Trauma Common DAPS

Data:

D: Client was referred by primary therapist for additional trauma specific treatment.

Clt reported symptoms of hyperarousal such as

Clt identified overbounded boundary style.

Clt identified underbounded boundary style.

Assessment:

Clt exhibited dysregulated hypoarousal AEB report of fuzzy vision, feeling disconnected, numbing sensation, and difficulty thinking clearly.

Clt exhibited dysregulated hypoarousal AEB report of tunnel vision, feeling disconnected, numb, and far away.

Clt exhibited dysregulated hyperarousal AEB report of racing heart, the sensation of heat, intense muscle tension, and dilated pupils.

Clt exhibited dysregulated hypoarousal AEB report of feeling "outside of" their body.

Clt has difficulty sensing somatic experience AEB delayed responses and reporting "I don't know".

Clt exhibits cognitive distortion as a result of dysregulated arousal.

Clt has inadequate relational resources to manage traumatic symptoms.

Clt has inadequate somatic resources to manage traumatic symptoms.

Clt has inadequate internal resources to manage traumatic symptoms.

Clt has inadequate psychological resources to manage traumatic symptoms.

Level of Care

Clt is at risk of relapse AEB inability to regulate physiological arousal in response to daily stressors as a result of trauma.

Clt is at risk for relapse AEB inability to regulate physiological arousal as a result of past trauma without therapist intervention.

Clt has difficulty reporting experience mindfully AEB answering questions in the past and future tense.

Clt is making progress toward the goal of identifying dysregulated physiological arousal; however, clt requires more time in treatment to meet the goal of regulating physiological arousal.

Clt is making progress toward the goal of regulating physiological arousal; however, clt requires more time in treatment to develop the ability to recount traumatic memories without dissociated arousal.

Clt requires more time in treatment to meet the goal of regulating physiological arousal as a result of trauma in order to maintain sobriety.

Clt requires more time in treatment to meet the goal of identifying dysregulated physiological arousal as a result of trauma in order to maintain sobriety.

Clt requires more time in treatment to meet the goal of recounting traumatic memory without dissociated arousal in order to develop emotional regulation, delayed gratification, frustration tolerance, and impulse control to deal with daily stressors.

Clt requires more time in treatment to meet the goal of regulating dysregulated physiological arousal as a result of past trauma, in order to develop emotional regulation, delayed gratification, frustration tolerance, and impulse control to deal with daily stressors.

Clt requires more time in treatment to meet the goal of identifying dysregulated physiological arousal as a result of past trauma, in order to develop emotional regulation, delayed gratification, frustration tolerance, and impulse control to deal with daily stressors..

Trauma Common DAPS (cont)

Plan:

Therapist will assist client in developing 5 somatic and 5 relational resources for regulating physiological arousal.

This therapist will provide individual trauma therapy 1x/week and group therapy on Trauma Symptom Reduction and Stabilization 2x/week. Clt will continue to work with primary therapist toward other treatment goals.

This therapist will provide individual trauma therapy 2x/week and group therapy on Trauma Symptom Reduction and Stabilization 2x/week. Clt will continue to work with primary therapist toward other treatment goals.

Groups:

Data:

Group met to provide trauma psychoeducation.

Group met to develop resources for identifying and regulating physiological arousal as a result of past trauma.

Individual

Clt was engaged in group AEB leaning forward in chair, asking clarifying questions, and volunteering to do dyadic work with this therapist in front of the group.

Clt was engaged in group AEB engaging other members, asking clarifying questions, and sharing with the group that...

Plan:

Therapist will provide group therapy focused on Symptom Reduction and Stabilization 1x/week.

Therapist will provide group therapy on Trauma Symptom Reduction and Stabilization 2x/week.

Therapist will provide group therapy on Trauma Symptom Reduction and Stabilization 3x/week.

Common DAP Phrases

Clt is making progress toward the goal of maintaining sobriety; however, clt requires more time in treatment to develop emotional regulation, delayed gratification, frustration tolerance, and impulse control to deal with daily stressors.

Clt requires more time in treatment in order to stabilize...

Clt is making progress toward goal of ; however, clt requires more time in treatment to meet treatment goal of .

Clt is motivated by .

Clt continues to struggle with.. AEB...

Clt is at risk for ... AEB...

Clt's recent relapse has led to (insert life threatening experiences/behaviors).

Clt is currently being medicated/being treated for .

Clt reports Post Acute Withdrawal Symptoms such as .

Clt reports struggling with activities of daily living such as .

Clt reports changes in sleep such as difficulty falling asleep, difficulty staying asleep, and nightmares.

Clt reports changes in appetite and loss of weight.

Clt reported (severe, moderate, mild) cravings.

Clt reported an increase in cravings since last session.

Clt was engaged in group AEB participating in group exercise, sharing experience with the group, and asking clarifying questions.

Justifying Level of Care	
Cravings	Frequency/severity
Sleep	Changes, difficulty staying asleep, difficulty falling asleep, nightmares,
Appetite	Changes, weight loss/gain
Activities of Daily Living	Bathing, dressing, grooming, oral care, toileting, transferring, walking, climbing stairs, eating, shopping, cooking, managing medications, using the phone, housework, doing laundry, driving, managing finances
Post Acute Withdrawal Symptoms	Emotional outbursts or lack of emotion; Anxiety; Difficulty dealing with stress; Low energy; Having a hard time sleeping, strange dreams, and changes in sleep patters; Memory problems/hard to learn new things; Trouble thinking clearly, making decisions, and solving problems; Problems with balance and delayed reflexes; Feeling dizzy; Increased accident proneness
Mental Status Exam	See below

Mental Status Exam	
Speech	Rapid/pressured (hyper verbal) OR soft and hesitant;slurred;tangential
Judgement	Poor to Moderate;depends on how long client has been in treatment
Insight	Impaired; minimizes; rationalization; intellectualizes; lacks insight
Thoughts	pre occupied;difficulty concentrating;disorganized;illogical;obsessive;flashbacks;intrusive thoughts
Memory	Recent memory impaired; remote memory impaired; easily distracted
Mood	Depressed and anxious; mood liability (mood swings); helpless; hopeless; impulsive; irritable; restless; agitated; apathetic
Affect	Congruent to mood; flat affect; blunted; tearful; constricted, blunted, Flat; Constricted; Inappropriate; Labile; Full range
SI/Hi/Psychosis	Per patient report; if any suicidal thoughts (passive or with plan or intent) contract for safety
Post-Acute Withdrawal	stay away from things like "disorientation", "confusion" "vomitting" unless client is entering detox.
Craving	depends on how long in treatment; will be evaluated for anti-craving meds if cravings do not decrease

Mental Status Exam (cont)

Sleep	Poor: 2-3 hrs/night; Moderate: 5-6 hrs/night; Diffoculty staying asleep; difficulty falling asleep; drug dreams; nightmares
Appetite	Any weight fluctuation
Activities of Daily Living	Unkempt, slightly disheveled; odorous; disheveled poor hygiene
Other descriptors	Guarded, defensive, combative, introverted, social withdrawal, med seeking, justifying, elevated mood, preoccupied, passive, indifferent, solemn, suspicious, belligerent, abrupt, sluggish, timid, meek, people-pleaser, unyielding, stubborn, pompous, manipulative, and defensive

Integrated Diagnostic Summary/Clinical Impression

legal
health
family
cravings
employment
high risk behaviors
home environment

SLAP Suicide Assessment

Specific	How specific is the plan? The more specific the details, the higher degree the present risk.
Lethal	How lethal is the proposed method? How quickly would the person die if the plan was enacted? The greater the lethality, the greater the risk.
Available	How available is the proposed method? If the tool to be used is readily available, the greater the suicide risk.
Proximity	What is the proximity of helping resources? Generally, the greater the distance the person is from helping resources, if the plan were implemented, the greater the degree of risk.

Assessments with Scoring Cutoffs

DAST (Drug Abuse Screening Test)	Scores 1-5	Low
	Scores 6-10	Intermediate (likely meets DSM-V criteria)
	Scores 11-15	Substantial
	Scores 16-20	Severe
AUDIT (Alcohol Use Disorder Identification Test)	Scores 0-7	Adult Ed
	Scores 8-15	Simple Advice
	Scores 16-19	Brief Counseling
	Scores 20-40	Specialist
PHQ-9 (Depression)	Scores 1-4	Minimal Depression
	Scores 5-9	Mild Depression
	Scores 10-19	Moderate Depression
	Scores 15-19	Moderately Severe Depression
	Scores 20-27	Severe Depression

Assessments with Scoring Cutoffs (cont)		
PCL-5 (PTSD)	Cutoff: 36	
Recovery Capital	Max 175	
Self-Compassion Scale	Scores 1-2.5	Mild
	Scores 2.5-3.5	Moderate
	Scores above	High
Beck Anxiety Inventory	Scores 0-21	Mild
	Scores 22-35	Moderate
	Score above 35	Severe
BPS (Bio-Psycho-Social w/ Integrated Diagnostic Summary)		
ASAM PPC-2R (Patient Placement Criteria for the treatment of Substance Related Disorders)	Patient Placement Criteria for the treatment of Substance Related Disorders	

Case Presentation Outline	
1. Demographics & Diagnosis & Precipitating event	Age, gender, ICD-10 Diagnosis name and code, ethnicity/cultural relevance/spiritual, living situation/sober living/residential/homeless and Education. Precipitating event for client seeking treatment (what made them pick up phone and come to treatment). Note agencies, organizations, or groups involved including court cases, probation, CPS, referring source...
2. Client Background/Relevant History	Previously in treatment? Age of First time to therapy or rehab. Any psychiatric hospitalizations, relevant previous treatment episodes, number of times in rehab, suicide attempts/ideations ever in life. Share any historical information which might clarify client's current situation, or the situation may have arisen suddenly without obvious historical causes. Significant adverse or traumatic events, school performance, family structure, alcoholism or addiction in family.
3. Key findings/observations/Ct desires	Give details of the current situation relevant to understanding why this situation is a case. For example, give observable signs/symptoms of illness, environmental factors that may impinge on client, and potential resources within the situation/client. Ct desires/perception of problems, Client quotes are helpful here.

Case Presentation Outline (cont)	
4. Formulation	Describe your understanding of why things are as they are. This should reflect one or more theoretical perspectives in some way. Note any countertransference issues.
5. Interventions and Plans	Treatment plan in Kipu may be referenced. Describe what you have done and what you plan to do about the situation. May wish to state where you on in progress on goals.
6. Reason for Presentation: What would you like help with?	Explain why you selected this case when you could have presented several other cases. Does it present a unique challenge or an unusual problem? Does it illustrate the effectiveness of an intervention? Would you like help with the case, or are you presenting it so others can learn from your experience? What do you want from us, instruct your audience.

Recovery Capital		
Personal	Physical	Physical health, financial assets, health insurance, Safe and recovery-conducive shelter, clothing, food, access to transportation
	Human	Identified values, personal knowledge, educational/vocational skills, problem solving capabilities, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, right perception, sense of meaning and purpose, interpersonal skills
Family/Social	Relationships	Partner, friendships, family of origin, family of choice, work, school, church, community organizations
	Recovery Support	"family" involvement in therapy and/or recovery efforts, friends/family in recovery, sober outlets for fellowship and leisurely activities
Community		Active efforts to reduce addiction/recovery related stigma
		Local recovery role models
		Availability of continuum of treatment resources
		Community recovery support institutions
		Sources of sustained recovery support and early re-intervention
		Culturally prescribed pathways of recovery that resonate with particular individuals and families