

# SAMPLE SESSION NOTE — TRAUMA-FOCUSED CBT (COMPLEX PTSD + EATING DIS)

## 1 Patient / Client Information

### 1 SESSION DETAILS

<b>Name</b> Priya K. Mehta	<b>Date of Session</b> 05/06/2026
<b>DOB</b> 07/04/1996	<b>Provider</b> Dr. Carla B. Reyes, PhD
<b>Age / Sex</b> 29 / Female	<b>Credentials</b> PhD — Licensed Clinical Psychologist   License #PSY-61204
<b>MRN / Client ID</b> BHC-2024-1192	<b>Session Type</b> Individual — Trauma-Focused CBT, In-Person
<b>Location / Setting</b> Boston Behavioral Health Center, Outpatient — Session 22 of open-ended treatment	<b>Session Duration</b> 55 minutes

## R Reason for Session

### 2 PRIMARY PURPOSE OF THIS SESSION

Session 22 of ongoing trauma-focused cognitive behavioral therapy (TF-CBT). Primary focus: continued imaginal exposure work targeting the core traumatic memory (sexual assault by a family member at age 16) in the context of Priya's complex PTSD with emotional dysregulation. Secondary focus: review of binge-purge episode that occurred 04/30/2026 — the first relapse since achieving 8 consecutive weeks of abstinence from purging. Treatment goals active this session: (1) process emotional content arising from recent imaginal exposure; (2) identify cognitive and emotional triggers linking trauma re-experiencing to eating disorder relapse; (3) reinforce adaptive coping chain.

## S Subjective

### 3 PATIENT-REPORTED INFORMATION

#### 3a CURRENT SYMPTOMS & CHANGES SINCE PRIOR SESSION

Ms. Mehta arrived visibly tense — described the past week as 'one of the hardest since we started this work.' She reports a binge-purge episode on 04/30/2026, following a family gathering where she encountered the perpetrator (her maternal uncle) unexpectedly. She rated her distress that evening at 9/10 and reports that her usual coping skills 'stopped working' in the moment. She has not had another episode since 04/30. She reports nightmares 4 nights this week (trauma-related, perpetrator present), difficulty with sleep onset (taking 60-90 minutes to fall asleep), and persistent hypervigilance when in enclosed spaces or around older men. She rates current anxiety at 6/10 and depression at 5/10. She described a significant cognitive intrusion during the exposure session last week: 'I keep hearing him say it was my fault' — this shame-based cognition appears to have intensified.

#### 3b PROGRESS, BARRIERS & FUNCTIONAL IMPACT

Ms. Mehta identifies the unexpected family exposure as the precipitant for the relapse — she had not been informed her uncle would attend the gathering. She reports that prior to 04/30 she felt 'the most stable I've been in years.' She has maintained her graduate school coursework (biomedical engineering PhD program, Year 3) without academic disruption, which she identifies as a protective factor. She notes increasing difficulty concentrating during long study sessions due to intrusive thoughts. She is frustrated with the relapse — 'I feel like I undid all the work' — a cognitive distortion explored in session.

#### 3c PERTINENT NEGATIVES — SAFETY SCREEN

Patient denies suicidal ideation, plan, or intent. Denies homicidal ideation. Denies self-harm urges beyond the purging episode. Denies current alcohol or substance use. Safety plan reviewed and current — emergency contact is her roommate (Anya Desai, 617-555-0214); crisis line (988) confirmed. She states she is 'not in danger — I'm angry and sad, but I'm safe.'

## O Objective

### 4 OBSERVABLE CLINICAL INFORMATION

#### Appearance

Well-groomed, conservatively dressed; appeared fatigued with mild dark circles. Slightly guarded body posture at session start.

#### Mood

'Frustrated and sad' — patient's words

#### Communication Style

Articulate, intellectually analytical of her own process — consistent with prior presentation

#### Observable Changes from Baseline

Psychomotor activation early in session resolved to calm regulated state by session end — significant improvement compared to initial dysregulated state

#### Participation & Engagement

Full engagement — remained present throughout 55 minutes; willingly entered exposure content despite distress.

#### Affect

Restricted range initially; broadened over the session course to include tearfulness, moments of insight-related relief, and brief genuine smile at session close.

#### Skill Use / Performance During Session

Applied thought record and cognitive restructuring with prompting; grounding technique practiced with fidelity post-exposure.

## I Interventions Provided

### 5 SERVICES DELIVERED THIS SESSION

#### 5a THERAPEUTIC MODALITY & IMAGINAL EXPOSURE

Session structured per TF-CBT protocol, Session 22. Imaginal exposure: Priya revisited the core traumatic memory using written trauma narrative (10-minute re-reading aloud by patient). SUDS ratings tracked: peak 8/10 at memory apex; 5/10 at 20 minutes post-exposure — appropriate habituation trajectory. Therapist maintained supportive presence throughout with minimal verbal interruption. Post-exposure processing: Priya identified the shame cognition 'It was my fault' as the primary cognitive distortion most activated by the exposure. Cognitive restructuring using the responsibility pie chart technique was introduced for this specific cognition — patient participated actively and generated 4 alternative attributions. In vivo exposure hierarchy reviewed — 'attending family gatherings where perpetrator may be present' elevated from Level 4 to Level 5 on hierarchy given recent unplanned exposure; plan modified accordingly.

#### 5b EATING DISORDER RELAPSE ANALYSIS & BEHAVIORAL STRATEGIES

Functional behavioral analysis of the 04/30 binge-purge episode conducted collaboratively. Chain identified: unexpected perpetrator exposure → acute shame spike → dissociative numbing → craving for 'control' mechanism → binge → purge → brief relief followed by intense guilt and shame → intrusive thoughts. Patient identified the gap in her coping chain: she did not use the STOP skill before the binge initiation. Reframed relapse as 'data about what triggers to prepare for' rather than failure — patient noted relief with this framing. Grounding technique (5-4-3-2-1 sensory) practiced for 4 minutes post-exposure to restore window of tolerance. Introduced 'urge surfing' as an additional skill for managing purge urges specifically.

## RE Response to Intervention

### 6 PATIENT RESPONSE

#### Engagement Level

Highly engaged — patient drove session depth and initiated the chain analysis without prompting

#### Emotional / Behavioral Response

Tearful during imaginal exposure; recovered to regulated state within 12 minutes post-exposure using grounding. Affect visibly lightened following responsibility pie chart exercise.

#### Understanding of Material

Excellent — patient made independent connections between trauma shame cognitions and ED relapse; spontaneously named 'cognitive-behavioral link'

#### Progress / Resistance / Barriers

No resistance. Notable progress: patient's willingness to stay in exposure despite peak SUDS of 8/10 represents significant therapeutic gain compared to early sessions where she terminated at SUDS 5/10.

Therapist observation: The 04/30 relapse, while clinically significant, appears to reflect a situationally-triggered failure of a previously effective coping system under extreme unplanned exposure conditions — not a fundamental treatment regression. Priya's ability to analyze the episode with sophistication and without global self-condemnation (after psychoeducation) suggests continued progress in the metacognitive domain.

## A Assessment

### 7 CLINICAL INTERPRETATION

#### 7a CURRENT CLINICAL STATUS & PROGRESS

Ms. Mehta presents with Complex PTSD (ICD-10 F43.11) and comorbid Bulimia Nervosa (F50.2), currently in active trauma processing. Situational setback (binge-purge relapse, 04/30) was precipitated by an unplanned encounter with the perpetrator — a high-risk stimulus she had not yet been exposed to in treatment hierarchy. Despite the relapse, she maintained abstinence for the remaining 6 days of the week and demonstrated strong insight and adaptive coping capacity in this session. PCL-5 score at last formal administration (04/22/2026): 48 — down from 71 at treatment intake. EDE-Q (04/22/2026): 2.8 — down from 4.9 at intake. Both represent substantial clinical improvement. Current clinical status: progressing with expected non-linear recovery trajectory.

#### 7b MEDICAL NECESSITY & RISK / SAFETY

Medical necessity for continued weekly individual psychotherapy is clearly established: active Complex PTSD with ongoing trauma processing in TF-CBT protocol; comorbid bulimia nervosa requiring concurrent behavioral monitoring; recent relapse requiring clinical reinforcement; and functional impairment in occupational concentration. Risk level: LOW — no active SI/HI, no self-harm beyond single binge-purge episode, strong protective factors (academic engagement, peer support, therapeutic alliance).

## PL Plan

### 8 NEXT STEPS

1. Continue TF-CBT weekly — next session 05/13/2026. Advance to in vivo exposure hierarchy Level 3 (attending social gatherings with safe attachment figures present). 2. Homework: Complete thought record x3 this week specifically targeting the 'It was my fault' cognition using the responsibility pie chart format. 3. Use urge surfing technique for any purge urges — log in food/mood diary. 4. Consult with dietitian Dr. Sarah Lin (scheduled 05/09/2026) re: meal plan adjustment given recent relapse. 5. PCL-5 and EDE-Q re-administration scheduled for 05/20/2026 (monthly formal assessment). 6. Consider discussion at next session of boundary-setting around family gatherings involving perpetrator — advance consent / notification protocol with supportive family members.

## F Follow-Up

### 9 NEXT SESSION

#### Next Session & Reassessment Focus

05/13/2026 at 10:00 AM — in-person, 55 min. Reassess: thought record homework completion, urge surfing use, sleep quality, nightmare frequency, binge-purge abstinence status, and in vivo hierarchy readiness.

### TIME DOCUMENTATION & BILLING

#### Total Time Spent

55 minutes

#### Counseling / Coordination Time

55 minutes

#### Primary ICD-10 Dx

F43.11 — PTSD, Acute (Complex PTSD)

#### CPT Code

90837 — Individual Psychotherapy, 60 minutes

#### Basis for Billing

Time-based — 55 minutes face-to-face

#### Secondary ICD-10 Dx

F50.2 — Bulimia Nervosa; F33.1 — MDD, recurrent, moderate

#### PROVIDER NAME

Carla B. Reyes, PhD

#### CREDENTIALS

PhD — Licensed Clinical Psychologist | License #PSY-61204

#### DATE & TIME

05/06/2026, 12:05 PM