT for insomnia group, the veteran and I met individually on a monthly basis.

By the conclusion of the insomnia group, the veteran was reporting improvements in many of his symptoms of PTSD, depression, grief, and insomnia. This improvement is described in greater detail in the termination summary below, but a selection of his self-report measures provide a good snapshot:

7/12/13: PCL-M = 33
4/5/13: PCL-M = 48
12/4/11: PCL-M = 47

7/25/13: BDI-II = 14/63
2/11/13: BDI-II = 20/63
12/4/11: BDI-II = 29/63

7/29/13: Inventory of Complicated Grief = 18/76
1/28/13: Inventory of Complicated Grief = 30/76

7/12/13: Insomnia Severity Index = 6, no clinically significant insomnia
5/24/13: Insomnia Severity Index = 16, moderate clinical insomnia

We discussed various options for ongoing treatment, including a brief course of individual therapy targeting some of the veteran's lingering symptoms (e.g., his discomfort with his tearfulness, irritability), a time-limited stress management or anger management group, and an ongoing support group for Vietnam era veterans offered in the PTSD Clinic. In discussions with the veteran, he decided to complete the stress management group, followed by the ongoing support group. I do not offer ongoing groups to every therapy patient because they are in limited supply at the VA and I believe it helps to build confidence if veterans try to utilize the skills they learned in therapy independently. However, I believed an ongoing group could be helpful for this veteran given his limited social support, prior positive responses to groups, and some difficulties transferring the progress he made in the therapy relationship with regard to trust to his other relationships.

Below I have included copies of my initial assessment with the veteran, an individual therapy note from before his brother's death, a bereavement group therapy note, and our final individual therapy note with a termination summary. While not exhaustive, I believe these notes are representative of our work together.

Informed Consent: The outpatient Geriatric Mental Health Clinic does not utilize a specific written consent for psychological services. I verbally reviewed the purpose of the initial evaluation and the limits of confidentiality with the veteran at the beginning of our first session and provided him with written documentation of this information. We also mutually agreed on goals during the treatment planning process and reviewed our progress towards these goals on a regular basis. I also specifically provided him with information regarding the content and expectations for trauma-focused treatment as well as his right to terminate. He agreed to participate in these services.

References:

Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A.,…Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for Posttraumatic Stress Disorder in the Veterans Health Administration. *Journal of Traumatic Stress*, 23, 663-673.

Karlin, B.E., Trockel, M., Taylor, C. B., Gimeno, J., & Manber, R. (2013). National dissemination of Cognitive Behavioral Therapy for Insomnia in Veterans: Therapist- and patient-level outcomes. *Journal of Consulting and Clinical Psychology*, 81, 912-917.

Resick P. A., Monson C. M., & Chard K. M. (2008). Cognitive processing therapy veteran/military version: Therapist's manual. Washington, DC: Department of Veterans' Affairs.

Stroebe, M. & Schut, H. (2010). The Dual Process Model of Coping with Bereavement: A decade on. *OMEGA: Journal of Death and Dying*, 61, 273-289.

Initial Assessment:

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LOCAL TITLE: MH Outpatient Initial Assessment
STANDARD TITLE: MENTAL HEALTH OUTPATIENT INITIAL EVALUATION NOTE
DATE OF NOTE: DEC 02, 2011@17:00     ENTRY DATE: DEC 04, 2011@19:20:20
      AUTHOR: MULLIGAN,ELIZABETH   EXP COSIGNER:
     URGENCY:                            STATUS: COMPLETED

The CPRS medical record indicates that there is not remote data on this patient.

Age: 68  GENDER: MALE   RACE: WHITE
MARITAL STATUS:  Single.

CLINICAL HISTORY
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PRESENTING CHIEF COMPLAINT:  The veteran was referred to the Geriatric Mental
Health Clinic after he called the Patient Call Center and requested services for anger
management. At his intake session the veteran identified his primary issues as
anger/irritability, intrusive thoughts about Vietnam, and tearfulness (i.e., he
said "Things are coming back to met about that time and I can't stop them. I'm
angry and I'm crying too much").

 Are you experiencing any of the following symptoms:
     No Coughing up blood
     No Shortness of breath
     No Pain or pressure in chest
     No Frequent or painful urination

HISTORY AND SYMPTOMS OF CURRENT ILLNESS: The veteran described various traumatic
events that occurred during his time in Vietnam (e.g., witnessing many injured
and deceased soldiers, including friends, being medically evacuated and being
told there was nothing he could do to help; witnessing other soldiers being
killed while he was on guard duty and being ordered not to fire). Although his
score on a self-report measure was just below the recommended cut off of 50
(PCL-M = 47), the veteran does meet criteria for PTSD at present based on his
presentation on interview and on the symptom cluster criteria. In particular, he
reported frequent intrusive thoughts about traumatic events he witnessed in
Vietnam and subsequent feelings of guilt and sadness, attempts to avoid thinking
and carrying on conversations about these events, feelings of distance from
others, a sense of foreshortened future, difficulty remembering important
aspects of the trauma, anger/irritability, difficulty with sleep onset and
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maintenance (reports ~4 hours per night), problems with concentration, and exaggerated startle response. He noted that most of these symptoms have been present since his time in Vietnam (e.g., he always had a short temper and would often throw customers out of the ice cream shop he owned for many years). However, he noted that his symptoms have worsened in recent years, which he attributed to the events of September 11 and strain related to providing care for his brother, who has Parkinson's disease. He also noted that he has been hesitant to come to the VA because he does not believe he deserves treatment as much as the veterans who were injured, but came at the suggestion of a friend.

In addition to PTSD symptoms, the veteran endorsed moderate to severe depressive symptoms (BDI-II = 29), most notably frequent crying, feelings of disappointment, failure, and worthlessness, loss of energy, and loss of interest in previously enjoyed activities. He also reported some passive thoughts of death, but denied any active suicidal ideation, intent, or plan. He reported that these symptoms have coincided with his worsening PTSD symptoms and increasing caregiving responsibilities. For example, he provides some personal care for his brother and often reassures him when he has hallucinations. The veteran displayed good insight regarding his brother's condition (i.e., he said "I realize it's hard to teach him because he is going the other way,") but also said that he often yells at his brother when he becomes frustrated and later regrets it. The veteran denied any history of prior depressive episodes.

PAST PSYCHIATRIC HISTORY: The veteran denied any history of outpatient mental health treatment or inpatient psychiatric hospitalizations.

HISTORY OF SUICIDAL ACTS AND SELF-HARM: This patient has no history of suicide attempt.

HISTORY OF VIOLENCE/ASSAULTING OTHERS/LEGAL PROBLEMS: Denied – Some history of physical altercations when intoxicated

SUBSTANCE USE HISTORY: The veteran reported that he drank heavily following his return from Vietnam up until the early 1980s. He denied any legal or work-related problems because of his alcohol use. However, he stated that he was pulled over by the police multiple times for driving while intoxicated but was never charged, that he totaled his car while drunk, that he had a tendency to get into physical fights while intoxicated, and that he frequently experienced blackouts. He denied any history of participating in outpatient or inpatient treatment for substance abuse. He stated that since 2002 he has been consuming approximately 4 drinks per year, all at a birthday party for his neighbor's child. He denied any problematic use of other substances, or misuse or prescription medications.

MENTAL ILLNESS AND SUBSTANCE ABUSE IN FAMILY MEMBERS: The veteran reported a strong family history of alcohol abuse/dependence (father and two brothers). He also reported a family history of Parkinson's disease (father and brother).

PSYCHOSOCIAL HISTORY:
a) Childhood/Developmental History: The veteran was born and raised in Whitman, MA. He had 2 older brothers and 1 older sister (1 brother is deceased from alcohol-related complications). His father was an alcoholic and the veteran stated "We did our best to live around him". He reported a history of childhood physical abuse perpetrated by his father and stated that he also witnessed his father physically abusing his mother and his siblings. He and his brother Q would occasionally sleep in the woods when their father was drinking to protect themselves. He denied PTSD symptoms related to this abuse. He also denied a history of sexual abuse. His family struggled financially, and the veteran began working in a Laundromat while in high school. He stated that he would work until 2am, and then wake up at 6am for school, which made it impossible to do his homework. He also described minor behavioral problems at school, including cutting class and getting caught smoking. The veteran was often teased by his classmates for his inexpensive clothing. He reported close relationships with

his brothers, but said they often got into physical altercations. The veteran reported a very close relationship with his mother, and he provided care for her prior to her death from pneumonia at age 93 in the 1990s.

b) Adult Relationship History: The veteran reported that his longest romantic relationships were two heterosexual relationships, both of which occurred before he joined the military at age 23. He stated that he was "too busy working" after his return from Vietnam for any subsequent romantic relationships. He has no children.

c) Current significant family and/or peer group relationships: The veteran has limited social support. He identified his brother and his sister as his primary support system. As mentioned above, the veteran's brother has Parkinson's. They live together, and the veteran provides direct care. His sister lives in Florida.

d) Financial Status, Housing, Employment: The veteran lives with his brother in a house in Abington, MA. He has been retired since 2005. He denied any current financial strain, and stated that he and his brother are able to afford their home using the veteran's railroad pension and his brother's social security. The veteran held a series of jobs throughout his life including loading trucks, working for the railroad, owning a bar, owning an ice cream shop, and working for Shaw's. The veteran reported that his irritability sometimes affected his employment (e.g., would throw difficult customers our of his ice cream shop; often argued with managers at Shaw's).

e) Religious/Spiritual or Cultural Issues that might influence treatment: The veteran was raised Catholic, but he does not consider himself a religious or spiritual person.

f) Relevant community resources accessed by patient: Vet Rep, currently filing a C&P claim for medical issues and PTSD

g) Legal assessment:
Do you currently have pending legal problems? No

Educational Assessment
1) What was the highest grade you completed in school? 12

2) Did you graduate from high school? Yes

3) Patient's interests and involvement in education already obtained: Management

4) Patient's learning style: Not assessed

5) Patient's interest in additional education at this point: None at this time

Significant barriers to learning: None endorsed

Is patient interested in a referral to Incentive Therapy or Compensated Work Therapy for further education assessment? No

Leisure:
How do you currently spend most of your free time? The veteran spends much of his time at home providing care to his brother. He also volunteers at the VA 3 days per week and exercises frequently (swims at the VA Z-3 days per week, walks 30 minutes 2x/week and lifts weights).

Do you find this way of spending your free time enjoyable? Sometimes

ENVIRONMENTAL ISSUES
Current Living Situation:

With brother
Current Occupational Status:
Retired

MILITARY HISTORY:
Branch, main duties, location if overseas: The veteran joined the Army at age 23. He served for 3 years total, including 1 year in Vietnam (1965-1966). He was a personnel clerk, with a variety of duties including delivering the mail, assisting the surveyors, and being on guard duty. He stated that as the mail carrier he got to know many of the other soldiers well, and they often confided in him about their home lives. He also said he tried to volunteer for several missions, but was never selected. For this reason, he did not see direct combat, but often witnessed the aftermath (e.g., seeing injured soldiers being brought back to the base, hearing about friendly fire over the radio, seeing a helicopter being shot down).

MEDICAL INFORMATION

ALLERGIES AND ADVERSE DRUG REACTIONS: HCTZ HYDROCHLOROTHIAZIDE
(include response to medications, any medication side effects)

CURRENT MEDICAL PROBLEMS: HTN, hyperlipidemia, tinnitus, mild thrombocytopenia - the veteran's medical history is also significant for GERD, ocular migraines, hypothyroidism, s/p hydrocele repair 1975, and s/p L inguinal hernia repair 1993.

PHYSICAL HEALTH SCREENING:
PCP

CURRENT SIGNIFICANT PAIN PROBLEMS:
Please rate on a scale of 0-10 (0 = no pain, 10 = worst you've ever felt)
Current Pain Level: 0 - No pain
Is pain currently at an acceptable level for you? Yes

NUTRITION ASSESSMENT:
CHEWING PROBLEMS: No
SWALLOWING PROBLEMS: No
OTHER GI ISSUES: No
APPETITE: Good
FEEDING ASSISTANCE REQUIRED: No
FOOD ALLERGIES: None known
SUPPLEMENT/HERBAL USE: No
REFER TO NUTRITION SERVICE: No

MEDICATION RECONCILIATION:
I did not update the non-va medication list due to the following:
I am not a prescriber

Active and Recently Expired Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	CARBOXYMETHYLCELLULOSE 0.5% OPH(PURITE) INSTILL 1 DROP (PURITE 0.5%) INTO EACH EYE AS NEEDED FOR EYE LUBRICATION	ACTIVE
2)	LEVOTHYROXINE NA 0.05MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR THYROID REPLACEMENT	ACTIVE
3)	LISINOPRIL 40MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY TO CONTROL BLOOD PRESSURE	ACTIVE
4)	NIACIN (NIASPAN) 500MG SA TAB TAKE (DO NOT CRUSH) ONE TABLET BY MOUTH AT BEDTIME FOR CHOLESTEROL	ACTIVE
5)	OMEPRAZOLE 20MG EC CAP TAKE ONE CAPSULE BY MOUTH	ACTIVE

EVERY DAY 30 MINUTES BEFORE BREAKFAST FOR STOMACH ACID
6) SIMVASTATIN 10MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME FOR REDUCING CHOLESTEROL ACTIVE
7) TERBINAFINE HCL 1% CREAM APPLY MODERATE AMOUNT TO SKIN TWICE A DAY FOR FUNGAL INFECTION ACTIVE

No Active Remote Medications for this patient

CURRENT NICOTINE AND CAFFEINE USE: The veteran quit smoking in 2002. Prior to that, he smoked approximately 2ppd since adolescence. He drinks approximately 4 cups of coffee per day.

MENTAL STATUS EXAM:

ORIENTATION AND CONSCIOUSNESS: alert and attentive, oriented x3

APPEARANCE AND BEHAVIOR: cooperative and reasonable, grooming appropriate

SPEECH: normal rate/rhythm

LANGUAGE: intact

MOOD AND AFFECT: affect is congruent with mood, mood depressed, tearful at times

PERCEPTUAL DISTURBANCE (hallucinations, illusions): none

THOUGHT PROCESS AND ASSOCIATION: normal, coherent

THOUGHT CONTENT (delusions, obsessions etc.): no unusual thought content

SUICIDAL OR VIOLENT IDEATION: none

INSIGHT: good

JUDGMENT: good

MEMORY: intact

FUND OF KNOWLEDGE Average

MENTAL STATUS COMMENTS: The veteran arrived on time for his appointment. He was well groomed and appeared his stated age. He was pleasant and cooperative throughout the session. He was tearful at times. Of note, the veteran expressed some concern about seeing a mental health provider (i.e., he said "Who will see these notes?" and "There is still a stigma") as well as some concern about my perception of him (i.e., he said "So, do you think I am crazy?"). He was also verbose and occasionally tangential, and expressed insight about this behavior (i.e., he said "I have always been a rambler").

SUMMARY AND FORMULATION:

Mr. CZ is a 68-year-old Caucasian, single Vietnam era veteran who was referred to the Geriatric Mental Health Clinic by his PCP (Eileen Wilmarth-Guerette RNP) after he contacted the Patient Call Center and requested anger management services. His presentation today was consistent with PTSD related to traumatic experiences during his time in Vietnam (1965- 1966). Although the veteran's symptoms have been present since his return from Vietnam and seem to have affected his functioning throughout his life (e.g., difficulty getting along with others at work, history of Alcohol Abuse in Sustained Full Remission, lack of long-term romantic relationships), they have worsened in recent years, which he attributed to the strain of providing care for his brother with

Parkinson's disease, the events of September 11, and his retirement. Additionally, the veteran is endorsing significant depressive symptoms at present, and future sessions will focus on determining if Major Depressive Disorder or Adjustment Disorder with Depressed Mood is the most appropriate diagnosis given his ongoing caregiving stress. The veteran was receptive to participating in biweekly individual therapy with this clinician, and may also benefit from participation in groups (e.g., the introductory psychoeducational group in the PTSD clinic).

I. SCREENING ASSESSMENT OF DANGER TO SELF:

1. Have you ever tried to harm yourself in the past?
NO
2. During the past month have you had any thoughts about harming yourself?
NO
3. During the past month have you harmed yourself or attempted suicide?
NO
4.
NO significant current risk of harm to self (both items 1 and 2 "no").

V. SCREENING ASSESSMENT OF DANGER TO OTHERS:

23. Have you ever tried to seriously harm someone else in the past?
NO
24. During the past month have you had any thoughts about harming someone else?
NO
25.
NO significant current risk of harm to others (both items 23 and 24 "no").

INITIAL DSM-IV DIAGNOSIS:
Axis I Clinical Disorder:
PTSD
Major Depression versus Adjustment Disorder with Depressed Mood
Alcohol Abuse in Sustained Full Remission
Axis II Personality Disorders/Traits: Deferred
Axis III Current Medical Conditions: See Medical History above
Axis IV Current Psychosocial Stressors: primary support group (caregiving responsibilities for brother)
Axis V GAF Score (current level of functioning): 52

MH INTEGRATED SUMMARY
I. MULTIDISCIPLINARY ASSESSMENT SUMMARY (Include here any findings, observations, or symptoms that are outside normal limits, especially those contributing to the need for hospitalization. Note any personal or cultural factors that are clinically relevant by virtue of their potential impact on these clinical items, their assessment or management. Also note any inconsistent or missing data. Summarize patient strengths that might be enlisted to facilitate, and patient liabilities that may limit, progress toward treatment goals. Finally, integrate all of the above information into a set of clinical problems.):

PTSD, Major Depression versus Adjustment Disorder with Depressed Mood, Alcohol Abuse in Sustained Full Remission- Please refer to the summary and formulation for more information

II. ACTIVE PROBLEMS THAT WILL BE ADDRESSED DURING THIS EPISODE OF CARE (From the clinical problem set above select 2 or 3 that will be the focus of treatment. These problems should be selected and listed in order of clinical priority: problems that directly impact immediate safety have the

highest priority, followed by problems that affect safety or health in the intermediate time frame, followed by problems that have predominantly long-term effects.):

PTSD, Major Depression versus Adjustment Disorder with Depressed Mood

III. PROBLEMS THAT WILL NOT BE A FOCUS DURING THIS EPISODE OF CARE
(Include here, in decreasing order of priority/importance, all remaining problems from the original problem set, and any other problems (e.g., inactive/historical problems) that may have clinical relevance at a later date. Please provide an explanation/rationale for each deferral): N/A

IV. THE FOLLOWING HAVE BEEN COMPLETED (enter "Y" or "N"):
Yes Suicide/Homicide Risk Assessment
Yes Problem List updated
N/A AIMS done (if appropriate)
Yes GAF

Initial Treatment Plan:
1. The veteran agreed to participate in biweekly individual therapy with this clinician focused on his symptoms of PTSD and depression and ongoing caregiving strain.
2. The veteran was initially somewhat hesitant to consider group therapy (i.e.., he said "I don't want to have to talk about Vietnam with a group of people"), but he was receptive to the Introduction to PTSD psychoeducational group in the PTSD Clinic once he was provided with more information about the structure of this group. He agreed to think about this option, and we will discuss it further at future sessions.

Long Term goals: The veteran will report an improvement in his symptoms of PTSD and depression such that they no longer significantly interfere with his everyday functioning. He will also report improved ability to cope with caregiving strain.

Anticipated Duration 6-12 Months

I have reviewed the remote data, progress notes and initial assessment on this patient. Interventions in this treatment plan will address any high risk behaviors as appropriate."
GAF Screening:
GAF (Mental Health Instrument)
GAF Score: 52

Therapy Session (before brother's death):

LOCAL TITLE: Outpatient/Psychology
STANDARD TITLE: PSYCHOLOGY OUTPATIENT NOTE
DATE OF NOTE: JUL 13, 2012@17:17 ENTRY DATE: JUL 13, 2012@17:17:38
AUTHOR: MULLIGAN,ELIZABETH EXP COSIGNER:
URGENCY: STATUS: COMPLETED

The Outpatient Individual Psychotherapy Services Agreement was initiated with this provider on January 12, 2012. Psychotherapy services, including areas of progress and goals for therapy, were re-evaluated on 5/11/12. They will be evaluated again on or around 9/11/12.

Geriatric Mental Health: Individual Psychotherapy

DATA: 50 minute individual therapy session

PURPOSE: The purpose of today's session was to continue discussing the impact of traumatic events on the veteran's life and encouraging him to engage

in healthy coping skills for managing his anxiety and caregiving strain.

BACKGROUND: Mr. C Z is a 68-year-old, Caucasian, single Vietnam era veteran who was referred to the Geriatric Mental Health Clinic by his PCP after he contacted the Patient Call Center and requested anger management services. His presentation on intake was consistent with Major Depressive Disorder and PTSD related to traumatic experiences during his time in Vietnam (1965- 1966) as well as his childhood (physical abuse perpetrated by his father). Although the veteran's symptoms have been present since his return from Vietnam and seem to have affected his functioning throughout his life (e.g., difficulty getting along with others at work, history of Alcohol Abuse in Sustained Full Remission, lack of long-term romantic relationships), they have worsened in recent years, which he attributed to the strain of providing care for his brother with Parkinson's disease, the recent conflicts in Iraq and Afghanistan, and his retirement. The veteran denied any history of inpatient psychiatric hospitalization or outpatient mental health treatment. For more information please refer to the Mental Health Outpatient Initial Assessment dated 12/2/11 by this clinician.

PROBLEM/NEED: PTSD with depression
OBJECTIVES:

1. Veteran will become more aware of the effects that multiple traumatic events have had on him.
2. Veteran will gain an understanding of how symptoms of PTSD are affecting his life and interacting with other problems (e.g., anger, caregiver strain).
3. Veteran will develop consistent use of healthy coping skills to manage his symptoms of anxiety and depression.

PROGRESS/SESSION CONTENT: Today we continued our conversation regarding the veteran's thoughts and feelings about the therapy process and his interactions with me. The veteran stated, "Sometimes I wonder if you think we are getting anywhere in therapy". We had a conversation about the veteran's progress towards his goals for therapy (e.g., he still gets angry at times, but feels better able to manage his anger; he "doesn't blame [himself] as much for what happened in Vietnam"). Mr. Z also identified several symptoms that are still distressing to him, including sleep difficulties (estimates approximately ~5 hours per night) and tearfulness (reports episodes of crying of fairly short duration 5-6 days/week, typically while watching the news).

Additionally, the veteran expressed some surprise about his ability to trust me in therapy. In particular, he noted that the only other person he has trusted for many years in his brother Q, and that he finds it interesting that he feels comfortable sharing information with me given that he has not known me for very long. We began a discussion of how the veteran knows someone is or is not trustworthy, and we agreed to continue this conversation at out next session.

ASSESSMENT: Veteran arrived on time for his scheduled appointment. He was cooperative and remains highly motivated for treatment. He is also insightful and openly shares information with this clinician. Although his PTSD symptoms have improved over time (PCL-M = 40 on 5/11 versus 47 on 12/1/11), he has continued to endorse some symptoms, most notably sleep disruption, irritability, intrusive thoughts, tearfulness, and feelings of distance from others. The veteran has also endorsed improvements in his depressive symptoms both on interview and in a self-report measure (BDI-II = 17 on 5/11 versus 29 on 12/1/11). He continues to experience strain related to providing care for his brother. The veteran remains fairly verbose and occasionally circumstantial, but has insight about this issue and is responsive to redirection.

Axis I Clinical Disorder:
PTSD, chronic
Major Depressive Disorder, Single Episode, in Partial Remission
Alcohol Abuse in Sustained Full Remission

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Axis II Personality Disorders/Traits:  Deferred
Axis III Current Medical Conditions:  See Medical History
Axis IV Current Psychosocial Stressors: Primary support group (caregiving
        responsibilities for brother)
Axis V GAF Score (current level of functioning): 55

PLAN:
- Continue biweekly individual psychotherapy with this provider.
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Sample Group Therapy Note:

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GERIATRIC MENTAL HEALTH CLINIC: Bereavement Group

Intervention:  Time-limited bereavement group co-led by
Psychology Fellow, and Elizabeth Mulligan, PhD, who supervises Fellow.

Data:  Pt. seen for 60 min.; 4 members present.

Group Purpose:  To explore responses to the death of a loved one, strategies for
coping with loss, and learning to face life without that person in a setting of
mutual support and respect.

Group themes: Session 7 - Veterans discussed lessons they learned throughout
their lives about men crying/showing emotions as well as potential consequences
of these messages.

Individual issues:
Problem #1: Bereavement

Objective: To better understand thoughts and feelings related to the death of a
loved and to demonstrate an ability to cope with this loss.

Progress: Mr. Z talked about being taught not to cry during his childhood and
his time in the military, and shared how these lessons are inconsistent with his
current experience of grief. He noted that he is sometimes hard on himself when
he becomes tearful in response to triggers (e.g., watching something about the
military on television, coming across something of his brother's), but he also
acknowledged the potential risks of trying to avoid his emotions. He also noted
his initial discomfort seeking mental health treatment.

Assessment/Mental Status: The veteran arrived on time for the group. Of note, he
previously acknowledged he has a tendency to make jokes when uncomfortable, but
did so less frequently during this group. He was circumstantial at times and
occasionally attempted to have side conversations but is responsive to
redirection. In previous sessions, he scored the following on self-report
measures:

1/28/13: Inventory of Complicated Grief = 30/76
2/11/13: Beck Depression Inventory-II = 20/63 (moderate depression)

Plan:
- Continue 8-session bereavement group.
- Continue individual psychotherapy with Elizabeth Mulligan, PhD.
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Final Individual Therapy Note and Termination Summary:

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LOCAL TITLE: Outpatient/Psychology
STANDARD TITLE: PSYCHOLOGY OUTPATIENT NOTE
DATE OF NOTE: AUG 26, 2013@15:43     ENTRY DATE: AUG 26, 2013@15:43:12
      AUTHOR: MULLIGAN,ELIZABETH   EXP COSIGNER:
     URGENCY:                          STATUS: COMPLETED
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*** Outpatient/Psychology Has ADDENDA ***

The Outpatient Individual Psychotherapy Services Agreement was initiated with this provider on January 12, 2012. At our last session on 8/12/13, we discussed psychotherapy services, including areas of progress and goals for therapy, and decided meet one more time individually to summarize our work together. After that point, Mr. Z is planning to attend the time-limited stress management group in the Geriatric Mental Health Clinic, which will likely begin in mid-September.

Geriatric Mental Health: Individual Psychotherapy

DATA: 50 minute individual therapy session

PURPOSE: The purpose of today's termination session was to review our work together.

BACKGROUND: Mr. C Z is a 70-year-old, Caucasian, single Vietnam era veteran who was referred to the Geriatric Mental Health Clinic by his PCP after he contacted the Patient Call Center and requested anger management services. Prior to that time, he had no history of inpatient psychiatric hospitalizations or outpatient mental health treatment. His presentation on intake was consistent with Major Depressive Disorder and PTSD related to traumatic experiences during his time in Vietnam (1965- 1966) as well as his childhood (physical abuse perpetrated by his father). Although the veteran's symptoms have been present since his return from Vietnam and seem to have affected his functioning throughout his life (e.g., difficulty getting along with others at work, history of Alcohol Abuse in Sustained Full Remission, lack of long-term romantic relationships), they have worsened in recent years, which he attributed to the strain of providing care for his brother with Parkinson's disease, the recent conflicts in Iraq and Afghanistan, and his retirement. Of note, the veteran's brother passed away on July 28, 2012. For more information please refer to the Mental Health Outpatient Initial Assessment dated 12/2/11 by this clinician.

PROBLEM/NEED: PTSD with depression
OBJECTIVES:
1. Veteran will become more aware of the effects that multiple traumatic events have had on him.
2. Veteran will gain an understanding of how symptoms of PTSD are affecting his life and interacting with other problems (e.g., anger, caregiver strain).
3. Veteran will develop consistent use of healthy coping skills to manage his symptoms of anxiety and depression.

PROBLEM/NEED: Bereavement (death of brother Q in July 2012)
OBJECTIVE:
1. The veteran will be better able to understand his feelings about the death of his brother and demonstrate an ability to cope with this loss.

PROBLEM/NEED: Insomnia
GOAL: To improve sleep quality and satisfaction with sleep.
OBJECTIVES:
1: The veteran will demonstrate consistent use of strategies for stimulus control, sleep restriction, and sleep hygiene as well as an awareness of the rationales for these strategies.
2: The veteran will report improved sleep efficiency (ratio of Total Sleep Time/Time in Bed).

PROGRESS/SESSION CONTENT: The veteran reported ongoing improvements in his bereavement (i.e., "I have my melancholy moments, but a lot has improved over time"), insomnia (has been using the strategies he learning in the Coping with

Insomnia group more consistently; slips back into his old pattern of variable bedtimes and wake times on a fairly regular basis, but is able to self-correct), and depression. With regard to his PTSD, he noted that he has a better understanding of the effects that traumatic experiences in childhood and Vietnam have had on him. He still experiences intrusive thoughts at times, but they are not as frequent and he is more able to accept these thoughts. His primary areas of concern at this time are ongoing anger/irritability and tearfulness (several minutes of crying in reaction to the news on a daily basis when at home). He benefits from some normalizing of this crying.

At our last session, we discussed various options for ongoing mental health treatment, including group psychotherapy (time-limited anger management, stress management or guided autobiography groups or an ongoing support group), individual psychotherapy focused specifically on anger and tearfulness, or discontinuing therapy at this time. The veteran continued to express a preference for the time-limited stress management group.

The veteran reported that he was recently awarded 50% SC for PTSD. He noted that he sometimes feels guilty about this award because he believes veterans who saw more combat deserve to be service-connected more than him. We talked about this issue in the context of the observations the veteran made during the course of treatment about holding himself to a higher standard than others and consistently feeling that he does not deserve certain things. We then reviewed the veteran's individual therapy treatment summary (see below). The veteran expressed appreciation for our work together, and I wished him well.

MENTAL STATUS/ASSESSMENT: The veteran was alert and oriented X3. He is somewhat circumstantial at baseline and has insight about this tendency. He denied SI/HI today. The veteran's symptoms of depression, PTSD, grief, and insomnia have all improved over time. His most distressing symptoms at this time are tearfulness and anger/irritability.

Axis I Clinical Disorder:
  PTSD, chronic
  Major Depressive Disorder, Single Episode, in Partial Remission
  Alcohol Abuse in Sustained Full Remission
Axis II Personality Disorders/Traits: None
Axis III Current Medical Conditions: Tinnitus, LUTS, HTN, GERD, ocular migraine,
       thrombocytopenia, hyperlipidemia, hypothyroidism R knee meniscal tear-
Axis IV Current Psychosocial Stressors: Bereavement (recent death of brother)
Axis V GAF Score (current level of functioning): 59

PLAN:
- We terminated individual therapy at this time. The veteran would like to participate in the time-limited stress management group offered in the Geriatric Mental Health Clinic. He is aware that it will likely begin in mid to late September.

Individual Therapy Treatment Summary (a copy was provided to the veteran)

Goals for therapy:
1. To gain a better understanding of the grief process and to learn methods for coping with your loss.
2. To gain a better understanding of your military experience and the effect it has had on your life.
3. To learn strategies for improving your sleep.

Things you noticed and methods for maintaining progress:
1. Remember that there is no right or wrong way to grieve. It is important to give yourself time to feel the various emotions associated with your loss (for example, sadness and anger), while also building coping strategies and enjoyable activities into your life.
2. You talked about ways that you are living your life in a way that is

consistent with your brother's values and with what he would want for you, such as by volunteering at the VA.
3. You initially had a tendency to blame yourself for your brother's death, but you were also able to recognize how much you did for him. You acknowledged that your brother made some lifestyle choices that may have affected his health (for example, drinking).
4. You discussed personal strengths that have helped you to get through difficult times in the past, including your dedication to your family and your willingness to help others.
5. You related to many of the symptoms of PTSD and identified various ways in which your experiences both in childhood and in Vietnam have affected your life. You questioned why you were thinking more about your time in Vietnam at this point in your life, and came up with several potential reasons (for example, retirement, your brother's illness, the recent conflicts in Iraq and Afghanistan).
6. You shared the stories of your childhood and your time in Vietnam with me. You noticed that one of the key similarities between your childhood and your time in Vietnam was a sense of not being in control and of not being able to protect everyone around you (for example, at one point you said "I walked out of my father's home and directly into another place where I had no control").
7. We talked about your difficulties trusting other people, and how they might be related to your past experiences. We discussed what it felt like to trust both your brother and me.
8. You recognized that the best way to improve your sleep is to practice healthy strategies on a regular basis. You may slip back into some of your old habits (for example, going to bed very late at night), but you can refer to the materials from the insomnia group regarding what you need to do to get back on track. For example, you may set an alarm to remind yourself of when to get ready to go to bed.
9. You became more able to identify your anger, and to consider the risks and benefits of various course of action before acting on this anger.

Next step:
8 session stress management group in the Geriatric Mental Health Clinic - Thursdays from 1-2, likely starting Thursday, September 19.
Contact information: Beth Mulligan, PhD .

09/18/2013 ADDENDUM STATUS: COMPLETED
BRIEF TREATMENT SUMMARY: The veteran and this provider met for ~38 individual therapy sessions from November 2011-August 2013. He initially presented with symptoms consistent with PTSD, Major Depression, and Alcohol Abuse in Sustained Full Remission. Sessions were initially biweekly, but we transitioned to monthly sessions while the veteran attended an 8-session Coping with Bereavement group beginning in January 2013 and a 6-session Cognitive Behavioral Therapy for Insomnia group beginning in May 2013. Treatment targets included the following: (1) gaining a better understanding of how multiple traumatic events, including physical abuse perpetrated by the veteran's father during childhood and combat-related experiences in Vietnam, have had an effect on the veteran's life/how he views himself and the world; (2) gaining a better understanding of the grief process and to learning methods for coping with the death of the veteran's brother in July 2012; (3) learning strategies for improving his sleep.

Therapy initially focused on helping the veteran to develop healthy coping strategies including relaxation, behavioral activation, and anger management. Prominent themes in the veteran's trauma work included feelings of guilt that he tried to protect people (his family during childhood; his friends in Vietnam), but was unable to do so as well as the veteran's difficulties trusting others. For example, in Vietnam the veteran served as a personnel clerk, which included a variety of duties such as delivering the mail, assisting the surveyors, and going on guard duty. Per his report, he attempted to volunteer for missions, but was not selected. He also tried to help when a large number of deceased and injured soldiers were brought back to the base, but was told to leave by a commanding officer. The veteran also struggled with issues of esteem, including

questioning whether he deserved treatment given that he was not directly involved in combat (although he was clearly exposed to several traumatic events related to the aftermath of combat). Additionally, he was initially focused on why his symptoms had become more prominent later on his life. We discussed how it was likely that he had symptoms of PTSD all along, but they became more prominent as he got older because: (1) his methods of avoidance were no longer as feasible (drinking alcohol, working); (2) he was triggered by 9/11 and recent conflicts; and (3) providing care for brother brought back some of the same themes of feelings of helplessness when trying to protect people he loves. Over time, the veteran demonstrated an enhanced understanding of the effects of trauma on his life. He still experiences symptoms such as intrusive thoughts at times, but they are not as frequent and he is more able to accept these thoughts.

The veteran lived with his brother Q and served as a primary caregiver for him after he was diagnosed with Parkinson's disease up until his death in July 2012. The veteran and Q always had a very close relationship, as they often worked together to stay away from their father in childhood and this loss was very difficult for him. In both individual and group therapy, the veteran benefitted from grief work focused on accepting the reality of the loss, challenging his tendency to blame himself for Q's death (e.g., "I should have noticed something wasn't right), and encouraging him to reflect on his values and what he wants his life to look like now that Q is gone. Volunteering at the VA is one activity that that veteran really values. The veteran still experiences loneliness and tearfulness at times, but his grief is less frequent and less intense and he experiences less self-blame.

With regard to the veteran's sleep, in general he reported improvements over time as he learned and implemented the strategies in the CBT-I group. He demonstrated some tendency to slip back into his old pattern of variable bedtimes and wake times on a fairly regular basis, but has the capability to self-correct.

The veteran's improvement in all of these areas is reflected in changes in self-report measures:

7/12/13: PCL-M = 33
4/5/13: PCL-M = 48
12/4/11: PCL-M = 47

7/25/13: BDI-II = 14/63
2/11/13: BDI-II = 20/63
12/4/11: BDI-II = 29/63

7/29/13: Inventory of Complicated Grief = 18/76
1/28/13: Inventory of Complicated Grief = 30/76

7/12/13: Insomnia Severity Index = 6, no clinically significant insomnia
5/24/13: Insomnia Severity Index = 16, moderate clinical insomnia

The veteran identified his anger/irritability as a primary area of concern at this time. He was provided with information about time-limited anger management and stress management groups, and decided to participate in stress management. An ongoing support group will be considered after that, as further individual therapy is not anticipated at this time. Therapy groups are a nice fit for this veteran because he continues to struggle with issues with trust and with transferring the gains made in our therapeutic relationship to other relationships. Areas of strength include his resilience in the face of numerous traumatic and stressful events as well as his capacity for insight and self-reflection. The veteran is aware he can contact this clinician should he have questions or concerns about mental health treatment in the future.