Biopsychosocial Assessment

# Client Interview

## Identifying Information

Begin by completing the basic demographic information for your client.

* Name(s): **Trevor Reznik**
* Date of birth: **Unknown**
* Primary language: **English**
* Referred by: **Employer, National Machine**
* Intake date: **12/2/2004**
* Evaluated by: **MVF**

## Description of Client(s)

Briefly describe what you observe about the client’s physical status, such as age, gender, ethnicity, appearance, behaviors, and any impressions that stand out to you.

* **Client is a white male whose age appears to be somewhere in his mid-to-late thirties. Client presents with disheveled clothing and appears dangerously frail with a pale countenance, unshaven, with dark circles beneath his eyes and noticeable cuts and bruises about his face. Client is mostly withdrawn with a quiet and unassuming demeanor but often appears restless and fidgety, smoking nervously. Occasionally, he murmurs, apparently talking to himself incoherently. Client appears to be a distinctly haunted individual, consistently distracted and emotionally troubled. Client inhabits a dreary, industrial cityscape somewhere in California.**

## Presenting Problem

Briefly describe why the client is seeking counseling. It is appropriate to start the session with a question like, “What is the reason for your visit today?” or “What brings you in today?” Summarize the client’s response in a few sentences

* **Client reports that he “has not slept in a year.” [Therapist note: Literally? Apparently.]**

**Client reports near-constant fatigue, ennui, intermittent depression and anxiety, and a general dissatisfaction with life and his work as a machinist from which he was recently fired. His appetite for food and life in general have waned significantly in the past year for unknown reasons, and client has lost a significant amount of weight (at least 60 lbs). Client reports that he is haunted by a constant and strange milieu of guilt, despair, dread, doom and gloom, loneliness, delusions [say other people] and [perhaps] visual hallucinations. He believes there is a conspiracy at work to destroy him or drive him crazy. [Therapist side note: Client stated at one point, “A little guilt goes a long way . . .” When asked what he was guilty about, Client replied, “I don’t know . . .”]**

## History of Problem

Describe the symptoms, experiences and background of the problem, previous occurrences, and interventions in a brief paragraph. Get the client’s full story. Be as conversational as possible and listen carefully to what your client is saying. Your goal is to build a friendly relationship, have the client feel comfortable with you, keep the focus on the client and their story, and gather information—not to sound like this is an interrogation. A release of information to obtain discharge notes from other providers may be appropriate.

Consider using questions or statements that prompt the client to provide details about important topics:

* How long this has been a problem?
* When did you first notice this problem?
* Tell me more about your problem.
* How long has this issue been a concern to you?
* Have others been concerned or noticed the symptoms?
* How often does this problem occur?
* How often have the symptoms occurred in the past?
* I’d like to hear more about how often this happens.
* Have interventions worked?
* Have you had counseling for this issue before? If so, what was the outcome of your counseling?
* Could you walk me through all the things that you have done in the past, including any previous counseling?
* What differences have you had in physical health or emotional mood?

Summarize the client’s responses.

* **Client reports having no family to speak of and that he has been a loner and an outsider for much of his life, particularly the past year. Aside from the company of a kind-hearted prostitute and a friendly waitress at the airport diner that he frequents, client is chronically lonely, although paradoxically it appears he generally prefers to be by himself to read or watch television. Client notes that both of his companions have issued concerns regarding his weight and severely emaciated appearance. Client recalls both have stated precisely, “If you were any thinner, you wouldn’t exist.” Client reports experiencing déjà vu, increasing confusion and brain fog, paranoia and visual hallucinations, such as a strange series of post-it notes appearing on his refrigerator depicting a game of hangman. In once such incident, client found his refrigerator leaking blood or some other such substance. This incident seems to have some reference to reality as it coincided with client's landlady entering his apartment one day complaining of a leak and a terrible smell both coming from his apartment. Most notably, Client reports frequently encountering a sinister-looking stranger named Ivan who client believes to be real (but he may be hallucinating). Client reports finding or seeing a particular photo of Ivan in various unlikely places. Nobody else can see this figure and there appears to be no tangible record of him in existence.**
* **Client reports a recurrent nightmare, dissociation or hallucination in which he finds himself struggling to dispose of a body wrapped in a large carpet in the dark waters of a city pier. [Therapist Note: a nightmare would contradict the assertion that Client has literally “not slept in a year”.]**
* **Client also reports patterns of both erratic and obsessive-compulsive behaviors such as constantly leaving post-it notes about his apartment to remind himself of errands and needed purchases; and the frequent compulsion to wash his hands with bleach and clean his bathroom floor tiles with a toothbrush and bleach until the entire bathroom is spotless. *What is it Client is attempting to scrub away exactly?* Client reports** **having some memory issues, such as forgetting to pay his utilities, (thus the necessity for constant post-it notes.) Client’s electricity has recently been shut off, presumably due to delinquent payments.**

## Social History

Describe the client’s social support system in a few sentences, including the following:

* where the client lives and with whom
* quality of relationships with family and friends
* support received from others

Remember to keep the conversation flowing and not to overwhelm your client with questions.

Consider using questions or statements that prompt the client to provide details about their history:

* Tell me about where you live and with whom.
* What are your relationships like?
* Who do you get along with well, and who are you not close with?

Summarize the client’s responses.

* **Client lives alone in a small apartment. As an admitted loner, Client reports no close friends or family. Client used to go fishing and hang out with work buddies from the factory on poker night but has ceased these activities for quite some time and for unknown reasons. Client reports his only human companionship comes from the call girl (Stevie) he sees on a semi-regular basis, and a waitress (Maria) he chats with at the airport diner he frequents. Client shared that recently Stevie informed him she would “give up hooking for the right guy,” meaning client (Trevor). Client admitted that his intermittent outbursts of anger, rage, paranoia and psychosis have caused irreparable damage to relationships or potential ones. Client reports more and more frequent encounters with a strange co-worker called Ivan (a tall, thuggish-looking bald man who wears black leather and cowboy boots, has dismembered fingers on one hand and drives a red convertible sports car, Firebird). These encounters are becoming more and more disturbing to client (and eliciting dangerous behavior from client such as speeding, reckless driving, and running red lights in vehicular pursuit of the figure who manifests seemingly at random times).**

## Family History

Describe the client’s family of origin and relationships with family in the past and present in a few sentences.

Remember to keep the conversation flowing and not to overwhelm your client with questions.

Consider using questions or statements that prompt the client to provide details about their history:

* Tell me about your family of origin. Who did you live with growing up?
* What were the relationships like in your family?
* What are your family relationships like now?

Summarize the client’s responses.

* **Client reports his mother has passed away. He held her in high regard and cherishes her memory, describing her as a “wonderful mother.” He holds on to several of her possessions, including a beautiful crystal bowl (which his landlady reportedly covets). Client reports his father left the family when he was a young boy but has not elaborated on his relationship with his father.**

## School History

Summarize the client’s responses.

* **Client has not reported his school history.**

## Work History

Describe the client’s relevant work history and experiences in a few sentences, including the following:

* current employment situation
* time spent in the career/profession
* positive or negative experiences of work
* any sporadic work history or frequent job changes

Remember to keep the conversation flowing and not to overwhelm your client with questions.

Consider using questions or statements that prompt the client to provide details about their history:

* Tell me about your job. Do you enjoy what you do?
* How long have you been in this position?
* What types of jobs have you had previously?

Summarize the client’s responses.

* **Client worked for an undisclosed number of years as a machinist for a company called National Machine. It was a repetitive and mind-numbing job he did not particularly enjoy but for the most part did not dislike either. He reports that his main supervisor was “a real prick,” a sawed-off, impatient slavedriver named Tucker. Client reports that Tucker frequently picked on Client and engaged in petty retribution, mainly after Client called him out on disregarding OSHA safety regulations for the sake of greater productivity from his “grease monkeys.” Client reports that his employers began to notice his appearance and behavior changing, his demeanor becoming more withdrawn and laconic and subsequently insisted on a drug test. Client reports that various people perceive him to be a drug addict, based on his extremely frail and gaunt appearance.**
* **Client was fired from his machinist job shortly following an accident in which a co-worker tragically lost an arm. Following the accident, client’s co-workers unapologetically expressed their concerns about working with him, verbally and otherwise, with one boldly stating to his face, “No one wants you here. Nobody.” Client was judged to be at fault for the accident and, following a second near-accident (in which client nearly suffered the same fate or worse) client acted out in rage at co-workers and his supervisor. Client was immediately terminated. Client continues to believe there is a conspiracy at work against him involving his co-workers and supervisors, including the man (Miller) who lost his arm. This belief continues despite Miller assuring client he had no hard feelings, mainly due to the generous financial settlement he had gotten from National Machine. Later, Client would angrily confront Miller at his home and Miller would punch Client in the stomach, demanding he get off his property.**

## Spiritual

Summarize the client’s responses.

* **Client reports he briefly tried “Jesus Christ” for his insomnia but that did not work either.**

## Legal

Indicate whether the client has current or previous legal issues. If current, what is the status? Is the client on probation, etc.?

* **Client described an incident in which he was accused by a detective of filing a false police report. Client fled from the police station on foot and escaped down a subway sewer grate. Client had intentionally stepped into traffic and seriously injured himself with the intention of framing the mysterious figure Ivan for the hit and run. This was done to locate the figure Ivan via his license plate number which client could only do by reporting a crime. Client reported no other past legal issues (aside from an occasional speeding ticket.)**

## Trauma History/Abuse

Describe any past or current traumatic events or abusive situations that the client may have experienced. Indicate whether this is ongoing and if the client has received counseling in the past for it.

Keep in mind that the client may not want to disclose their history of trauma or talk about their abuse in depth, especially in the first session. Be sensitive to a client’s hesitation to discuss it and remain aware of their discomfort around these topics and questions. Allow them time to respond or respect their silence and the choice to not respond at this time.

Remember to keep the conversation compassionate and flowing—do not overwhelm your client with questions.

Consider using questions or statements that prompt the client to provide details about their history:

* Have you experienced any type of traumatic events?
* Have you been a victim of abuse?

Summarize the client’s responses.

* **Client reported experiencing a recent traumatic incident at work. While client was assisting a co-worker recalibrate a machine, client was distracted by his mysterious co-worker, the new arc welder, Ivan (displaying an odd “cutting the throat” gesture) which resulted in client unintentionally activating the machine. Despite his efforts, it subsequently would not shut off. During the accident investigation, client admitted culpability, and it was revealed there was no record or evidence of any new arc welder named Ivan at National Machine. Client was subsequently terminated following another incident of erratic behavior and has since, understandably, been plagued with guilt, anger, confusion, self-doubt, suspicion and paranoia.**
* **Client reported a recent traumatic experience at an amusement park. When client took his friend Maria’s son (Nicholas) on a gruesome and gratuitous, not-kid-friendly ride, “Route 666 and the Highway to Hell,” the child suffered an epileptic seizure, but did recover.**
* **Client reported a recent traumatic day attempting to locate the mysterious character Ivan through the license plate number of the man’s red Firebird convertible. A clerk at the DMV was unhelpful and rude, informing client that only the police could disclose such information, if a crime had been committed. Client formulated the plan of framing Ivan for a hit and run by purposefully stepping into traffic. After he became seriously injured, client proceeded to the police department to file a report. Eventually, a detective informed client he was in trouble for filing a false report. The number matched a vehicle client himself had reported stolen a year ago. Client had no recollection of this and became even more perplexed, fleeing from the police on foot and escaping via a subway sewer grate. (See, also, Legal issues.)**
* **Client has not yet revealed any other significant past trauma or victimization of abuse. Client did report his father leaving the family early on in his life.**

## Suicidal/Homicidal

Indicate if the client has had any suicidal or homicidal thoughts, plans, or attempts. Note if these are in the past or present and if they are passive or active. If client currently has suicidal or homicidal thoughts, complete a full suicide risk assessment. If a more thorough suicide/homicide evaluation is conducted, it may be documented in a separate section.

Be sensitive and aware of a client’s hesitation to discuss. Risk assessment is necessary if there are any indicators of suicide or homicide. Be direct when asking questions about these topics.

Consider using questions or statements that prompt the client to provide their thoughts:

* Have you thought about suicide (or homicide)? (If client says anything other than “no,” continue with direct questions or prompts.)
* Tell me what you were thinking about.
* Do you have a plan?
* When is the last time you had this thought?

Summarize the client’s responses.

* **Client has been having some passive suicidal and homicidal thoughts or fantasies. He reports has not had these in the past. The last time he thought about this was a week ago. He has no plan, no means, and today has no intent.**
* **Client described a recent incident in which he purposefully stepped into oncoming traffic to injure himself. Client is adamant this was not a suicide attempt. Client claims this was done in order to falsely charge a hit and run in order to locate the mysterious figure Ivan through his license plate number, which client alleges could only be done by filing a police report. (See also, Legal issues and Trauma History/Abuse).**
* **Full assessment completed. Client is at moderate to severe risk.**

## Health and Wellness History

Discuss client’s past and present substance use, sleep habits, and exercise and eating habits. Ask direct questions to gather this self-explanatory information.

### Substance Use

* **Client is a daily smoker. Client reports he normally does not drink often, and only socially. Client admits he has been drinking more lately, particularly since the appearance of the mysterious figure, Ivan.**

### Sleep Habits

* **As previously noted, Client has not slept in at least a year.**

### Exercise Habits

* **Client reports no routine exercise.**

### Eating Habits and Appetite

* **Client reports significant weight loss in the past year. Client reports he has mostly lost his appetite in the past year or so.**

# Mental Status

Assess your client’s mental status by discussing what you observe about the client in your session.

## Activity

Describe the client’s behaviors, especially the client’s physical movements.

* What did you notice about the client’s movements?

Summarize the client’s responses.

* **Client appeared restless and fidgety during the session. Client mostly avoided eye contact and smoked. Client was distant, distracted and withdrawn but overall responsive and cooperative.**

## Mood and Affect

Describe the client’s mood and affect (visible expression of feelings and emotions).

* What was the client’s overall mood?
* How did the client show that mood non-verbally (the affect)?
* Were these congruent? (Did the client’s affect align with the stated mood?)

Summarize the client’s responses.

* **Client spoke low and quietly, presenting with a flat affect. Client appeared occasionally irritable, reporting feelings of guilt, suspicion, paranoia, sadness with a general malaise of depression and ennui. Client was clearly troubled and appeared overwhelmed regarding the totality of his ongoing symptoms. Client reports increased difficulties managing his erratic behavior, negative emotions and troubling preoccupations and thoughts.**

Describe the client’s thought process, content, and perception in how they respond to questions and tell their story.

* Listen to how the client responds to questions and presents their story to assess their thought process. Describe their thought process in the telling of their story using terms like logical, illogical, linear, tangential, circumstantial, rational, etc.
* Listen for the content of their story and responses to assess their content. Describe their content with words like negative, depressive, obsessive, hopeful, etc.
* Listen to their descriptions of reality in their story to assess their perception. Describe whether there are any perceptual disturbances, such as:
* Hallucinations – hearing, seeing, or feeling things that are not there
* Delusions – thoughts or beliefs that conflict with reality
* Illusions – misperceptions, such as hearing the wind and thinking it is someone crying, or seeing a shadow and thinking it is a person

Summarize the client’s responses.

* **Client reported depressive, disjointed and sometimes obsessive thoughts with experiences of dissociation and increasing confusion regarding timelines of events and the true nature of his own reality. Client reported experiencing visual hallucinations, including unnatural movements of clock numbers, and individuals and objects manifesting with no apparent reference to reality. Perhaps jokingly, client reports once stating to his waitress (Maria) that he believed himself to be Elvis Presley. Client has entertained thoughts that his former co-workers/supervisors at National Machine are/were conspiring against him. Client presents with intermittent symptoms of psychosis. Client presents with obsessive-compulsive and schizoid personality traits (APA, 2013).**
* **Side note: It is this therapist’s tentative theory that Client’s accounts of pleasurable and flirtations conversations with his friendly server Maria at the “Fly Away” airport diner may possibly be delusions, episodes of dissociation, fantasies, daydreams and/or hallucinations. This includes client’s time allegedly spent at an amusement park with his friend Maria and her son. (However, it is unlikely these are dreams, if client has not slept in over a year as he alleges.)**

## Cognition, Insight, and Judgment

If completed, indicate any results of a Mini Mental Status Exam (MMSE) in this section. Discuss whether the client appears to understand the symptoms and issues being experienced.

* How is the client’s insight (ability to recognize the issues and why these issues are occurring)?
* How is the client’s judgment (ability to make good decisions and behaviors)?
* Did you get a sense that the client understands why these things are occurring?
* Does the client think about choices and decisions before acting? Has the client been aware of behavioral consequences?

Summarize the client’s responses.

* **Client presents with insight into his issues but remains confused with considerable concern as to why these issues may be occurring. Client presents dark and negative, often fatalistic thoughts and frequently doubts his own sanity as well as questioning the true nature of his reality. Client is constantly suspicious of others. Client’s increasingly questionable judgment, dysfunctional behavior, incoherent cognition and other symptoms including paranoia appear to correlate with client’s chronic insomnia.**

# Case Summary

## Legal and Ethical

Discuss any potential legal or ethical issues you need to consider as the counselor. This is not about the client having a legal issue.

Consider these factors after you are finished with your intake and are thinking about the case:

* Is there a need to break confidentiality due to danger to self or others?
* Is there any child or elder abuse or neglect occurring?
* What cultural values and considerations should be made with this client?
* Are there any dual relationships?
* What is your scope of practice?

Use the American Counseling Association (ACA) *Code of Ethics* as a guide for recognizing and discussing any potential legal and ethical situations.

Summarize the client’s responses.

* **Client stated that he has passively thought about suicide and/or homicide but hasn’t had a plan, means, or intent, and has not had a thought in over a week. Client has reported engaging in dangerous behavior (to self and others) in the recent past despite his reportedly good intentions. Client reminded that in the case of danger to self or others, confidentiality would need to be broken to keep him safe. Client was given numbers for crisis lines and after-hours safe line. Client will be asked at the beginning of each session about suicidal/homicidal thoughts.**
* **Suicide risk assessment completed. Client is at moderate to severe risk.**

## Strengths

**Client shows at least average to slightly above-average intelligence, including an excellent vocabulary and an interest in reading the classics (Dostoyevsky). Client displays considerable concern with limited insight into the existential nature of his complex current life crisis. Client is highly independent and mostly self-sufficient, having shown at least adequate productivity and reliability at work in the past. Client reports that, prior to the past year or so, he was sociable at work, and generally liked by his co-workers. Client appears highly motivated to resolve his symptoms and improve his overall mental health.**

## Challenges

**Client reports a very limited social support system with few friends and no contact with family. Client is experiencing financial hardship resulting from his recent job loss. Client is enduring significant challenges coping with symptoms and coming to terms with the nature of his situation and reality. Client has shared multiple recent traumatic experiences and has likely not yet shared others from his past.**

## Discussion

Summarize the presenting problem and symptoms, along with any pertinent history and social factors that lead to a diagnosis. This section justifies your diagnosis; include any differential diagnoses here.

Consider these factors when writing the discussion:

* the symptoms that brought the client in to counseling
* the history of the presenting problem
* any social, environmental, or medical factors

Summarize the client’s responses.

* **Client presents with sadness, depressed mood, low energy and motivation, intermittent loss of appetite, and severe sleep disturbance. His symptoms meet the criteria for major depressive disorder as evidenced by his sadness, diminished interest in activities, loss of appetite, hypersomnia, and diminished ability to concentrate. His symptoms are moderate to severe as evidenced by the interference in occupational and social functioning. Client reports generally less severe symptoms like these in the past, therefore this is recurrent*.* Additionally, client presents with obsessive-compulsive, dissociative and psychotic symptoms including paranoia, delusional thinking, and possible hallucinations. Client appears to meet criteria for PTSD. [Therapist note: From an existential perspective, Therapist does not necessarily value diagnoses aside from a general framework for helping to understanding myriad personality traits and tendencies].**

# **Tentative Diagnosis**

Using the information gathered thus far, make a diagnosis using the *DSM-5®*. Include the diagnostic title and code as well as any specifiers.

* **296.32 – Major Depressive Disorder, moderate, recurrent (APA, 2013).**
* **297.1 (F22) -- Delusional Disorder**
* **309.81 -- PTSD with Derealization.**
* **300.6 -- Depersonalization/Derealization disorder**
* **301.4 (F60.5) Obsessive-Compulsive Personality**
* **301.0 (F60.0) Paranoid Personality Disorder**

## Recommended Assessments to Support Diagnosis

Identify any assessments that have been used or that you might use to support a diagnosis or rule out a differential diagnosis.

* **Insomnia Severity Index and Fear of Sleep Index (FOSI)**
* **PHQ-9 and Beck Depression Inventory**
* **Multidimensional Inventory of Dissociation**
* **DIES and CTQ (Dissociation and Trauma)**
* **International Trauma Questionnaire (ITQ)**
* **Brown Assessment of Beliefs Scale (BABS)**
* **PANSS (Schizophrenia)**

## Case Conceptualization

Explain the issues, symptoms, and diagnosis of the case through the lens of a theoretical perspective.

Consider these factors when writing the case conceptualization:

* the biopsychosocial aspects of the case
* the theory applied in this case: cognitive behavioral therapy (CBT), humanistic, Adlerian, psychodynamic, or behavioral
* how the concepts of the theory explain the client’s symptoms and issues

Summarize the client’s responses.

**Client (T.R.) presents with severe insomnia accompanying significant weight loss and increasing symptoms of depression, dissociation, obsessive-compulsive behavior, reckless behavior, and psychosis, including paranoia, delusions, disorganized thinking and visual hallucinations (Anderson, 2004). Abundant research indicates that exposure to specific types of trauma increases the odds of insomnia twofold to threefold over having never been exposed (Hall-Brown et al, 2015). Trauma experts concur that sleep disturbance and/or fear of sleep, closely related to hyperarousal, is the proverbial canary in the coalmine regarding emotional instability, particularly related to trauma (Sinha, 2015; Gentry, 2016; Werner et al, 2021). Trauma also affects sleep architecture, the means by which the body naturally navigates sleep cycles and stages, with the REM stage (in which more bizarre or fantastical dreams are typically experienced) being the most affected (Ross, 2014). Historically it is well recognized that invariably insomnia/hypersomnia is one of the first symptoms to arise from a troubled psyche.**

**Client presents with symptoms of major depressive disorder, PTSD/C-PTSD, and some form of delusional, psychotic and/or dissociative disorder. Some degree of these symptoms appears to be present both prior to and following a triggering event of his involvement in an accident at work involving the dismemberment of a co-worker for which client accepted the blame. He has never really enjoyed his work but has been responsible with maintaining his job until recently, when he was terminated following the aforementioned incident and another near-accident resulting in client acting out in rage and paranoia.**

**Through a positive and empathetic therapeutic relationship with appropriate psychoeducation and optimistic expectations, Client needs increased social and vocational support to help bolster his sense of self and redirect him toward a healthier lifestyle. Client may require intensive trauma-informed therapy to enhance emotional self-regulation and temporary pharmacological interventions to manage symptoms of depression and dissociation/psychosis more effectively. Healthier behavioral choices, greater self-care, challenging negative self-perceptions, and reconnecting with those who care about him would reduce the intensity of the symptoms client is experiencing. Replacing shame and guilt with self-compassion, and pessimism/gloom with hope, as well as rediscovering true meaning and purpose in his life, are important areas of focus in order for client to achieve optimal recovery and healing from his [significant likelihood of] complex trauma. Once sufficient ability to self-regulate and co-regulate with Therapist is achieved, exposure therapy and/or narrative or psychodynamic therapy may be indicated to further explore client’s past significant life experiences. Achieving effective interoception is likewise crucial for healing trauma (van der Kolk, 2015). Additional evidence-based interventions for trauma treatment include EMDR, hypnosis, parts work and somatic experiencing (Gentry, 2016).**

**A case such as T.R. raises many questions concerning delusions and psychosis. For instance, where do they come from? Are they the products of a diseased mind, biology and genetics as the mainstream medical establishment has promoted through most of the twentieth century? Or is psychosis a by-product of an individual’s life experiences, particularly trauma, as Freud, Breuer, Pierre Janet and C.G. Jung most notably proposed? And if so, how is psychosis useful or psychologically meaningful? (Moskowitz, 2019). What does psychosis tell us about a person’s life experiences, specifically trauma? As opposed to auditory hallucinations, a cardinal symptom of schizophrenia, delusions and other sensory hallucinations appear to be linked to trauma and memory. These may likely be memory-based flashbacks unbeknownst to the subject (Hardy, 2017**). “It is speculated trauma memory intrusions may be experienced on a continuum from contextualized to fragmented, depending on memory encoding and retrieval” (Hardy,p. 697).  **Ample research suggests disorganized early attachment is predictive of delusions and dissociation as a coping mechanism to deny, relieve and disconnect from this early pain (trauma or neglect) later in life (Lyons-Ruth et al, 2006; Dutra et al, 2009). Garfield (2009) argues that delusions arise from the overwhelm of past traumatic situations a person cannot cope with or integrate.**

**Presuming that the character, Ivan, is a hallucination or delusion, a fairly easy presupposition in this case, from a Jungian lens, the recurrent manifestations of the shady figure clearly represent the shadow of T.R. purposefully bleeding through the unconscious barrier of our client like so many other pathologies. To quote Jung, “In a case like this . . .” [a so-called normal person becoming delusional] “the unconscious usually responds with violent emotions, irritability, lack of control, arrogance, feelings of inferiority, moods, depressions, outbursts of rage, etc., coupled with lack of self-criticism and the misjudgments, mistakes, and delusions which this entails” (Jung, 1967, p. 454). As ones life becomes unbalanced, the mind (psyche) will produce warning signs to get our attention to restore balance. Ignoring such demands, according to Jung, puts one at significant risk of suffering complexes as delusions and potentially other psychosis.**

# **References and Resources**

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*

(5th ed.). American Psychiatric Association.

Anderson, B. [Director]. (2004). *The Machinist. [Film].* Castelao Producciones [Production Company].

Paramount Classics [Distributor].

Dutra et al. (2009). Disturbed Maternal Communication and the Double Bind.

Dutra, L., Bureau, J. F., Holmes, B., Lyubchik, A., and Lyons-Ruth, K. (2009). Quality of early

care and childhood trauma: a prospective study of developmental pathways to

dissociation. *J. Nerv. Ment. Dis.* 197, 383–390. doi: 10.1097/NMD.0b013e3181a653b7

Garfield, D. (2009). *Unbearable Affect: A Guide to the Psychotherapy of Psychosis.* John Wiley

and Sons.

Gentry, J.E. (2016). *Forward-facing Trauma.* Compassion Unlimited.

Hall Brown TS, Akeeb A, Mellman TA. (2015). The Role of Trauma Type in the Risk for

Insomnia. *Journal Clinical Sleep Medicine.* 11(7):735-9. doi: 10.5664/jcsm.4846. PMID:

25766711; PMCID: PMC4481056.

Hardy, A. (2017). Pathways from trauma to psychotic experiences: A theoretically informed

model of posttraumatic stress in psychosis. *Frontiers in Psychology, 8,* Article

697. [https://doi.org/10.3389/fpsyg.2017.00697](https://psycnet.apa.org/doi/10.3389/fpsyg.2017.00697)

[Accessed 8/29/22]. https://www.frontiersin.org/articles/10.3389/fpsyg.2017.00697/full

Herrman, J. (1992). *Trauma and Recovery.* Basic Books, NY.

Jaspers, (1913/1963). Delusional Atmosphere (Wahnstimmung) before primary delusions.

Jung, C. G. (1967). *The Collected Works of C.G. Jung, Volume 13.* Princeton University Press.

Kryger, J.. (2021) *Principles and Practice of Sleep Medicine, 7th ed.* Elsevier.

Lyons-Ruth K, Dutra L, Schuder MR, Bianchi I. (2006). From infant attachment disorganization to

adult dissociation: relational adaptations or traumatic experiences? Psychiatr Clin North

Am.Mar;29(1):63-86, viii. doi: 10.1016/j.psc.2005.10.011. PMID: 16530587; PMCID:

PMC2625289.

Moskowitz, A., Dorahy, and Schafer (2019). *Psychosis, Trauma and Dissociation (2nd ed).* Wiley.

Robbins, M. (2019). *Psychoanalysis Meets Psychosis: Attachment,*

*Separation, and the Undifferentiated Unintegrated Mind.* Routledge.

Ross RJ. (2014) The changing REM sleep signature of posttraumatic stress disorder. *Sleep.*

37(8):1281-2. doi: 10.5665/sleep.3912. PMID: 25083007; PMCID: PMC4096196.

Sinha SS. (2015). Trauma-induced insomnia: A novel model for trauma and sleep research.

*Sleep Med Rev*. 25:74-83. doi: 10.1016/j.smrv.2015.01.008. Epub 2015 Feb 4. PMID:

26140870.

Staub, C. (2019). Concept of diverse sleep treatments in physiotherapy. *European Journal of*

*Physiotherapy*, *21*(3), 177–184. https://doi.org/10.1080/21679169.2018.1505948

Van der Kolk. (2015). *The Body Keeps the Score.* Penguin.

Werner GG, Riemann D, Ehring T. (2021) Fear of sleep and trauma-induced insomnia: A review

and conceptual model. Sleep Med Rev. 55:101383. doi: 10.1016/j.smrv.2020.101383. Epub

2020 Sep 8. PMID: 32992229.