Case Study (2): Bill

[Name]

[Class Name]

[Due Date]

[Instructor]

# Introduction

The case study at hand evaluates the situation faced by Bill, a 19-year old college student. He is the victim of a DUI, who was hit by a drunk driver three months ago. Prior to the accident, Bill was considered an exuberant guy who loved hanging out with friends. He lived on-campus and the accident took place one evening right outside the dorms. Ever since the accident, Bill has not only decided to move back home, but he also states that he can’t move back to college since he does not feel safe. Additionally, Bill has been plagued with nightmares ever since the night of the accident. As mentioned, Bill was an outgoing guy that became increasingly paranoid and irritable. He does not enjoy the activities he once did, such as playing basketball and has become detached from everyone.

In my opinion, Bill is in the early stages of PTSD and needs to be evaluated further to understand the magnitude of the disorder. He also needs to be rehabilitated, so that he can return to his normal self since his current behavior is damaging to interpersonal relationships fostered by him.

# Diagnosis

Bill will be diagnosed on the basis of the study of behavioral patterns shown by other victims of MVA i.e. Motor Vehicle Accident and the measures that proved fruitful in their diagnosis, as well as rehabilitation. For this purpose, DSM-V will be taken as a reference point for both diagnosis and treatment options.

According to DSM-V, Bill suffers from a major depressive disorder, with a mixed feature specifier that includes the presence of hypomanic symptoms (DSM-5, 2015, p. 184). Furthermore, the patient also suffers from Trauma- and Stressor-Related Disorders, which are characterized by low mood, fearfulness, and feelings of hopelessness (DSM-5, 2015, p. 285). These individuals tend to respond to triggers which serve as reminders of traumatic events (Maj, 2013). A further study of patients suffering from the onset of PTSD i.e. Post Traumatic Stress Disorder following a motor vehicle collision was also studied and a number of similarities with Bill’s case were found. According to a survey, motor vehicle accidents, or MVA is a leading cause of PTSD in the general population (Beck & Coffey, 2007). These patients psychologically re-experience the trauma through a number of ways, which maybe both acute and chronic in nature (Salam, 2017). The symptoms include distressing dreams about the incidence. They also have the tendency to avoid places or situations that may increase the chances of occurrence of another MVA. They also exhibit signs of numb emotional response, which is characterized by absence of emotions, as well as isolation and a feeling of detachment from others (Williams, Rheingold, Knowlton, Saunders, & Kilpatrick, 2015). Finally, they show signs of increased physical arousal, where they are highly irritable, are unable to sleep peacefully through the night and are startled by the simplest things (Guest, Tran, Gopinath, Cameron, & Craig, 2017).

These events exist in comorbidity with other psychological problems including mood disturbances and even depression (Barbano et al., 2019). Furthermore, the patient will be diagnosed using the structured clinical interview: PTSD module, which has been updated to respond to the latest DSM, the 5th edition (Weiss, 2004). The Treatment-Outcome Posttraumatic Stress Disorder Scale (TOP-8) will also be used here (Davidson & Colket, 1997).

# Treatment

Once the PTSD diagnosis has been established in the patient, it is essential that symptom frequency and severity are also measures, followed by a treatment planning and monitoring (Craig et al., 2016). Following the assessments, there are a number of interventions that can serve as the ideal treatment plan.

Exposure-based interventions are one of the most commonly used methods to deal with PTSD (Lancaster, Teeters, Gros, & Back, 2016). It is rooted in the same principles as Pavlov’s experiment was back in the 1920s. Thus, in order to treat the patient, Prolonged Exposure Therapy will be used. It is an 8 to 15 session long protocol, which can be administered on a weekly or a bi-weekly basis, depending on the patient’s response. Each session will be 60 to 90 minutes long, with initial sessions comprising of brief relaxation breathing exercises. Over the next several sessions, the patient revisits the trauma memory for a prolonged period of time, i.e. 30 to 45 minutes. This is called imaginal exposure and the patient is asked to remember as many details as possible, which is a complete opposite of a PTSD characteristic, where the patient tries to avoid the memory or things that remind him of the incident. This is paired with Vivo exposure where the patient is physically exposed to trauma-inducing situations in a controlled environment to help them face their problem and reduce their trauma-related onset of the disorder.

# Expected Outcome

Following the diagnosis of what ails the patient, and the various options available to him, his treatment will duly begin. Prolonged Exposure Therapy has exhibited great results with significant and reliable reductions in their PTSD symptoms (Lancaster et al., 2016). Thus, the expected outcome ideally is that the patient feels rehabilitated and his psychological state can be elevated enough to push the worse of his PTSD-related can be relieved in 8 to 15 sessions. However, the sessions will continue as long as the patient needs them to continue, which can even take years. Therefore, no matter how long it takes and how many sessions it will require, the patient will be effectively treated so that he may be rehabilitated and return to his normal, jovial-self once again.

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