Case: **PSYCHOLOGICAL REPORT FROM 11-M ATTACKS**

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KEYWORDS: report, terrorist attack, clinical psychology.

Miss Rocío Fausor, psychologist at Complutense University's Clinical of Psychology, presents this report at the request of the patient to be presented at the Ministerio del Interior de España in view of the psychological effect being aggravated**.**

PERSONAL DATA

NAME AND MIDDLE NAME: Miguel Not Real Name (*)

AGE: 49 years old, at the time of the assessment.

FAMILY STRUCTURE: he is married at the time of the assessment and he is living with both his wife and 3 children.

OCCUPATION: Unemployed.

(*All the data has been changed in order to preserve the identity of the patient)

REASON OF CONSULTATION

At the time of the assessment, the patient reported he felt sick, irritable and suffering from intense feelings of sadness, which he claimed was making him "*verbally aggressive*". Moreover, he pointed out feeling a lack of interest in relating to people in general and even to his family. This is has been causing him to be dispirited and he said "*I do not have any social support in Madrid"*. He stated that this uneasiness originates from 11-M terrorist attack, where he was injured.

ASSESSMENT INSTRUMENTS

The assessment consisted of firstly a semi structured clinical interview that informed us of social-demographical data and an overview of the terrorist attack; the interview was based on a general view module of Structural Clinical Interview Axis I for DSM-IV, Clinical version (SCID-I-VC; First, Spitzer, Gibbon y Williams, 1999) and on Trauma Interview (Foa, Hembree y Rothbaum, 2007). Secondly it consisted of a Structural Clinical Interview for DSM-IV axis I (SCID-I-VC First, Spitzer, Gibbon y Williams, 1999), consisting of "A" module for mood disorders and "F" module for anxiety disorders. The assessment includes some questionnaires for measuring symptoms of anxiety and depression: BDI- II (Beck, Steer y Brown, 1996), BAI (Beck, Epstein, Brown y Steer, 1998), PCL (PTSD Checklist, civilian version; Weathers, Litz, Herman, Huska y Keane, 1993), PSWQ (Meyer, Miller, Metzger y Borkovec, 1990).

DOCUMENTATION EXAMINED

The patient gave documentation about the services he went to from 2004 to 2008 at the request of the psychologist.

Note: this report is not compiled by an expert so the data in it is based on patient's information and no one has researched the credibility of the testimony, nor researched from a forensic approach. This report contains 7 pages numbered and signed by the psychologist that publishes it.

Interviews:

- **Semi structured clinical interview that informed us of social-demographic data and gave us an overview of the terrorist attack based on the module of Structural Clinical Interview Axis I for DSM-IV, Clínical version (SCID-I-VC; First, Spitzer, Gibbon y Williams, 1999) and on Trauma Interview (Foa, Hembree y Rothbaum, 2007)**

Miguel arrived to the consultation with an adequate physical appearance twenty minutes before the appointment. His behaviors in terms of time place and person were fine and he does not present any problems with basic psychological issues regarding attention, memory and language. During the interview he answered all the questions, except from when he was asked to remember the terrorist attack; in that moment he claimed to be having a hard time and he did not want to talk about it. The patient looked clearly nervous, with sweaty hands and avoided eye contact with the therapist.

The interview started by collecting some social-demographic data, in doing so it became known that Miguel was from France and at the time of the assessment he was living in Madrid with his family (wife and children). He commented he was working as a social mediator until the company closed down. He is unemployed and has been looking for a job since then. The patient added that he spends his days doing activities with his children and going running.

After that, the interview broached the terrorist attack he suffered (a description of it, physical and psychological effects, treatments received at the time of the assessment, the legal process he is involved in because of it, and other concerns of the patient). As it has previously been stated, the patient was nervous when he was asked to talk about his experience at 11-M, and he added he would rather miss this part out. He only said "*it was a fateful day, horrible… in all senses… it was unexpected, a surprise and I was sleepy because it was early in the morning… so I thought it was a dream but it was real".*

The patient explains that he still has some physical effects from the terrorist attack he experienced, this is supported by the medical reports he presented about his pain. In particular, he said he feels pain on the bone in his left leg and it does not let him sleep well, but he does not know where this comes from. He added he is taking analgesics to reduce the pain.

As far as the psychological symptomatology is concerned, the day after the terrorist attack Miguel was diagnosed with anxiety symptoms related to posttraumatic stress disorder (as it is written in one of the reports he brought). Three days after that, he went back to the hospital and he was diagnosed with acute stress disorder and it is when he was referred to The Mental health center. Which is where they explored his anxiety, hyper-arousal, nightmares, intrusive re-experiencing, avoiding behaviors and he was diagnosed with posttraumatic stress disorder. In the center he received psychiatric treatment, and for the first time psychological as well from 2004 to 2005 (as it is written in the documents he presented where it is not stated which kind of psychological treatments he received or the amount of sessions). A summary treatment received since 2004 to the present is showed in Table I.

Table I: Treatment received until these days.

Center	Diagnose	Assistance date	Treatment
Hospital	Anxiety. Posttraumatic stress.	March 12th, 2004	**Farmacological treatment** -Orfidal 0-0-1
	Acute stress. (308 CIE-9).	March 15th, 2004	**Farmacological treatment** -Valium 1-1-1 -Rexer 15mg si persiste insomnio
Mental Health Center	Postraumatic estress disorder.	March 15th, 2004	**Farmacological treatment** -Rexer 30mg 1-0-0 -Tranxilium 50mg s ½ -½ -½
		June 3th, 2004	*(Report sent out by a psychologist)*
		September 15th, 2004	*(Report sent out by a psychiatrist)*
		September 27th, 2004	*(Report sent out by a psychologist)*
	Specific phobias to eating meat, fish and eggs. Posttraumatic stress disorder.	December 23th, 2004	*(Report sent out by a psychologist and psychoatrist)* -Rexer 30mg -Tranxilium 45mg
	Posttraumatic stress disorder.	January 24th, 2005	*(Report sent out by a psychiatrist)* -Rexer 30mg 0-0-1½ -Tranxilium 50mg s ½ -½ -½
	Chronic.Posttraumatic stress disorder.	January 10th, 2006	*(Report sent out by a psychiatrist)* -Rexer 30mg 0-0-1½ -Tranxilium 50mg s ½ -0 -½
		November 3th, 2008	*Prescription* -Rexer 30mg 2-0-1 -Tranxilium 50mg s 1 -½ -1

In summary, Miguel has been diagnosed with acute stress and posttraumatic stress throughout since 2004, according to the reports. And he received three pharmacological treatments, the latest of which he is currently undergoing, although the doses have varied. Furthermore, he received psychological treatment at the same center since the terrorist attack and up to 2005, as it is stated in the reports.

- **SCID I: Clinical Interview for DSM- IV (First et al., 1999). Modules A and F.**

  The structural clinical interview SCID I is an interview protocol that allowed the therapist to diagnose DSM-IV axis I.

The interview assesses current symptomatology (values mood, anxiety, drugs abuse…) and the evolution of the different problems since the terrorist attack took place. In relation to this, Miguel points out feeling depressed, and having an inability to experience pleasure in activities that were previously enjoyed, a lack of motivation and no energy. He says he feels constantly restless and therefore feels useless and helpless and suffers from poor concentration and memory. He refers to having thoughts of death or suicide and he adds he would not carry them out because of his children and he has never made a suicide plan. The patient emphasizes that in spite of how bad he felt after the terrorist attack, at the time of the assessment his anxiety and inability to experience pleasure are a lot more intense than before.

Miguel states that when he rides a train or even when he is in a crowded place he feels overwhelmed. He comments on having anxiety attacks since the terrorist attack and his latest one was the day before coming to the appointment. When he rode on a train *"I felt a palpitation and suddenly I sweated and*

became overwhelmed and I felt difficulty breathing and I started trembling. I had to look for a place to sit down or wait to get off the train at the next stop". Other symptoms that the patient says he has had in other situations are shaking, confusion, dizziness and nausea. He points out nausea makes him keep close to toilets. He says he is scared when the train is stopped and he is conscious of when the doors are closing. As he said, he does not ride on the subway if he can avoid it because of the symptoms, and he added he never goes on the subway if it is full. He maintains he is worried about "losing control" so he does not leave his house if he does not take his medication or he does not walk with someone. If that is not the case, he says he prefers to stay at home because *"he feels unsecure*".

In order to overcome his insecurities, he said he takes an anxiolytic (Rexer®), because he doubts his ability to control himself and he tends to be isolated. He added he prefers being alone when he has thoughts related to death as well as thoughts about causing pain to other people. Furthermore he commented that these thoughts were "*what if I shoot him*" "*I'm going to punch this guy"* the thoughts are not exclusively about others but are about himself as well "*if I am on a bridge, I think about if I should jump off, I will do it*" and he does not know why he has these thoughts. The patient explains that when he has these thoughts he has specific ways of dealing with them in order to reduce his anxiety level, such as taking his medication, separating himself from others, avoiding arguments in order not to hurt others or himself.

He comments, that he worries about all this, because he feels aggressive even in his house with his family. He says "*kids cannot be quiet all the time and I get very anxious, but I cannot afford to lose my children's love, that is the worst thing that could happen, my children being afraid of me*". He then makes an effort, not to argue, to take his medication and listen to music when he has these thoughts. This also happens, for instance, when his children are playing and pretend to scare him, he says he gets angry and has a difficult time and "*I'm always on tenterhooks*". When he feels he has calmed down he buys them candy, because he feels guilty about his behavior and thinks "*that was a mistake".*

Related to this stimuli the patient commented he felt irritable and has had memory problems since 11-M, (the terrorist attack that he suffered when he was 40 years old.) Since then, he says he has had flashbacks of the attack, as well as intense negative psychological and physiological responses to any objective or subjective reminder of the traumatic event, (this includes sweaty and trembling hands, which was witnessed during the appointment when he was asked to retell his experience, as it was previously stated).

He has had subjective re-experiencing and recurring distressing dreams. Even so, he says he avoids speaking and thinking about the attack or going to places or doing activities that remind him of the experience.

The patient comments that his capacity to feel close to other people has decreased since the terrorist attack, as he feels indifferent to what goes on around him. And he adds he cannot see blood even in cartoons, as he says that it scares him a lot and he has "*a difficult time".*

After applying the two SCID I modules (mood and anxiety) and analyzing the results, it has been proven that he has reached the criteria for the following diagnoses: Major depressive disorder, severe without psychotic symptoms; chronic posttraumatic stress disorder; panic disorder with agoraphobia and a Specific phobia to blood. (Table II).

Table II: Structural Clinical Interview (SCID I) Results.

Clinical Interview for DSM- IV (First et al., 1999)	
Results	• F32. 32 Major depressive disorder, severe without psychotic symptoms. • F43.1 Posttraumatic stress disorder, chronic. • F40.01 Panic disorder with agoraphobia. • F 40.2 Specific phobia to blood.

Questionnaires

With the objective of corroborating and compiling the data provided by the patient at the interviews, some questionnaires were included at the assessment process: BDI-II, BAI, PCL and PSWQ. Every questionnaire is translated and adapted to the Spanish population. Its characteristics and the patient's results are summarized in table III.

Table III: Questionnaires results

Questionnaire	**Data Sheet**	**Results**
BDI-II (Beck et al., 1996).	It detects depressive symptoms and its severity.	Rs=29, severe depressive symptomatology (29-63).
BAI (Beck et al., 1998).	It detects anxiety symptoms and its severity.	Rs=22. Moderate anxiety symptomatology (16-25).
PCL-C (Weathers et al., 1993).	It detects posttraumatic symptoms and its severity.	Rs=62. Clinically significant. (Rs >40 civil population)
PSWQ (Meyer et al, 1990).	It assesses the frequency, intensity, control and generality of patient's worry.	Rs =74. High worry level. (Old age Spanish population average 64,1;SD=4; By Nuevo, Montorio and Ruíz, 2002)

DIAGNOSE

Based on all of the data collected from the interviews and after it has been contrasted with the results from the symptomatology questionnaires taken during the assessment process, diagnose given using the DSM – IV – TR criteria:

- **AXIS I:**
  F32. 32 Major depressive disorder, severe without psychotic symptoms.
  F43.1 Chronic posttraumatic stress disorder.
  F40.01 Panic disorder with agoraphobia.
  F 40.2 Specific phobia to blood.
- **AXIS II:** V71.09 No diagnosis
- **AXIS III:** Z03.2 No diagnosis.
- **AXIS IV:** Z03.2 No diagnosis.
- **AXIS V:** EEAG= 55. This scale considers psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. A result of 55 means moderate anxious depressive symptoms, difficulty in social, occupational functioning.

CONCLUSIONS AND OTHER CONSIDERATIONS

The assessment process shows that the patient presents:

- Depressive symptomatology primarily shown as sadness, lack of interest and motivation, agitated behavior, fatigue, poor concentration and difficulty falling asleep, is compatible with a **Major Depressive Disorder, severe without psychotic symptoms**. This is confirmed by Structural Clinical Interview (SCID-I), module A for mood disorders, Semi-structural clinical interview which is where the patient reflects on his inability to cope with day to day situations. And the BDI-II questionnaire, in which he obtained a high score (29) which shows severe depressive symptomatology.
- Posttraumatic stress disorder symptomatology defined by several avoidance behaviors with situations that are related to 11-M, hyper-arousal, nightmares, intrusive re-experiencing, that makes him experience high distress levels, which is related with chronic Posttraumatic Stress Disorder. The presence of this disorder is stated in the Structural Clinical Interview (SCID-I), module F for anxiety disorders, Semi-structural Clinical Interview and in the PCL-C questionnaire where he obtained the score of 62, clinically significant.
- He has hyper-arousal symptomatology, which is confirmed by the BAI questionnaire where he obtained a moderate anxious symptomatology score of 22. The high score with his?? cognitive symptomatology (fear of dying, fear of losing control…) could be related with the high score obtained (74) in the PSWQ questionnaire, which is higher than the cut-off point. However, it does not appear to significantly affect his daily life. That is the reason why it is not suitable to diagnose Generalized anxiety disorder, as reflected in the Structural Clinical Interview (SCID-I), module F for anxiety disorders.
- A large proportion of the panic attacks and agoraphobic behaviors suffered by the patient could be explained by Posttraumatic Stress Disorder (because they are linked to stimuli associated with the traumatic experience). However, other behaviors transcend this area, for example being scared to lose control in crowded places or anywhere else if he does not take his medication. This is the reason why the diagnosis is **Panic Disorder with agoraphobia**.
- In the Structural Clinical Interview (SCID-I), F module for anxiety disorders, the patient commented he cannot see blood and referred to having a very difficult time even if he sees it in cartoons. Due to all these factors the diagnosis is a **Specific Phobia to Blood.**
- Finally, the patient recently presented with intrusive thoughts related to hurting others or himself, and he perceives this as very disturbing. He overcomes the discomfort with avoidance behaviors like taking anxiolytics, not arguing or isolating himself from others. The symptomatology appears to be getting worse, and it should also be treated.

Looking at all the detailed information in

this report, it is recommended that Miguel follows a specific treatment for his problems. Especially, taking into account that until now, the treatment has succeeded in reducing his symptoms

Thus, it is considered necessary to recommend that Miguel follows a treatment program based on effective psychological therapy for posttraumatic stress disorder, depression and to manage his panic attacks and agoraphobia and his specific phobia, as well as his obsessive symptoms. Therefore, the treatment should include cognitive restructuring, stress control techniques, exposure and behavior activation techniques.

For the record I sign this report,

In Madrid, March20th, 2013.

Sd: Rocío Fausor