# Case Study: Alice

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EDG 6337 Psychopathology and Psychopharmacology

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**CASE STUDY WORKSHEET**
**DIFFERENTIAL DIAGNOSIS**

Name: Alice
DOB: 01/23/2008
Age: 17
Sex: Female
Education Level: Senior in High School
Presenting Problem: PTSD, Suicidal Ideation, Binge Drinking

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Review records:
*Clinical Interview*
*Informants*
*Medical Records*
*Physicians*
*School records*
*Clinicians*
*Others*
*Psychological evaluations/reports*

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**Step 1: Gather complete database.**
**History of current illness:**

- Alice is a 17-year-old female referred to therapy after presenting to the emergency department with intense suicidal ideation and a plan to end her life. She has not made a prior suicide attempt. Her suicidal thoughts are chronic and have been escalating over the past several months. The primary trigger appears to be a sexual assault that occurred 8 months earlier, which led to the development of PTSD symptoms including avoidance, nightmares, guilt, and persistent shame. Since the assault, Alice's alcohol and substance use has increased significantly, and she now binge drinks about once per week and occasionally uses cannabis, esctascy/molly, and other substances. She has also engaged in self-harming behaviors (cutting) and reports ongoing family conflict, particularly with her mother. Therapy prior to this referral focused on stabilizing her suicidal risk.
    - Questions:
    - How frequently does Alice experience suicidal ideation now?
    - Are there specific triggers that intensify her symptoms or self-harming behavior?
    - When did Alice first begin experimenting with substances?
    - Does Alice intake substances alone, in a social setting, or both?
    - Has she ever made a safety plan in therapy?
    - How has the previous therapist approached trauma work, was it CBT-based or stabilization only?
    - Does Alice feel any sense of hope or motivation for the future?

- Initial Thoughts: First thoughts are that trauma is at the core of everything right now, shame, isolation, substance use, avoidance. PTSD is clearly present, but I'm also wondering about Major Depressive Disorder (NIMH, 2023) and possibly emerging traits of Borderline Personality Disorder, given chronic suicidal ideation, emotional dysregulation, self-harm (APA, 2022). I'd want to assess risk thoroughly and introduce structure early, CBT or Trauma-Informed CBT could be essential (Beck, 2020). Safety, emotion regulation, and trust will be key initial steps.

**Previous mental health history:**

- Alice began therapy six months prior to the study, initiated after her hospital visit. She has not been formally treated for any mental health disorder before that point. There is no reported history of psychiatric hospitalization, but she has been experiencing symptoms of trauma, depression, and substance misuse for months, possibly years. No known history of previous diagnoses until PTSD was confirmed by the referring psychologist.
    - Questions:
    - Were there any early signs of anxiety or depression prior to the assault?
    - Has Alice ever spoken about self-esteem or identity struggles before this event?
    - Did school staff ever raise concerns about her emotional or behavioral well-being?
- Initial Thoughts:
  There's a sense that Alice's mental health needs may have been under-identified prior to the trauma, especially considering her achievement orientation and silence surrounding the assault. The trauma appears to have amplified existing vulnerabilities, such as low self-worth and possible family instability. Early detection and support may have altered the trajectory of her distress (Dorsey et al., 2017).

  Additionally, the trauma may have disrupted Alice's developmental narrative, her internalized understanding of self, safety, and agency. She may now view herself primarily through the lens of victimization or brokenness, which could reinforce negative self-appraisals and maladaptive coping (Briere & Scott, 2015). This shift in self-concept is critical to consider in both case conceptualization and treatment planning, as it may impact her capacity for resilience and engagement in therapy.

**Personal & social background:**

- Alice was previously an honors student in a selective academic stream. Before the trauma, she had goals of attending university and was highly motivated. She now lives with her mother, older sister (19), and brother (22), and describes significant conflict with her mother. Alice first used alcohol at 14, tobacco and cannabis at 15, and began using MDMA, cocaine, and ketamine at 17. She only disclosed the rape to one friend and her psychologist. Socially, she now mostly attends parties while intoxicated and no longer goes out sober. She's withdrawn from school, no longer studies at home, and skips classes regularly.
    - Questions:
    - Who does Alice feel emotionally close to, if anyone?
    - What were her friendships like prior to the trauma?

    - How does she perceive school now, does she still want to graduate or attend college?
    - Does she feel safe at home?
- Initial Thoughts:
  She has lost all grounding. No safe space at home. No emotional regulation tools. She's detached from her identity as a student, and her social life is now tightly linked to substance use (SAMHSA, 2022). I'd like to explore whether she can re-engage in school in small, supportive ways. Her strengths before the trauma give hope for resilience if stability can be re-established.

  Given that Alice demonstrated risk-taking behaviors as early as age 14, the school has an important role in evaluating her needs and coordinating services. A trauma-informed school approach, using multi-tiered systems of support (MTSS), behavioral screening, and individualized academic accommodations, could help identify early warning signs and connect her with appropriate interventions (Blodgett & Dorado, 2016). School counselors, educators, and support staff can also work collaboratively to create safety, consistency, and a sense of belonging, which are crucial for re-engaging traumatized youth in the learning process.

**Family history:**

- Alice's parents divorced when she was 8 years old. She sees her father weekly. He is a first responder who reportedly has PTSD and uses alcohol to cope. Alice believes he drinks heavily due to his trauma but has never received treatment. There's frequent conflict between Alice and her mother. There's no mention of parental abuse, but the household appears emotionally dysregulated.
    - Questions:
    - What's Alice's relationship like with her father, supportive or emotionally distant?
    - Has Alice ever witnessed violence or instability growing up?
    - Does anyone in the family have a history of suicide attempts, psychiatric treatment, or substance dependence?
- Initial Thoughts: This could be an intergenerational trauma case. Her father's untreated PTSD and substance use may have modeled unhealthy coping behaviors (SAMHSA, 2022). There's likely emotional invalidation happening at home. I'd want to explore family dynamics more and potentially involve family in psychoeducation if clinically appropriate. Her home environment may be a barrier to recovery.

**Medical history**:

- There is no mention of chronic medical conditions. Alice's medical concerns appear to be related to injuries from self-harming and substance use. There are no medications currently reported. No history of psychiatric hospitalization, but she has had an emergency department visit for suicidal ideation.
    - Questions:
    - Has she had any medical complications from substance use or self-injury?
    - Is she currently on any psychiatric or medical medication?

    - Has she had a recent physical exam to rule out co-occurring medical issues (e.g., anemia, thyroid, etc.)?
- Medical stability needs to be assessed, especially if substance use is escalating. I'd want to coordinate with her PCP or a psychiatrist if needed. Also, trauma can cause somatic symptoms, so I'd ask about sleep, headaches, appetite, etc. Medical care might be another area where trust was broken or neglected.

**Plan of action:**

- Request and review previous medical and psychological records.
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- Request and review previous school records, including attendance and academic performance.
- Request and review reports from Alice's previous clinician(s), including risk assessments and treatment notes.
- Coordinate a release of information to communicate with Alice's primary care provider (PCP) to rule out medical contributions to mood or substance use (e.g., thyroid issues, nutritional deficiencies).
- Initiate a referral for psychiatric evaluation to consider pharmacologic support (e.g., fluoxetine) for comorbid PTSD/MDD symptoms (Sinacola et al., 2021).
- Conduct a comprehensive suicide risk assessment, including exploration of access to lethal means, protective factors, and prior safety planning.
- Develop or revise a safety plan collaboratively with Alice, incorporating coping skills, support contacts, and crisis response steps (Grohol et al., 2022).
- Explore eligibility for a Section 504 Plan or school-based accommodation for emotional disability, as recommended for trauma-affected adolescents experiencing school impairment (Perfect et al., 2016).
- Coordinate with school-based personnel (e.g., school counselor, school psychologist, social worker) to identify past behavioral patterns and academic struggles, especially given Alice's history of risk-taking behavior since age 14. Collaboratively develop a multidisciplinary school support plan, integrating trauma-informed classroom strategies, check-in/check-out systems, and re-engagement activities that foster a sense of safety and self-efficacy at school (Blodgett & Dorado, 2016).
- Initiate trauma-informed family engagement if appropriate, providing psychoeducation to parents/caregivers about trauma, boundaries, and support roles (Dorsey et al., 2017).
- Explore a referral to a substance use specialist or integrated treatment program experienced in co-occurring trauma and substance use in adolescents (SAMHSA, 2022).
- Track and monitor functional progress across therapy (symptoms, engagement, school, safety) using validated tools such as the UCLA PTSD Reaction Index or PHQ-9 for Adolescents.

**Mental Status Exam:**

- With the symptoms Alice resented, I will give her a mental status exam to evaluate and assess her appearance, mood, cognition, perception, thoughts, behavior, insight, and judgement to assist in the diagnosis process.

- Appearance
  - Alice appears disheveled and fatigued. Her clothing is casual but not unkempt, though she makes minimal effort in personal grooming.
  - Based on the information provided, she appears to be of appropriate weight for her age and gender, though her substance use and self-neglect may contribute to health risks in the future.
- Speech
  - Alice's speech is soft and slow at times, particularly when discussing her trauma.
  - She does not appear pressured or manic, but there may be a lack of enthusiasm or energy when she talks about herself or her future.
  - Her tone reflects underlying sadness and emotional exhaustion.
- Eye Contact:
  - Alice avoids direct eye contact during much of the interaction, especially when discussing emotionally distressing subjects. This may be due to feelings of shame, depression, or anxiety.
  - Her avoidant eye contact seems related to discomfort rather than distractibility.
- Motor activity
  - Alice exhibits mild psychomotor slowing. She may appear still or withdrawn, with little movement unless prompted. There are no overt signs of agitation such as pacing or fidgeting, though she may engage in subtle signs of tension like wringing her hands or keeping her arms crossed.
  - Muscle tension may be present when she discusses emotionally charged topics.
- Affect
  - Alice's affect is consistent with her reported mood. When she discusses her trauma, she becomes visibly emotional, tearful, and withdrawn.
  - Her affect is restricted but appropriate for the situation, reflecting sadness, shame, and hopelessness.
- Mood
  - Alice reports feeling "numb," "guilty," and "ashamed." She describes persistent sadness and hopelessness, especially in relation to her trauma and the impact it has had on her life. She denies current suicidal intent but acknowledges ongoing suicidal thoughts.

- Cognition
  - Alice is oriented to person, place, and time.
  - However, she has difficulty sustaining attention during extended conversations and is sometimes easily distracted.
  - Her thought process is logical but slowed, and she occasionally struggles with word-finding when emotionally distressed.
  - She is able to recall both short- and long-term memories but becomes visibly uncomfortable when recalling traumatic events.
- Perception
  - Alice does not report any hallucinations.
  - Her perception of reality is intact, and her thoughts are logically connected to her situation and experiences. There is no indication of perceptual disturbances.
- Thoughts
  - Alice experiences chronic suicidal ideation but has no current plan or intent. These thoughts are intrusive and connected to feelings of worthlessness and shame.
  - There are no signs of grandiosity, paranoia, or religious delusions. She does not present homicidal ideation or intent.
- Behavior
  - Alice is generally cooperative with the examiner and does not appear guarded or hyperactive. However, she presents as withdrawn, especially when asked to discuss personal or traumatic experiences.
  - She does not appear aggressive, but she may display irritability or emotional detachment as a defense mechanism.
- Insight
  - Alice's insight into her condition is fair.
  - She is aware that she has been deeply affected by the assault and acknowledges that her substance use and self-harm are unhealthy coping mechanisms. However, she sometimes minimizes the severity of her risk-taking behaviors or blames herself for the trauma, indicating distorted cognitive patterns.
- Judgment
  - Alice's judgment is currently impaired, especially in relation to her substance use, risk-taking behaviors (e.g., driving under the influence),

and self-harm. While she understands that these behaviors are dangerous, her emotional pain appears to override rational decision-making.

- Her overall judgment is poor to fair, depending on the context.

(Sinacola et al., 2021)

**Narrative Description of the Mental Status Examination (MSE)**

Alice is a 17-year-old Caucasian female of average height and weight. Her hygiene appeared somewhat neglected, and she was dressed casually but appropriately for the evaluation. She appeared tired and withdrawn. Alice was oriented to person, place, and time (oriented ×3). Her speech was soft and slow, with a flat tone and occasional hesitation when discussing emotionally difficult topics. Eye contact was minimal and avoidant, particularly when discussing the trauma she experienced.

There were no signs of hallucinations or delusional thinking, and her thought processes were logical and goal-directed. Her memory appeared intact, with the ability to recall both recent and past events, though she displayed emotional distress when discussing traumatic memories. Attention and concentration were mildly impaired, and she was easily distracted during the evaluation.

Alice described her mood as "numb" and "ashamed," with a congruent affect that was flat and tearful at times. She reported ongoing suicidal ideation without a current plan or intent and disclosed a history of non-suicidal self-injury. No homicidal ideation was reported. She denied substance dependence but acknowledged regular binge drinking and intermittent drug use. Insight into her condition was fair, as she demonstrated some awareness of how her trauma has affected her behavior. Judgment appeared impaired, particularly in regard to substance use and risky behaviors such as driving under the influence. Cognitive functioning was within the expected range for her age, and there were no noted learning or developmental delays.

(Sinacola et al., 2021; Grohol et al., 2022)

**Questions & Plan of Action:**

**By completing the MSE, I am able to evaluate and examine the signs presented by the client and determine the congruency between her self-report and observed symptoms.** This structured assessment helps establish a baseline for diagnosis and treatment planning by identifying patterns in cognition, mood, behavior, and thought processes. It also allows for the monitoring of changes over time and ensures that any immediate safety concerns, such as suicidal ideation or impaired judgment, are clearly documented (Grohol et al., 2022).

**Why would you use the MSE for your client?**
The Mental Status Examination (MSE) is a crucial tool for evaluating Alice's current psychological functioning. It allows me to assess whether her verbal self-reports align with her observed behavior, emotional expression, cognitive functioning, and overall mental state. Given Alice's history of trauma, suicidal ideation, and substance use, the MSE provides a structured

way to document the severity of symptoms, evaluate safety concerns, and guide future diagnosis and treatment planning. It also helps track changes in her condition over time (Sadock et al., 2023).

**What signs are being presented by the client?**
Alice presents with several concerning signs, including:

- Flat, tearful affect and self-reported mood of numbness and shame
- Avoidant eye contact and limited emotional expression
- Reports of chronic suicidal ideation and a history of self-harm
- Withdrawn behavior and social isolation
- Mild psychomotor slowing and low energy
- Impaired judgment, especially related to substance use and risky behavior (e.g., driving intoxicated)
  Fair insight into her condition, with some distorted self-perceptions (e.g., self-blame for trauma)
- These signs are consistent with trauma-related stress reactions, depression, and maladaptive coping (American Psychiatric Association, 2022).

**What disorders would you suspect based on the presenting signs?**
Based on Alice's symptoms and history, the following disorders may be considered:

1. **Post-Traumatic Stress Disorder (PTSD):** Alice meets several DSM-5-TR criteria, including re-experiencing, avoidance, negative alterations in mood and cognition, and hyperarousal..PTSD is especially common among adolescent survivors of sexual trauma (APA, 2022; Foa et al., 2023).

2. **Major Depressive Disorder (MDD)** –Her chronic suicidal ideation, emotional withdrawal, and anhedonia, the inability to feel pleasure or a loss of interest in activities that a person once enjoyed suggest MDD, which often co-occurs with PTSD in adolescents (APA, 2022; NIMH, 2023).

3. **Substance Use Disorder (Alcohol and Other Drugs)** – Alice's pattern of binge drinking and polysubstance use meets the criteria for substance misuse as a coping mechanism, often seen in trauma-affected youth (APA, 2022; SAMHSA, 2022).

**<u>Step 2</u>: Construct a Differential Diagnosis**

<u>General broad categories</u>:

- Neurodevelopmental Disorders
  - These disorders begin in early childhood and affect development in areas such as cognition, communication, and motor functioning. They often lead to challenges in academic, social, or occupational performance. Examples include Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), Intellectual Disabilities, and Communication Disorders. These are typically

lifelong conditions that begin early and can impact multiple domains of development (APA, 2022).

- Schizophrenia Spectrum and Other Psychotic Disorders
    - This category includes disorders characterized by disruptions in thinking, perception, and behavior, such as hallucinations, delusions, and disorganized speech. Disorders include Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, and Delusional Disorder. These conditions often involve a break from reality and impair daily functioning (Sadock et al., 2023; APA, 2022).
- Bipolar and Related Disorders
    - Bipolar disorders are marked by extreme mood swings, including manic or hypomanic episodes and periods of depression. These shifts can affect energy, activity levels, judgment, and behavior. Examples include Bipolar I Disorder, Bipolar II Disorder, and Cyclothymic Disorder (APA, 2022).
- Depressive Disorders
    - These disorders involve persistent sadness, hopelessness, and a loss of interest in daily life, also known as anhedonia. They often impair sleep, appetite, and concentration. Diagnoses include Major Depressive Disorder, Persistent Depressive Disorder (Dysthymia), and Disruptive Mood Dysregulation Disorder.(NIMH, 2023; APA, 2022).
- Anxiety Disorders
    - Anxiety disorders are characterized by excessive fear, worry, and related behavioral disturbances. Physical symptoms like restlessness, rapid heartbeat, and tension are common. Disorders include Generalized Anxiety Disorder, Panic Disorder, Social Anxiety Disorder, and Specific Phobia (APA, 2022).
- Obsessive-Compulsive and Related Disorders
    - These disorders involve repetitive, unwanted thoughts (obsessions) and/or behaviors (compulsions) that the person feels driven to perform. These actions often aim to reduce anxiety or distress. Examples include Obsessive-Compulsive Disorder (OCD), Hoarding Disorder, and Trichotillomania (hair-pulling) (APA, 2022).
- Trauma- and Stressor-Related Disorders
    - These conditions are triggered by exposure to trauma or significant stress. Common symptoms include re-experiencing, avoidance, emotional numbing, and hyperarousal. Disorders include Post-Traumatic Stress Disorder (PTSD), Acute Stress Disorder, and Adjustment Disorders (Foa et al., 2023; APA, 2022).
- Dissociative Disorders
    - Dissociative disorders involve disruptions in memory, identity, consciousness, or perception, often as a response to trauma. Individuals may feel disconnected from themselves or their surroundings. Diagnoses include Dissociative Identity Disorder, Dissociative Amnesia, and Depersonalization/Derealization Disorder (APA, 2022).
- Somatic Symptom and Related Disorders
    - These disorders involve physical symptoms that are distressing or disruptive, even when no clear medical cause is present. The focus is on how individuals interpret and react to these symptoms. Examples include Somatic Symptom Disorder, Illness Anxiety Disorder, and Conversion Disorder (APA, 2022).

- Feeding and Eating Disorders
    - This category includes disorders that affect eating behaviors and body image, often with dangerous physical and emotional consequences. They typically begin in adolescence and may involve restriction, binging, or purging. Diagnoses include Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder. (APA, 2022).
- Elimination Disorders
    - Elimination disorders involve inappropriate elimination of urine or feces and are usually diagnosed in children. These behaviors are not caused by medical conditions and often reflect developmental or emotional issues. Common diagnoses are Enuresis and Encopresis (APA, 2022).
- Sleep-Wake Disorders
    - These disorders involve difficulties related to sleep quality, timing, or duration. They may affect physical health, mood, and daily functioning. Diagnoses include Insomnia Disorder, Narcolepsy, and Circadian Rhythm Sleep-Wake Disorder (APA, 2022).
- Sexual Dysfunctions
    - Sexual dysfunctions are conditions that impair an individual's ability to experience sexual satisfaction or function. They may involve issues with desire, arousal, or orgasm, and can be caused by psychological or medical factors. Examples include Erectile Disorder, Female Orgasmic Disorder, and Genito-Pelvic Pain/Penetration Disorder (APA, 2022).
- Gender Dysphoria
    - Gender Dysphoria occurs when a person experiences significant distress due to a mismatch between their assigned gender at birth and their experienced gender. This distress can impact daily functioning and emotional well-being. The condition may be present in both children and adults (APA, 2022).
- Disruptive, Impulse-Control, and Conduct Disorders
    - These disorders involve problems with emotional and behavioral self-control. Individuals may display aggression, rule-breaking, or difficulty following social norms. Common diagnoses include Oppositional Defiant Disorder, Conduct Disorder, and Intermittent Explosive Disorder (APA, 2022).
- Substance-Related and Addictive Disorders
    - These disorders involve the compulsive use of substances despite harmful consequences. They may also include behavioral addictions such as Gambling Disorder. Diagnoses include Alcohol Use Disorder, Cannabis Use Disorder, and Stimulant Use Disorder (SAMHSA, 2022; APA, 2022).
- Neurocognitive Disorders
    - These disorders involve a decline in cognitive functions such as memory, attention, and reasoning. They are typically seen in older adults but can result from injury or illness at any age. Diagnoses include Delirium, Mild and Major Neurocognitive Disorder, and Alzheimer's Disease (APA, 2022).
- Personality Disorders
    - Personality disorders are long-term patterns of thinking, feeling, and behaving that deviate from cultural expectations and impair functioning. These traits are stable over time and often resistant to change. Examples include Borderline

Personality Disorder, Narcissistic Personality Disorder, and Antisocial Personality Disorder (Paris, 2022; APA, 2022).

- Paraphilic Disorders
    - Paraphilic disorders involve intense and persistent sexual interests that cause distress or involve harm or risk to others. They differ from atypical sexual interests in that they cause dysfunction or violate consent. Diagnoses include Pedophilic Disorder, Voyeuristic Disorder, and Exhibitionistic Disorder (APA, 2022).
- Other Mental Disorders and Additional Codes
    - This section is used when symptoms cause significant impairment but do not meet the full criteria for a specific disorder. These are labeled as "Other Specified" or "Unspecified" mental disorders. It allows clinicians to document clinically significant issues outside standard diagnostic categories (APA, 2022).
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication
    - These conditions involve motor symptoms caused by psychiatric medications, especially antipsychotics. Examples include Tardive Dyskinesia, Parkinsonism, and Akathisia. They are important to recognize and monitor during treatment (APA, 2022).
- Other Conditions that may be a focus of Clinical Attention
    - These are not mental disorders but may influence diagnosis or treatment. Examples include academic or relationship problems, grief, or exposure to abuse. They provide context for care even when no formal diagnosis is made (APA, 2022).

<u>Specific categories</u>:

- Trauma- and Stressor-Related Disorders
  Diagnosis: Post-Traumatic Stress Disorder (PTSD)
  DSM-5-TR Code: 309.81

  The Trauma- and Stressor-Related Disorders category includes disorders directly connected to a trauma or significant stressor, making it unique among diagnostic groups. These conditions include PTSD, Acute Stress Disorder, Adjustment Disorders, and Reactive Attachment Disorder. What sets this category apart is that the exposure to a traumatic event (e.g., death, injury, sexual violence) is an essential diagnostic requirement. Post-Traumatic Stress Disorder (PTSD), in particular, is a chronic condition that emerges after trauma and includes psychological and physiological symptoms that disrupt daily functioning.

  Alice meets full criteria for PTSD as outlined in the DSM-5-TR (APA, 2022). She experienced a sexual assault eight months prior, meeting Criterion A (direct exposure to actual or threatened sexual violence). She experiences recurring nightmares, intense feelings of shame and guilt, and withdrawal from social environments, symptoms aligned with Criterion B (intrusion symptoms) and Criterion C (avoidance). Alice also meets Criterion D, as she expresses persistent distorted beliefs (self-blame), emotional numbing, and disinterest in activities she once valued, such as academics. Lastly, she exhibits signs of Criterion E, including risk-taking behavior (e.g., driving under the

influence) and chronic suicidal ideation. These symptoms have lasted more than one month (Criterion F) and impair her academic, social, and emotional functioning (Criterion G), with no evidence of substance-induced psychosis or other medical cause (Criterion H).

Compared to Acute Stress Disorder, which lasts less than one month, Alice's symptoms are chronic and trauma-specific. Adjustment Disorder might also be considered in less severe presentations of stress responses, but it lacks the intense re-experiencing, intrusive memories, nightmares, and physiological hyperarousal that define PTSD. In Alice's case, the intensity, complexity, and duration of symptoms confirm a diagnosis of PTSD. Her ongoing substance use, emotional withdrawal, and suicidal ideation reinforce the importance of trauma-informed care.

- Depressive Disorders
  Diagnosis: Major Depressive Disorder (MDD), Recurrent, Moderate
  DSM-5-TR Code: 296.32

  Depressive Disorders are defined by persistent negative mood, cognitive distortions, and a significant decrease in functioning. The most commonly diagnosed condition in this category is Major Depressive Disorder (MDD), characterized by at least five symptoms lasting for two weeks or more, including either depressed mood or loss of interest/pleasure. These disorders are differentiated from bipolar conditions by the absence of manic or hypomanic episodes. MDD has a significant impact on sleep, concentration, motivation, and often leads to suicidal ideation or behavior, particularly in adolescents following trauma.

  Alice's presentation meets the full criteria for MDD, moderate and recurrent. She reports persistent feelings of numbness, sadness, and hopelessness. Her motivation and pleasure in life have diminished—she no longer engages in school or social activities unless under the influence. She reports chronic suicidal ideation and self-harming behaviors, indicating deep emotional pain. According to the DSM-5-TR (APA, 2022), Alice meets Criterion A with the presence of depressed mood, anhedonia, fatigue, diminished concentration, recurrent thoughts of death, and low self-worth. These symptoms cause clinically significant distress and impairment (Criterion B) and are not attributable to a substance or medical condition (Criterion C).

  MDD is more severe than Persistent Depressive Disorder (Dysthymia), which is typically lower in intensity but chronic in nature. Alice's symptoms are intense, functionally impairing, and clearly connected to a major life disruption (the trauma). Although her depression overlaps with PTSD, the criteria for both disorders are independently met. MDD should therefore be treated alongside PTSD to address core mood dysregulation, motivation, and suicidal thinking. Evidence-based therapies such as CBT, DBT, or trauma-focused interventions are essential in improving her mood and self-worth.

- Substance-Related and Addictive Disorders
  Diagnosis: Alcohol Use Disorder, Moderate

DSM-5-TR Code: 303.90

The Substance-Related and Addictive Disorders category includes conditions related to the overuse of substances such as alcohol, cannabis, stimulants, opioids, and sedatives. A diagnosis of Substance Use Disorder depends on meeting at least two of eleven criteria within a 12-month period. Symptoms are grouped into impaired control, social impairment, risky use, and pharmacological indicators (tolerance/withdrawal). Disorders in this category are considered chronic and relapsing, often co-occurring with mood and trauma-related conditions, especially in adolescents.

Alice meets the criteria for Alcohol Use Disorder, Moderate, due to her pattern of binge drinking, which she began at age 14. She currently consumes around 10 drinks per episode and reports drinking with the intent to become intoxicated. According to DSM-5-TR (APA, 2022), Alice fulfills at least four criteria: (1) consuming more than intended, (2) recurrent use in hazardous situations (driving under the influence), (3) continued use despite social/interpersonal problems, and (4) strong cravings. This level of use places her in the moderate severity range. Alice also occasionally uses cannabis and MDMA, though alcohol is her primary substance.

What sets her diagnosis apart from substance experimentation or risky adolescent behavior is the chronicity, severity, and emotional function of her drinking. Alice uses alcohol to cope with emotional pain, trauma-related symptoms, and social anxiety. Her drinking is not episodic or recreational; it is intentional and impairing. Compared to Conduct Disorder or Impulse-Control Disorders, her substance use is not driven by defiance or externalizing behavior—it's closely tied to internal emotional distress and trauma.

Treating Alcohol Use Disorder in Alice will require trauma-informed interventions, possibly integrating CBT for addiction, harm reduction strategies, and psychoeducation. Addressing her substance use is vital to stabilizing mood, improving academic engagement, and reducing self-harm and suicidality.

**<u>Step 3</u>: Diagnosis**

**Diagnosis 1**: Post-Traumatic Stress Disorder (PTSD)

DSM-5-TR Code: 309.81 (F43.10) – PTSD
ICD-11 Code: 6B41.0 – Post-traumatic stress disorder

**Diagnosis 2**: Major Depressive Disorder (MDD), Recurrent, Moderate

DSM-5-TR Code: 296.32 (F33.1) – MDD, Recurrent, Moderate
ICD-11 Code: 6A71.1 – Recurrent depressive disorder, current episode moderate

**Diagnosis 3**: Alcohol Use Disorder, Moderate

DSM-5-TR Code: 303.90 (F10.20) – Alcohol Use Disorder, Moderate
ICD-11 Code: 6C40.21 – Harmful pattern of use of alcohol, episodic

**Step 4: Medication**

- State the drug which should include:
    - the generic name of the drug: **Fluoxetine**
    - the brand name/s of the drug: **Prozac, Sarafem**
    - and what disorder/condition the drug addresses:
        - Major Depressive Disorder (MDD)
        - Post-Traumatic Stress Disorder (PTSD)
        - May also indirectly support reduction in substance cravings related to mood regulation
- Explain the mechanism of action of the drug
    - Fluoxetine is a **Selective Serotonin Reuptake Inhibitor** (SSRI). It works by blocking the reabsorption (reuptake) of serotonin in the presynaptic neuron, allowing more serotonin to remain in the synaptic cleft between neurons. This increased serotonin availability enhances serotonergic neurotransmission in brain areas associated with mood regulation, emotional control, and impulse inhibition (Sinacola et al., 2021).
    - Neurotransmitter Level Detail:
        - Normally, after serotonin is released into the synapse, it is reabsorbed by the presynaptic neuron via the serotonin transporter (SERT). Fluoxetine inhibits this transporter, prolonging the presence of serotonin at the receptor sites of the postsynaptic neuron. This helps stabilize mood, reduce anxiety, and improve overall emotional resilience (Stahl, 2021; Vaswani et al., 2003).
- For adolescent patients like Alice (age 17), the recommended dosing for Fluoxetine begins low and is gradually increased based on clinical response:
    - Starting Dose: 10 mg/day
    - Usual Maintenance Dose: 20 mg/day
    - Maximum Dose: Up to 60 mg/day (in rare, severe cases and with close psychiatric supervision)

- Alice is currently taking 20 mg per day, consistent with standard adolescent treatment protocols for MDD and PTSD (American Academy of Child & Adolescent Psychiatry [AACAP], 2018).
- Fluoxetine is generally well-tolerated in adolescents, but like all SSRIs, it comes with potential side effects. These may include:

    - **Common Side Effects:**

    - Nausea or gastrointestinal discomfort
    - Headache
    - Insomnia or sleep disturbances

- Fatigue or drowsiness
- Appetite loss or weight changes
- Anxiety or nervousness in early treatment phases

- **Serious** (but less common) Side Effects:

- Increased suicidal ideation, especially during the first 2–4 weeks of treatment (requires close monitoring)
- Serotonin syndrome (especially if combined with other serotonergic drugs)
- Emotional blunting or apathy in some cases
- Hyponatremia (low sodium levels), especially in females
- The FDA requires a black box warning for all antidepressants in individuals under age 25, noting the potential for increased suicidal thoughts during initial treatment stages. Alice's clinician should ensure close monitoring, especially given her high-risk profile (Bridge et al., 2007).

**Clinical Considerations:**
Given Alice's dual diagnosis of PTSD and MDD, Fluoxetine is a strong pharmacological choice. It has demonstrated efficacy in adolescents for both disorders and is often considered first-line due to its longer half-life, which provides more consistent blood levels and easier withdrawal tapering compared to other SSRIs (Cipriani et al., 2016).

Since Alice is also engaging in substance use, careful monitoring is necessary to assess drug interactions, medication adherence, and potential misuse. Therapy alongside medication is critical for success.

**Step 5: Treatment Plan**

**Long Term Goal 1:**

Alice will reduce trauma- and depression-related symptoms (e.g., nightmares, avoidance, shame, anhedonia, suicidal ideation) while increasing emotional regulation and overall psychological stability.

**Interventions**:

1. **Trauma-Focused Cognitive Behavioral Therapy** (TF-CBT):

- Utilize trauma narrative and graduated exposure to help Alice process her sexual assault in a safe, structured manner (Foa et al., 2023).

- Address re-experiencing symptoms through imaginal and in-vivo exposure (a type of behavioral therapy technique that helps clients confront feared real-life situations), and reduce avoidance through guided desensitization techniques (Foa, Hembree, & Rothbaum, 2007).

- Support trauma recovery through coping modules targeting grounding, emotion regulation, and cognitive reframing (Cohen et al., 2017).

2. **Emotion Regulation Skills Training** (DBT-Informed):

- Use Dialectical Behavior Therapy (DBT) tools to teach Alice how to label emotions, manage distress, and reduce impulsivity (Linehan, 2015).

- Provide mindfulness exercises and emotion tracking logs to promote awareness of internal states and build regulation strategies.

- Implement assertiveness training to help Alice navigate peer relationships and risky social settings.

3. **Safety Planning**:

- Create and regularly update a personalized suicide safety plan, including warning signs, distraction techniques, support resources, and crisis steps (Stanley & Brown, 2012).

- Discuss access to lethal means and establish a harm-reduction protocol in collaboration with Alice and her family/support team.

- Reinforce self-monitoring for early signs of emotional escalation and provide coping alternatives.

**Long-Term Goal 2:**

Alice will reduce substance use behaviors (e.g., binge drinking and polysubstance use), increase healthy coping alternatives, and gradually re-engage in academic and social functioning in a supportive, structured manner.

**Interventions**:

1. **Substance Use Relapse Prevention** (CBT-Based):

- Identify substance use triggers (e.g., parties, emotional distress) and high-risk situations through functional behavior assessments (Marlatt & Donovan, 2005).

- Implement relapse prevention planning focused on skill-building, support networks, and coping alternatives (SAMHSA, 2022).

- Use role-play and behavioral rehearsal to practice assertive refusal skills and sober social decision-making (Carroll & Onken, 2005).

2. **Academic Support and School Reintegration**:

- Coordinate with Alice's school counselor to create an Individualized Academic Support Plan or initiate a Section 504 eligibility review, given the significant impact of PTSD and depression on her academic functioning.
    - Supportive accommodations may include : reduced coursework, flexible deadlines, mental health-related absences, or access to a quiet space.
    - These interventions promote structure, reduce overwhelm, and align with trauma-informed practices in school settings (Chu et al., 2021; Kerns et al., 2022; U.S. Department of Education, 2021).
- Monitor weekly school participation and adjust goals based on Alice's readiness and mental health needs.
- Facilitate reintegration into non-academic domains (e.g., art, sports, volunteering) to rebuild identity and social resilience (Ungar, 2012).

3. **Family Engagement and Psychoeducation**:

- Offer structured family sessions to educate caregivers on trauma, recovery, adolescent development, and substance use (Murray et al., 2015).

- Coach caregivers in supportive communication and reinforcement strategies to promote recovery-congruent behaviors at home (Murray et al., 2015).

- Explore family dynamics and emotional invalidation patterns that may reinforce Alice's dysregulation or avoidance (Murray et al., 2015).

**Short-Term Goal 1:**

Alice will identify and challenge at least three maladaptive trauma-related thoughts (e.g., self-blame, hopelessness) using cognitive restructuring techniques in therapy.

**Interventions:**

1. **Cognitive Restructuring (CBT):**

    - Use guided discovery and Socratic questioning to help Alice recognize cognitive distortions and irrational beliefs about the trauma, such as "It was my fault" or "I am broken" (Foa et al., 2023).
    - Provide worksheets to practice reappraising these thoughts with more balanced, self-compassionate alternatives (Foa et al., 2023; Beck, 2020).
    - Introduce journaling as a self-monitoring strategy to help Alice identify recurring patterns in mood, sleep, appetite, and behaviors (e.g., avoidance, substance use). Journaling can also serve as a reflective tool for processing emotional triggers and reinforcing progress in cognitive shifts (Smyth & Pennebaker, 2018).

2. **Psychoeducation on Trauma:**

    - Educate Alice about the physiological and psychological effects of trauma to normalize her experience and reduce shame (Najmi et al., 2015).
    - Introduce the concept of trauma and memory, clarifying that trauma responses are survival-based, not moral failings (Courtois & Ford, 2013).

**Short-Term Goal 2:**

Alice will reduce binge drinking episodes to no more than one time per month over the next 8 weeks and explore at least two alternative coping strategies.

**Interventions:**

1. **Substance Use Monitoring (Motivational Interviewing):**

    - Collaboratively track alcohol use and triggers in a daily log.

    - Use motivational interviewing to explore ambivalence about change and reinforce intrinsic goals like safety and academic success (Miller & Rollnick, 2013; SAMHSA, 2022).

2. **Develop Healthy Coping Strategies:**

    - Introduce grounding techniques (e.g., 5-4-3-2-1 method), mindfulness, and distress tolerance skills to manage trauma triggers and emotional overwhelm without substances (Linehan, 2015).
    - Practice these in session and assign them as homework to build consistency (Linehan, 2015).
    - Support Alice in creating a personalized crisis/safety plan that she can share with trusted adults or peers, identifying specific coping tools, emergency contacts, and emotional regulation strategies.
    - Encourage Alice to build a “sober box”, a collection of comforting and motivational items (e.g., grounding tools, affirmations, calming scents, photos) to turn to during urges or dysregulation.
    - Integrate emotional literacy exercises, such as “Name the emotion,” to help Alice increase awareness of her emotional states, label feelings accurately, and explore their roots (Perry & Szalavitz, 2017). These tools aim to reduce impulsivity and promote adaptive responses to distress.

3. **Referral to Adolescent Substance Use Support Group:**

    - Facilitate a referral to a trauma-informed adolescent recovery group (e.g., SMART Recovery Teens or a school-based counselor-led group) to decrease isolation and increase accountability (SAMHSA, 2022)

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