Clinical Report: Bill Wynsky

Diagnosis, Formulation, and Treatment Processes

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School of Psychology

Master in Clinical Psychology

Assessment and Treatment of Complex Psychological Disorders

Kingswood, New South Wales, November 2025

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PART I

DIAGNOSES

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DIAGNOSES

1.1 Provisional Diagnoses

Bill's clinical presentation meets criteria for multiple DSM-5-TR diagnoses requiring careful differential assessment (American Psychiatric Association, 2022). Post-Traumatic Stress Disorder [309.81] emerges as the primary diagnosis, with Criterion A unequivocally met through direct combat exposure and witnessing his closest friend's death via gunshot to the head in Afghanistan. Bill demonstrates all required symptom clusters with clinically significant severity: intrusive symptoms manifest through vivid combat-themed nightmares occurring biweekly, unwanted trauma memories intruding during waking hours, and physiological reactivity to trauma cues (touching friend's dog tag); persistent avoidance evidenced by steadfast refusal discussing military experiences, emotional numbing during trauma recounting, and avoidance of reminders including military media; negative cognition and mood alterations encompassing persistent negative beliefs ("I am weak," "I'm a bad person"), persistent shame and guilt, markedly diminished interest in previously enjoyed activities (soccer, socialising), emotional detachment from family members, and constricted positive affect; marked arousal and reactivity alterations including irritability culminating in property destruction (punching walls), hypervigilance, exaggerated startle responses, concentration impairment affecting daily functioning, and severe sleep disturbance with new-onset parasomnias. Symptoms persist beyond one month with profound functional impairment across interpersonal, occupational, and social domains (Friedman et al., 2011; Phoenix Australia – Centre for Posttraumatic Mental Health, 2019).

Major Depressive Disorder, Moderate [296.22] diagnosis appears warranted given persistent depressed mood described as feeling "low" and "empty," anhedonia affecting previously pleasurable activities, excessive worthlessness and inappropriate guilt unrelated to trauma, diminished concentration capacity, and recurrent death thoughts with passive suicidal ideation (visualising throwing himself under buses), persisting several months representing marked change from premorbid functioning (Kroenke et al., 2001). Alcohol Use Disorder, Mild [305.00] reflects problematic consumption patterns demonstrating tolerance development (increased quantities: 20–40g weeknights, 100g weekends versus previous social drinking), unsuccessful control efforts despite recognition of problems, continued use despite persistent interpersonal consequences (relationship breakdown), and psychological dependence using alcohol for stress management, meeting three DSM-5-TR criteria (Saunders et al., 1993).

1.2 Differential Diagnoses

Complex PTSD (ICD-11) warrants primary differential consideration given comprehensive symptom presentation meeting all diagnostic requirements: core PTSD symptoms plus self-organisation disturbances encompassing affect dysregulation (anger outbursts, emotional numbing), negative self-concept ("bad person," persistent shame), and interpersonal difficulties (detachment, relationship failures), though this diagnosis exists outside DSM-5-TR nosology (Cloitre et al., 2013; World Health Organization, 2018). Persistent Complex Bereavement Disorder remains differential given traumatic loss circumstances, though broader symptomatology exceeds bereavement-specific criteria (Prigerson et al., 2009). Adjustment Disorder with Mixed Anxiety and Depressed Mood [309.28] appears insufficient given symptom severity, duration exceeding six months, and specific PTSD criteria fulfilment. REM Sleep Behavior Disorder necessitates polysomnography evaluation given new-onset sleepwalking potentially representing dream enactment behaviour associated with combat nightmares (Mysliwiec et al., 2014).

1.3 DSM-5 Diagnostic Challenges

The DSM-5-TR categorical framework presents substantial limitations capturing Bill's complex phenomenology. Artificial diagnostic boundaries separate interconnected symptoms; alcohol use, depression, and PTSD manifestations likely represent integrated affect regulation attempts rather than discrete, independent disorders, risking fragmented treatment approaches (Kolk et al., 2005). The framework inadequately conceptualises developmental trauma's profound personality organisation impact; Bill's childhood domestic violence witnessing, perceived maternal protection failure during psychiatric hospitalisation, and immigration-related cultural dislocation created foundational vulnerabilities that military trauma subsequently reactivated, yet this developmental trajectory receives minimal diagnostic weight within current nosology (Herman, 1992). Additionally, DSM-5-TR fails adequately addressing moral injury: Bill's profound survivor guilt and witnessing civilian abuse without intervening represents violated deeply-held moral beliefs requiring different therapeutic approaches than fear-based traumatic stress (Litz et al., 2009).

PART II

FORMULATION

2

FORMULATION

2.1 Biopsychosocial Framework

Bill's presentation reflects complex developmental vulnerability and military trauma interactions within an integrated biopsychosocial framework requiring multifaceted conceptualisation.

2.1.1 Predisposing Vulnerabilities

Multiple childhood experiences created intersecting vulnerability pathways. Immigration from South Africa aged six coincided with parental conflict escalation during critical attachment formation periods, disrupting secure base establishment essential for emotional regulation development (Schore, 2003). Witnessing father's alcohol-fuelled violence toward mother established trauma exposure templates, dysregulating neurobiological stress response systems and creating hypervigilance patterns, emotional dysregulation vulnerabilities, and maladaptive coping strategies modelling substance use for distress management (Brewin et al., 2000). Mother's psychiatric hospitalisation when Bill was eight represented critical attachment rupture, with expressed shame regarding protection failure ("couldn't protect her") establishing enduring schemas of personal inadequacy, excessive responsibility, and fundamental helplessness subsequently reactivated by military experiences. Parental separation at twelve created additional losses and divided loyalties ("guilty leaving his father"). School bullying targeting perceived intellectual deficits ("dumb") compounded negative self-concept development, with early educational discontinuation limiting vocational opportunities beyond military service. These accumulated adversities created what Briere & Scott (2015) conceptualise as "complex developmental trauma": disrupted attachment patterns, impaired self-concept formation, emotion dysregulation vulnerabilities, and interpersonal difficulties increasing susceptibility to subsequent traumatic stress.

2.1.2 Precipitating Factors

Military service initially provided compensatory experiences addressing earlier developmental deficits: structure, belonging, identity, and meaningful peer connections ("real friends for the first time"). This environment temporarily scaffolded self-organisation capacities compromised by developmental trauma. However, Afghanistan combat exposure overwhelmed these compensatory mechanisms through multiple pathways. Witnessing his closest friend's death activated profound survivor guilt whilst shattering assumptions about predictability, control,

and fairness. Forced retreat leaving friend's body triggered abandonment schemas established during childhood maternal protection failures. Equally significant, witnessing civilian abuse by service members without intervening created moral injury: deep psychological wounds resulting from perpetrating, witnessing, or failing preventing acts violating core moral beliefs, generating shame, self-condemnation, and existential crisis distinct from fear-based responses (Litz et al., 2009). Subsequent medical discharge following knee injury removed military identity scaffolding, precipitating psychological decompensation as underlying vulnerabilities re-emerged without environmental supports.

2.1.3 Perpetuating Mechanisms

Multiple interconnected factors maintain Bill's difficulties through self-reinforcing cycles. Cognitive factors include persistent negative trauma-related cognitions ("I should have saved him," "Good people die while bad people survive") creating information processing biases selectively attending to confirmatory evidence whilst dismissing disconfirmatory information (Ehlers & Clark, 2000). Behavioural patterns perpetuate dysfunction: alcohol provides temporary numbing but prevents processing whilst creating additional shame ("becoming like father"), social withdrawal maintains disconnection preventing corrective experiences, and avoidance prevents habituation. Neurobiological alterations sustain symptoms through chronically dysregulated stress systems evidenced by hypervigilance, exaggerated startle, and anger dyscontrol, suggesting altered amygdala-hippocampal-prefrontal circuitry characteristic of PTSD (Shin & Liberzon, 2010). Environmental factors including temporary accommodation, employment uncertainty, and family separation create ongoing instability maintaining threat perception.

2.1.4 Protective Factors

Despite severity, Bill demonstrates important strengths: help-seeking despite reluctance indicates motivation; family connections provide potential support; military identity offers belonging; future goals suggest hope; previous adaptive functioning indicates recovery capacity; absence of active suicide planning reduces immediate risk.

(See Appendix A for formulation schematic)

PART III

INTERVENTION

3

INTERVENTION

3.1 Risk and Safety Considerations

Three critical safety domains require immediate stabilisation preceding trauma-focused intervention. Suicidal ideation management represents highest priority given passive ideation with specific method contemplation. Implementation requires collaborative safety planning using Stanley-Brown Safety Planning Intervention: identifying personal warning signs (increased isolation, hopelessness), internal coping strategies (distraction techniques, self-soothing), social distractions, family/friend crisis contacts, professional resources, and means restriction including medication security and avoiding high-risk locations (Stanley & Brown, 2012). Weekly Columbia Suicide Severity Rating Scale administration ensures systematic monitoring with clear escalation protocols (Posner et al., 2011).

Alcohol use stabilisation necessitates immediate intervention given escalating patterns potentially compromising treatment engagement and increasing impulsivity. Motivational interviewing explores ambivalence, developing discrepancy between current consumption and valued goals (military service, future family) whilst supporting self-efficacy for change (Miller & Rollnick, 2013). Psychoeducation addresses bidirectional trauma-alcohol relationships, introducing self-medication concepts whilst highlighting perpetuation of symptoms. AUDIT-C provides validated monitoring throughout treatment.

Anger and behavioural dysregulation manifesting through property destruction requires immediate skill development preventing interpersonal violence escalation. Dialectical Behaviour Therapy distress tolerance modules offer concrete strategies: TIPP (Temperature change, Intense exercise, Paced breathing, Paired muscle relaxation) for acute crises; ACCEPTS (Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations) for sustained distress without destructive behaviour (Linehan, 2015).

3.2 Social and Cultural Considerations

Bill's treatment requires careful attention to intersecting sociocultural factors. South African immigration during childhood family dysfunction suggests acculturation stress affecting identity formation and belonging (Bhugra & Becker, 2005). Treatment should explore how cultural dislocation compounded trauma impacts, potentially incorporating narrative therapy examining cultural identity stories. Military culture's emphasis on strength, self-reliance, and stoicism

conflicts with vulnerability required for trauma processing; reframing treatment using military-consistent language (”operational readiness,” ”psychological fitness,” ”mission planning”) whilst acknowledging service meaning may enhance engagement (Hoge et al., 2004). Masculine socialisation creates additional emotional expression barriers; psychoeducation normalising neurobiological trauma responses rather than character weakness, using medical analogies comparing psychological to physical injuries, may reduce shame-based resistance (Tolin & Foa, 2006).

3.3 Treatment Interventions

Comprehensive treatment requires coordinated multidisciplinary intervention. Psychiatric evaluation for evidence-based pharmacotherapy: SSRIs (sertraline 50–200mg or paroxetine 20–60mg daily) demonstrating efficacy for military PTSD; prazosin (1–15mg nocte) specifically targeting trauma nightmares through noradrenergic blockade (Raskind et al., 2013). Sleep medicine consultation for comprehensive polysomnography evaluating parasomnia presentation differentiating PTSD-related disturbance from primary sleep disorders. Occupational therapy assessing functional capacity, vocational rehabilitation needs, and return-to-duty fitness (Penk et al., 2002).

Three evidence-based therapeutic interventions demonstrate strong empirical support for military PTSD.

Cognitive Processing Therapy (CPT) directly targets maladaptive cognitions maintaining PTSD through systematic examination of ”stuck points” where traumatic experiences conflict with pre-existing beliefs (Resick et al., 2017). Bill’s survivor guilt, moral injury, and negative self-concept represent cognitive maintenance factors CPT specifically addresses through Socratic dialogue and cognitive restructuring.

Prolonged Exposure (PE) facilitates emotional processing through systematic confrontation of avoided memories and situations, demonstrating robust military PTSD efficacy (Foa et al., 2007). Bill’s marked avoidance and emotional numbing suggest habituation-based intervention could reduce symptoms through fear structure modification (Rauch & Foa, 2006).

Skills Training in Affective and Interpersonal Regulation/Modified Prolonged Exposure (STAIR-MPE) provides phased treatment prioritising emotion regulation before trauma processing, particularly suited for complex presentations with developmental trauma (Cloitre et al., 2002).

3.4 Cognitive Processing Therapy Protocol

CPT follows manualised twelve-session protocol adapted for military populations (Resick et al., 2017). Sessions 1–2: Psychoeducation establishing cognitive model; impact statement exploring trauma’s belief effects. Session 3: ABC worksheets teaching thought-emotion connections; Socratic questioning challenging initial stuck points. Sessions 4–5: Written trauma accounts facilitating emotional processing whilst identifying maintaining cognitions. Sessions 6–7: Challenging Questions Worksheets systematically examining evidence, alternatives, thinking patterns. Sessions 8–12: Five thematic modules comprising Safety (threat assessment), Trust (rebuilding

capacity), Power/Control (accepting limitations, identifying genuine control), Esteem (balanced self-worth), Intimacy (connection capacity despite trauma).

Effectiveness monitoring: PCL-5 weekly (10-point reduction indicates clinically significant change); PHQ-9 tracking depression; Posttraumatic Cognitions Inventory assessing mechanism change (Weathers et al., 2013).

PART IV

REFLECTION

4

REFLECTION

4.1 Strengths and Limitations

I believe this report comprehensively integrates complex trauma presentations within evidence-based frameworks, acknowledging developmental vulnerabilities without deterministic conclusions. I was selective in the intervention selection, and was careful to balance empirical support with practical engagement considerations addressing military culture. However, I do admit that neurobiological factors including potential traumatic brain injury received insufficient consideration. Social determinants (housing instability, employment uncertainty) warranted greater therapeutic planning emphasis. There were also systemic military institutional factors perpetuating tigma that deserved deeper critical analysis.

4.2 Personal Clinical Challenges

Bill's moral injury narratives would certaintly activate my personal distress regarding institutional failures permitting atrocities. I think maintaining therapeutic neutrality whilst validating legitimate moral concerns requires careful self-monitoring preventing either dismissing ethical violations or reinforcing paralysing guilt which i would find difficult. My cognitive intervention preference might overshadow necessary emotional processing given Bill's defensive numbing. His suicidal ideation would trigger personal anxiety potentially leading to overly cautious risk management compromising therapeutic alliance. I would certaintly need extensive supervision to explore countertransference, and would need to rely on my peers to help me manage the disclosure of such traumas, and of course, personal therapy to process any vicarious traumatisation.

Appendices

A

Case Formulation Schematic

Biopsychosocial Formulation: Bill Wynsky

Factor Category	Specific Components
PREDISPOSING FACTORS	**Biological:** • Genetic vulnerability (paternal alcohol use disorder) • Potential epigenetic trauma transmission • Neurodevelopmental impacts of childhood adversity **Psychological:** • Insecure attachment (maternal hospitalisation age 8) • Childhood trauma exposure (domestic violence) • Negative self-schemas (”weak,” ”inadequate,” ”can’t protect”) • Emotion dysregulation vulnerabilities **Social:** • Immigration stress and acculturation challenges (age 6) • Family violence and dysfunction • School bullying and educational disruption • Limited socioeconomic resources
PRECIPITATING FACTORS	• Combat exposure Afghanistan (12 months service) • Index trauma: Friend’s death (shot in head, unable to retrieve body) • Moral injury (witnessed civilian abuse without intervening) • Multiple combat-related traumatic exposures • Medical discharge following knee injury (loss of military identity)

Factor Category	Specific Components
PERPETUATING FACTORS	**Cognitive:** • Trauma-related stuck points ("I should have saved him") • Negative self-concept ("weak," "bad person," "worthless") • Overgeneralised threat perception • Moral injury cognitions (violated values) **Behavioural:** • Experiential and situational avoidance • Alcohol use for emotional numbing (20–40g weeknights, 100g weekends) • Social withdrawal and interpersonal isolation • Aggressive behaviour (property destruction) **Physiological:** • Hyperarousal and hypervigilance • Sleep disturbance and parasomnias (sleepwalking) • Dysregulated HPA axis and stress response • Altered fear circuitry (amygdala hyperactivation) **Environmental:** • Temporary military accommodation (housing instability) • Career uncertainty (fitness for duty unknown) • Geographical separation from family support • Military culture stigma regarding mental health
PROTECTIVE FACTORS	• Help-seeking behaviour (despite initial reluctance) • Family connections maintained (mother, sister Hannah) • Military peer support and identity • Future-oriented goals (family, meaningful work) • Previous adaptive functioning capacity • No active suicide plan or intent • Physical health intact (successful knee recovery)

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