1 Patient Information

1 PATIENT DETAILS

Name
Denise M. Okafor

Date of Plan
05/06/2026

DOB / Age / Sex
07/14/1988 | Age 37 | Female

Provider
Dr. Sarah L. Montenegro, PhD — Clinical Psychology

MRN
BH-2026-5512

Diagnosis
F43.11 — PTSD, acute; F33.1 — MDD, recurrent, moderate

PP Presenting Problem & Clinical Summary

1a PRESENTING PROBLEM

Ms. Okafor is a 37-year-old Black woman and registered nurse presenting with a 14-month history of post-traumatic stress disorder following a violent assault at her workplace (a hospital emergency department) in March 2025, during which she was physically attacked by an intoxicated patient. She sustained minor physical injuries but significant psychological trauma. She reports intrusive re-experiencing of the event (flashbacks 3–5 times per week, nightmares 4–5 times per week), persistent hypervigilance at work and in public spaces, emotional numbing, avoidance of the ER environment (resulting in a 4-month medical leave), and a major depressive episode that developed 6 weeks post-trauma. Functional impairment is severe across occupational, interpersonal, and daily living domains.

1b CLINICAL SUMMARY

Ms. Okafor presents with a clearly delineated traumatic precipitant (workplace assault, March 2025) followed by the development of full PTSD symptomatology meeting all DSM-5 criterion clusters: intrusion (flashbacks, nightmares), avoidance (ER environment, discussions of the event), negative alterations in cognition and mood (shame, self-blame, emotional numbness, estrangement from colleagues), and hyperarousal (hypervigilance, exaggerated startle, sleep disturbance). Comorbid MDD developed 6 weeks post-trauma and persists — evidenced by anhedonia, low motivation, psychomotor slowing, and depressed mood rated 3/10 on most days. She has a history of resilience and high occupational functioning pre-trauma. Social support is limited — she divorced in 2023 and has limited family proximity (parents in Nigeria). She has two children (ages 9 and 11) who depend on her. Current PHQ-9: 16 (moderate-severe). Current PCL-5: 54 (significant PTSD severity). Prior treatments: SSRI initiated by PCP (sertraline 100 mg) — partial response for MDD symptoms; no specific trauma-focused psychotherapy prior to this intake.

G Goals of Treatment & Measurable Objectives

2a GOALS OF TREATMENT

1. Achieve remission of PTSD symptoms — PCL-5 score <33 (below clinical threshold). 2. Achieve remission or significant improvement in MDD — PHQ-9 score <10 (mild range). 3. Return to occupational functioning — return to nursing practice in a modified role within 6 months; full ER return negotiated with occupational health. 4. Rebuild interpersonal connection — re-engage with 2–3 social supports and reduce isolation.

2b MEASURABLE OBJECTIVES (SMART)

1. Within 8 weeks: Patient will identify and use 2 grounding techniques (5-4-3-2-1 and diaphragmatic breathing) with ≥80% fidelity when experiencing flashback triggers, as measured by self-monitoring log. 2. Within 12 weeks: Patient will complete a 12-session course of Prolonged Exposure (PE) therapy — engaging with imaginal and in vivo exposures with SUDS ratings documented. 3. Within 16 weeks: Patient will demonstrate a ≥30% reduction in PCL-5 total score (from 54 to ≤38). 4. Within 20 weeks: Patient will return to nursing work in a non-ER inpatient setting for ≥3 days/week as documented by occupational health records. 5. By 24 weeks: PHQ-9 score ≤10 sustained for ≥4 consecutive weeks, with behavioral activation engagement in ≥2 meaningful activities per week.

IN Interventions & Treatment Strategy

3a EVIDENCE-BASED INTERVENTIONS

Primary therapeutic modality: Prolonged Exposure (PE) therapy — evidence-based first-line treatment for PTSD per VA/DoD Clinical Practice Guidelines and APA PTSD Guidelines. PE will consist of 12–15 individual sessions: psychoeducation, diaphragmatic breathing training, in vivo exposure hierarchy construction and implementation, and imaginal exposure with processing. Concurrent modality: Behavioral Activation (BA) for comorbid MDD — activity scheduling targeting pleasurable and mastery-related activities to address anhedonia and avoidance. Pharmacological coordination: Sertraline 100 mg currently; psychiatry consultation requested for dose optimization or augmentation (consider prazosin for nightmares). Psychoeducation: Provided to patient on trauma response normalization, MDD-PTSD comorbidity, and rationale for exposure therapy.

3b FREQUENCY & DURATION

Session Frequency

Weekly individual therapy sessions — 60 minutes. Psychiatry coordination as needed (minimum monthly during active phase).

Expected Treatment Duration

Active phase: 24 weeks (approximately 6 months). Maintenance phase: Biweekly sessions for 3 additional months. Total anticipated course: 9 months.

3c RESPONSIBILITIES

Provider Responsibilities

Deliver PE protocol with fidelity — complete session-by-session documentation and exposure monitoring. Coordinate with prescribing psychiatrist for medication management. Complete PCL-5 and PHQ-9 at sessions 1, 4, 8, 12, 16, and 20. Provide occupational health letter supporting graduated return to work at 16 weeks.

Patient Responsibilities

Attend weekly sessions without cancellations exceeding 2 per 8-week block. Complete between-session exposures as assigned — in vivo hierarchy practice 3–5 times per week. Maintain self-monitoring log for triggers, SUDS ratings, and grounding technique use. Contact provider or crisis line if safety concerns arise. Engage with occupational health return-to-work process.

R Risk Assessment & Barriers

4a RISK ASSESSMENT

SI / Self-Harm Risk

Passive SI present — 'I sometimes think everyone would be better off' — but no active plan or intent. PHQ-9 item 9 scored 1 (several days). Safety plan in place. Risk stratified as low-moderate given protective factors. Risk to be reassessed at each session.

Behavioral Risks

Risk of work avoidance perpetuating PTSD chronicity if occupational return is not addressed early. Risk of social isolation amplifying MDD. Risk of dropout from exposure therapy — patient-identified as a concern; therapist-identified strategies to address avoidance within the therapy relationship.

Protective Factors

Strong maternal motivation — 'I have to get better for my children.' Prior high occupational functioning and professional identity. Insight into illness. Actively seeking treatment. Religious faith (attends church weekly). Financial stability (short-term disability through June 2026). No substance use. No prior suicide attempts.

4b BARRIERS TO TREATMENT

1. Limited social support system — divorced, family internationally. 2. Childcare demands as a single mother limiting session flexibility — evening appointment slot confirmed. 3. Financial: Short-term disability coverage is expiring in 3 months; return to work timeline is medically and financially motivated. 4. Stigma: Patient expressed concern about mental health stigma within the Nigerian cultural community and among nursing colleagues — psychoeducation provided on confidentiality. 5. Clinical: Avoidance is deeply entrenched — PE rationale required extensive psychoeducation to secure buy-in.

C Coordination of Care & Progress Monitoring

5a REFERRALS & EXTERNAL SERVICES

Referrals

1. Psychiatry — Dr. Elena Vasquez, MD for sertraline optimization and prazosin consideration (appointment confirmed 05/14/2026). 2. Occupational Health — hospital employee health for graduated return-to-work plan. 3. Employee Assistance Program (EAP) — financial counseling and legal resources for trauma-related disability documentation.

External Services

Trauma-informed support group through the local hospital's employee wellness program — Ms. Okafor declined at this time but will reconsider at month 3. 988 Suicide and Crisis Lifeline on file. Text HOME to 741741 (Crisis Text Line) provided.

5b PROGRESS MONITORING

Symptom Scales & Tracking

PCL-5 (PTSD Checklist for DSM-5) — administered at sessions 1, 4, 8, 12, 16, and 20. PHQ-9 — administered monthly. In-session SUDS ratings during imaginal exposure — session-by-session. Between-session exposure log reviewed weekly. GAD-7 as secondary measure of anxiety.

Plan Review Timeframe

Treatment plan review at 30 days (session 4), 60 days (session 8), 90 days (session 12), and 6 months (session 24). Formal update with patient signature at each 30-day review.

F Follow-Up

6 ONGOING CARE SCHEDULE

Ongoing Schedule
Weekly therapy sessions. Psychiatry every 4–6 weeks. Occupational health review at week 16. Plan reassessment at 30, 60, 90-day intervals.

TIME DOCUMENTATION & BILLING

Total Time
75 minutes (treatment planning session)

Counseling Time
60 minutes

Primary Dx Code
F43.11 — PTSD, acute

CPT Code
90837 — Individual Psychotherapy, 60 minutes + 90887 — Collateral service

Basis
Time-based psychotherapy and care planning

Secondary Dx Code(s)
F33.1 — MDD, recurrent, moderate; Z91.19 — Personal history of trauma; Z63.5 — Disruption of family by separation

PROVIDER NAME	CREDENTIALS	DATE & TIME
Dr. Sarah L. Montenegro, PhD — Clinical Psychology	PhD — Clinical Psychology	05/06/2026