S Subjective

1 PATIENT IDENTIFICATION

Name:	Marcus T. Delgado	**DOB / Age:**	07/03/1996 / 29 years
Sex:	Male	**MRN:**	77341092
Date of Session:	04/14/2026	**Session Type:**	Individual neuropsychotherapy — ongoing (Session 8 of 20)
Clinician:	Dr. Renee A. Strauss, PsyD	**Duration of Session:**	55 minutes
Accompanied by:	Unaccompanied		

2 CHIEF COMPLAINT

Primary concern (patient's words): "I had a really rough week. I keep having nightmares and I snapped at my girlfriend twice. I don't feel like I'm getting better fast enough."

3 SYMPTOM UPDATE

EMOTIONAL

Patient reports mood rated 5/10 this week — described as "frustrated, exhausted, and on edge." Significant emotional reactivity, particularly irritability in response to minor environmental stressors at home. Reports hypervigilance throughout the week — startle response triggered by a car backfire on Tuesday led to acute anxiety lasting approximately 45 minutes. Experienced three nightmares this week involving combat imagery from deployment; woke in acute distress on two occasions. Brief improvement in mood on Thursday evening after a walk with girlfriend.

COGNITIVE

Moderate attention difficulties throughout the week, particularly in the afternoon. Made two minor inventory tracking errors at work due to distractibility and intrusive trauma-related thoughts. Reports rumination approximately 1–2 hours/day in the evening, reviewing deployment incidents and self-critical thoughts about his anger toward girlfriend. Working memory impaired when emotionally activated. Difficulty initiating non-urgent responsibilities (scheduling appointments, responding to messages).

BEHAVIOURAL

Continued avoidance of crowded public spaces — abandoned grocery shopping trip on Saturday after 10 minutes due to overwhelming hyperarousal. Avoided news media all week (adaptive). Declined invitation from two coworkers to attend a Friday happy hour (avoidance of social situations). Impulsivity expressed primarily through two anger outbursts at home. No compulsive behaviours. Social engagement limited to girlfriend and one brief phone call with Army buddy. No substance use.

4 FUNCTIONAL STATUS

Work / academic functioning:	Employed as logistics coordinator — attended all 5 work days; functional but suboptimal; made 2 minor inventory errors; concentration difficulty in afternoons; no disciplinary action; supervisor unaware of PTSD diagnosis
Interpersonal relationships:	Relationship with girlfriend (4-year relationship, cohabitating) under moderate strain; two irritability-driven arguments this week; girlfriend described as supportive but "walking on eggshells"; limited peer contact; periodic text with one Army buddy; avoids family of origin due to stigma
Activities of daily living:	Completing ADLs independently; preparing meals 4–5 days/week; maintaining apartment; driving without difficulty; no functional deterioration in basic self-care since intake
Self-care:	Showering daily; sleep hygiene inconsistent (bedtime variability 11 PM–2 AM); skipped gym 3 of 5 days due to low motivation; ate meals regularly; no substance use

5 STRESSORS, TRIGGERS & CONTEXT

Recent life events:	Received notification 10 days ago that a former Army colleague was hospitalized following a suicide attempt; significantly activated trauma memories and disrupted sleep for the following week
Identified triggers:	News of colleague's hospitalization; loud unexpected sounds (car backfire); crowded grocery store environment; watching a war film with girlfriend on Wednesday evening
Environmental / interpersonal stressors:	Open-plan office environment with frequent interruptions; urban living with frequent sirens and construction noise; ongoing tension with girlfriend related to emotional withdrawal; financial pressure not currently a primary stressor

6 COPING STRATEGIES

Current coping mechanisms:	Deep breathing exercises (taught session 5); mindfulness app (Headspace, ~10 min/day, 3 of 7 days); physical exercise when motivation allows; journaling (used once this week); walking with girlfriend (used once, beneficial)
Effectiveness / limitations:	Deep breathing: short-term relief (15–20 min) but does not interrupt nightmares or prevent hyperarousal; journaling: helpful but difficult to initiate; avoidance remains primary default coping strategy; no alcohol or substance use as coping

7 RISK ASSESSMENT (SUBJECTIVE)

Suicidal ideation (SI):	Passive SI reported 2 days ago ("I thought about how tired I am of feeling this way") — no active ideation, no intent, no plan, no means sought; denies SI at time of session; safety plan reviewed	**Self-harm thoughts / behaviours:**	Denies current self-harm thoughts or behaviours; no history of non-suicidal self-injury; no current urges
Homicidal ideation (HI):	Denies any homicidal ideation or thoughts of harming others, including girlfriend; anger is self-directed and interpersonally reactive, not threatening	**Protective factors:**	Strong relationship with girlfriend despite current strain; employed and financially stable; engaged in therapy and attending consistently; no firearms in home; future orientation present — discusses career advancement and travel plans post-therapy

8 TREATMENT PROGRESS (PATIENT-REPORTED)

Perceived change:	~20–25% overall improvement since session 1; sleep slightly better than at intake; still feels "stuck" in hyperarousal patterns; frustrated that progress feels slow; notes he "understands more about why this is happening" — psychoeducation valued
Barriers to progress:	Difficulty completing homework assignments consistently; avoidance of trauma-related material outside of session; work schedule occasionally conflicts with session times; stigma around seeking additional psychiatric support

O Objective

9 GENERAL OBSERVATIONS

Appearance / grooming / hygiene:	Casually dressed in clean jeans and grey t-shirt; hair neatly groomed; appears adequately rested relative to previous sessions; no signs of acute self-neglect	**Psychomotor activity:**	Mild psychomotor agitation noted — repetitive foot tapping for first 20 minutes; settled following opening grounding check-in; no gross psychomotor slowing or retardation throughout session
Eye contact:	Intermittent — good eye contact during neutral topic discussion; averts gaze when discussing trauma-related content and emotional vulnerability; consistent with shame and hyperarousal	**Engagement / cooperation:**	Cooperative and engaged throughout session; verbally responsive and articulate; appropriately challenged one clinician reframe (constructively); motivated despite frustration with pace of progress

10 MENTAL STATUS EXAMINATION (MSE)

SPEECH

Rate / volume / coherence:	Slightly rapid speech during discussion of week's events; rate normalised with grounding; volume appropriate; fully coherent and goal-directed; no pressured speech or tangentiality

MOOD & AFFECT

Reported mood:	"Frustrated and exhausted — a 5 out of 10 at best this week"	**Range / stability:**	Mildly constricted range; predominantly dysphoric baseline; brief affective brightening with positive content; no lability or inappropriate affect
Observed affect:	Dysphoric to mildly anxious; brief brightening when discussing positive work achievements and girlfriend; congruent with reported mood throughout	**Appropriateness:**	Appropriate to content of discussion; tearful briefly when discussing colleague's hospitalization — appropriate contextual response

THOUGHT PROCESS

Thought process:	Linear and goal-directed; mild circumstantiality when processing colleague's hospitalization; returned to topic independently without redirection; no tangentiality or loosening of associations

THOUGHT CONTENT

Preoccupations: Rumination about deployment-related incidents; self-critical thoughts about anger episodes with girlfriend; health-related concerns about colleague. No obsessions or compulsions. No delusions or paranoid ideation. Passive SI reported subjectively (2 days prior) but denied at time of session — patient appears truthful and insight regarding SI is good. No HI. No perceptual disturbances. Trauma-related intrusive content present as expected with PTSD — ego-dystonic and distressing to patient.

PERCEPTION

Hallucinations / perceptual disturbances: None present; no auditory, visual, or tactile hallucinations; no illusions; no dissociative episodes reported this week (1 brief dissociative episode noted in session 5, none since)

COGNITION (BRIEF)

DOMAIN	FINDINGS
Orientation (time / place / person)	Fully oriented to person, place, date, and situation
Attention & concentration	Mildly reduced at session start; improved to normal with grounding; sustaine
Memory (recent / remote)	Intact for recent and remote events; hyperdetailed recall of deployment traur

INSIGHT & JUDGMENT

Awareness of condition: Good insight — accurately identifies PTSD symptoms and their functional impact; understands neurobiological basis of hyperarousal as presented in psychoeducation; accepts diagnosis

Decision-making capacity: Intact; making reasonable decisions regarding work, relationships, and healthcare; no evidence of impaired judgment; safety planning engaged with appropriately

11 NEUROPSYCHOLOGICAL / COGNITIVE OBSERVATIONS

Attention & processing speed: Mildly reduced during emotional activation — improves with grounding and regulation; able to sustain focus for 10–15 minute periods during session; response latency slightly increased when discussing trauma content

Executive functioning: Adequate for routine tasks; difficulty with initiation and planning under stress; procrastinates on low-urgency tasks; planning and problem-solving intact when calm and regulated

Memory functioning: Intact for autobiographical and semantic memory; hyperdetailed recall of trauma events (trauma memory consolidation consistent with PTSD); mild difficulties with new information encoding during high-stress periods this week

Language & comprehension: Fluent English speaker with strong vocabulary; comprehension of complex psychoeducational content excellent; able to accurately explain back session concepts; no language or comprehension deficits

12 SOMATIC / PHYSIOLOGICAL STATE

Arousal level: Mildly hyperaroused at session start (self-rated 6/10 on SUDs scale); reduced to 3/10 following grounding check-in; appropriate arousal maintained for remainder of session

Physical tension / discomfort: Bilateral shoulder and jaw tension reported throughout the week; jaw clenching during sleep reported by girlfriend; mild cervical muscle tightness observed posturally during session; no acute pain

Body awareness / interoception: Improving from baseline — able to identify anxiety cues (chest tightness, shallow breathing) with ~70% accuracy; still tends to notice physiological cues late in arousal cycle, reducing time for early intervention

13 SCREENING TOOLS (IF USED)

Tool used (e.g., PHQ-9, GAD-7): PHQ-9 (Depression Severity); GAD-7 (Generalised Anxiety Disorder)

Score: PHQ-9: 11 (Moderate depression, score range 10–14); GAD-7: 14 (Moderate–severe anxiety, score range 10–14)

Tool used (e.g., MoCA): PCL-5 (PTSD Checklist for DSM-5)

Interpretation: PCL-5: 48 (above clinical threshold of 31–33; consistent with PTSD diagnosis; decreased from intake score of 56 — clinically meaningful improvement of 8 points over 8 sessions)

A Assessment

14 CLINICAL SUMMARY

29-year-old male US Army veteran (2 tours, Afghanistan) presenting for session 8 of 20 of individual neuropsychotherapy for PTSD and comorbid anxiety and depression. This week's session was activated by news of a former colleague's suicide attempt, which significantly triggered trauma-related memories and disrupted sleep. Patient demonstrates dysphoric mood, hyperarousal, sleep disturbance, mild anger dysregulation, and ongoing avoidance behaviours consistent with his PTSD presentation. PCL-5 reduced from 56 at intake to 48 (8-point decrease), indicating meaningful symptomatic improvement. PHQ-9 improved from 16 to 11, GAD-7 from 18 to 14. Passive SI reported 2 days prior — no current active ideation; safety plan reviewed and intact. Good insight, strong therapeutic alliance, consistent attendance, and future orientation are positive prognostic indicators. Transition to trauma processing phase (Prolonged Exposure) is being prepared.

15 DIAGNOSIS

Primary diagnosis:	Post-Traumatic Stress Disorder (PTSD) — F43.10 (DSM-5; chronic, combat-related; moderate severity)
Secondary diagnoses:	Generalised Anxiety Disorder (F41.1); Major Depressive Disorder, recurrent, moderate (F33.1)

16 PROGRESS EVALUATION

Overall progress:	Moderate — PCL-5 score reduced from 56 to 48; PHQ-9 from 16 to 11; GAD-7 from 18 to 14; avoidance behaviours beginning to reduce; psychoeducation phase complete; preparing for trauma processing
Response to current interventions:	Responding well to psychoeducation, cognitive restructuring, and somatic regulation; homework compliance inconsistent; PE-based trauma processing not yet initiated; patient motivated and receptive

17 RISK FORMULATION

Current risk level:	Low to moderate — passive SI present 2 days prior without intent or plan; currently denies SI; risk elevated by colleague's suicide attempt and trauma reactivation; monitored and safety plan intact
Protective vs risk factors:	Protective: Engaged in therapy, employed, girlfriend support, no firearms, future orientation, no substance use. Risk: PTSD severity, passive SI, social isolation tendency, sleep disruption, deployment trauma history, stigma preventing psychiatric help-seeking

18 NEUROBIOLOGICAL / BRAIN–BEHAVIOUR FORMULATION

Patient's presentation reflects chronic limbic hyperactivation (amygdala-driven fear response, hypervigilance, startle) with reduced prefrontal cortical modulation — particularly in the dlPFC (emotion regulation, executive control, working memory) and vmPFC (fear extinction). Bottom-up dominance means trauma-related stimuli bypass rational appraisal and directly activate defensive threat responses. Hippocampal involvement: trauma memories stored with high sensory fidelity but lack temporal contextualisation, contributing to intrusive re-experiencing. HPA axis hyperactivity and sympathetic nervous system dominance maintain hyperarousal state. Treatment aims to strengthen fear extinction pathways through graduated exposure while building prefrontal regulation capacity through mindfulness and cognitive restructuring.

19 EMOTIONAL REGULATION & TRAUMA STATUS

Window of tolerance:	Moderate width — patient functions within the window during calm states; triggered above upper boundary (hyperarousal) by trauma cues; rarely drops below lower boundary (hypoarousal); window has widened slightly from session 1
Reactivity vs regulation capacity:	High reactivity baseline, particularly to auditory startle cues and interpersonal conflict; regulation capacity improving with somatic tools; self-monitoring improving; still reactive before regulation strategies are deployed
Trauma-related activation:	Moderate-high activation this week due to colleague's hospitalisation; flashback imagery (combat deployment) present during nightmares and 1 daytime intrusion while at work; activation reducing during second half of session with grounding and ventral vagal engagement

20 COGNITIVE & BEHAVIOURAL PATTERNS

Cognitive distortions:	All-or-nothing thinking ("I either hold it together perfectly or I fail"); catastrophising ("My anger will destroy my relationship"); self-blame ("I should have saved my colleague from this"); mind-reading ("She thinks I'm a monster")
Maladaptive beliefs:	Core beliefs: "I am fundamentally broken by what happened"; "Showing vulnerability is dangerous"; "I have to protect others by keeping them at a distance"; "I don't deserve to feel better" (survivor guilt component)
Behavioural reinforcement patterns:	Avoidance of triggers provides immediate anxiety relief — negative reinforcement perpetuates PTSD. Emotional withdrawal from girlfriend reduces feared conflict short-term but increases relational distance. Anger outbursts function as relief valve for hyperarousal, reinforcing the tension-building and reactive expression cycle.

21 ATTACHMENT / INTERPERSONAL PATTERNS

Relational style:	Anxious-avoidant attachment — uses emotional withdrawal and suppression as primary relational defences; capable of genuine warmth and connection when sufficiently regulated; protective instinct toward girlfriend coexists with interpersonal avoidance
Interpersonal dynamics:	Primary relationship (girlfriend) strained by emotional withdrawal and anger reactivity; no current peer support network outside of occasional contact with Army buddy; avoids family of origin due to perceived stigma around mental health treatment
Therapeutic alliance observations:	Strong working alliance (WAI estimated 8/10); patient appropriately challenges clinician reframes, demonstrating engagement and trust; self-discloses on emotionally difficult topics (SI, anger) with prompting; has not missed or cancelled a session in 8 weeks

P Plan

22 INTERVENTIONS USED (THIS SESSION)

Session opened with 5-minute grounding check-in (5-4-3-2-1 sensory technique + diaphragmatic breathing) — SUDs reduced from 6/10 to 3/10; patient engaged readily, noting this technique is now becoming habitual. Psychoeducation review: Revisited window of tolerance model in relation to this week's triggers; patient demonstrated full comprehension. Cognitive restructuring: Challenged "I should have saved my colleague" belief — examined evidence for and against; patient identified 3 counter-evidence points independently. Introduced PE rationale for upcoming sessions — patient expressed apprehension but agreed to proceed. Progressive muscle relaxation: Practiced targeting shoulders and jaw — significant tension reduction noted. Safety plan reviewed and updated in light of passive SI report.

23 PSYCHOTHERAPY PLAN

Integrative neuropsychotherapy combining Prolonged Exposure (PE) therapy (primary trauma-processing modality), Cognitive Processing Therapy (CPT) techniques for maladaptive beliefs, somatic regulation strategies, and interpersonal neurobiology. Sessions 9–12: Initiate imaginal exposure (PE protocol) starting with least-distressing deployment memory; concurrent cognitive work on "I am broken" core belief. Session 9 focus: PE rationale psychoeducation; in-vivo exposure hierarchy construction. Longer-term: Couples session offered — patient to discuss with girlfriend.

24 COGNITIVE & BEHAVIOURAL INTERVENTIONS

Homework — Cognitive: Complete thought record worksheet for one anger episode this week; identify automatic thought, emotion, and behavioural response; generate alternative thought using evidence review technique practised today. Behavioural activation: Schedule one enjoyable activity with girlfriend this week (non-avoidance); recommended: evening walk or cooking a meal together. In-vivo exposure (preparatory): Patient agreed to attempt one grocery store visit of 10+ minutes using grounding techniques; will record SUDs before, during, and after.

25 REGULATION & SOMATIC INTERVENTIONS

Continue daily diaphragmatic breathing practice (10 min/morning before work — set phone alarm as cue). Jaw and shoulder progressive muscle relaxation: Practice PMR sequence 5 minutes each evening before bed to address nocturnal muscle tension and jaw clenching. 5-4-3-2-1 sensory grounding: Use immediately when triggered — specifically practised for grocery store visit this week. Cold water face immersion: Introduced as acute regulation strategy for high-arousal moments; patient to try before any anger-escalation response at home.

26 HOMEWORK / PRACTICE ASSIGNMENTS

(1) Complete anger episode thought record (2 minimum; use worksheet provided). (2) Daily diaphragmatic breathing — 10 min/morning, log in journal. (3) One grocery store in-vivo exposure with SUDs tracking (bring notebook or phone notes). (4) Schedule and complete one planned enjoyable activity with girlfriend. (5) Use Headspace app 5+ days this week — PTSD sleep module to be activated. (6) Review PE rationale handout provided today — note any questions for session 9.

27 MEDICATION COORDINATION (IF APPLICABLE)

Coordination with psychiatrist / physician:	Coordinating with Dr. Alan Freed, MD (psychiatry, Northwestern Medical Group) — secure message sent 04/14/2026 with session summary and recommendation for prazosin 1 mg nightly to address trauma-related nightmares; response pending
Observed medication effects impacting therapy:	Sertraline 100 mg daily (prescribed by Dr. Freed) — patient reports mild reduction in baseline anxiety but nightmares and hyperarousal largely unchanged; no sedation, cognitive dulling, or sexual dysfunction reported; adherent to medication; no observed impairment during session

28 SAFETY PLAN

Safety plan updated and reviewed in session today. Step 1: Identify warning signs (intrusive thoughts + passive SI + social withdrawal). Step 2: Internal coping — diaphragmatic breathing, cold water face immersion, 5-4-3-2-1 grounding. Step 3: Contact girlfriend (Sofia Reyes, cell: verified) if unable to self-regulate. Step 4: Contact clinician via secure message (office hours) or crisis line after hours. Step 5: Veterans Crisis Line — 1-800-273-8255 (press 1); Text 838255. Step 6: Nearest ER — Northwestern Memorial, 251 E Huron St, Chicago, IL. Patient signed updated safety plan; copy given to patient.

29 FOLLOW-UP

Next session date:	04/21/2026 (Monday, 2:00 PM)
Frequency of sessions:	Weekly — every Monday at 2:00 PM; 55-minute individual sessions
Monitoring plan:	PCL-5, PHQ-9, and GAD-7 re-administered every 4 sessions (next: session 12); passive SI monitored weekly; clinician to send secure check-in message if no session confirmation by Sunday evening; coordinate with Dr. Freed re: prazosin initiation