NCMHCE

ARTHUR-BRENDE
STUDY SUPPLEMENT

NATIONAL CLINICAL MENTAL HEALTH COUNSELING EXAMINATION

DSM-5 UPDATED

ONLINE SCENARIO SIMULATOR

DSM-5™ Disorders: Diagnosis To Referral

Gary L. Arthur, Ed.D., LPC, NCC, CPCS
Joel O. Brende, M.D.

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STUDY PROGRAM

Arthur-Brende Study Supplement

for the

National Clinical Mental Health Counseling Examination

DSM-5™ Disorders: Diagnosis to Referral

A Companion to the
Arthur-Brende Online Scenario Simulator

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1 INTRODUCTION

Developing Skills with Practice Scenarios

This Study Supplement contains two sections: Section I contains an overview of the National Clinical Mental Health Counseling Examination (NCMHCE) as administered by the NBCC and Section II contains the DSM-5™ Disorder Overview.

This Study Supplement is best used in conjunction with the *Arthur-Brende Scenario Simulator*, which is an online, interactive resource of 37 different practice scenarios similar to those that make up the NCMHCE exam. The 37 scenarios are designed to help the practicing counselor diagnose and treat individuals with mental health disorders.

While the DSM-5™ contains some 300+ diagnoses, the information in this manual has at least one, and sometimes two or more, disorders contained in 16 classifications. The authors have chosen to develop 37 scenarios accounting for 36 different disorders. Some disorders are repeated, yet the scenarios are presented with different sets of circumstances.

DISCLAIMER:
A disclaimer is stated by Dr. Brende and Arthur in that they are not affiliated with the National Board of Certified Counselors or the panel that created, manages, scores and designed the scenarios for the NCMHCE. There is no communication between these bodies regarding the format of the scenarios or prior information shared by that board to these authors. In addition, all material is paraphrased where the DSM-5™ and NBCC information is contained within this supplement.

It is recommended that all users of this material periodically check with NBCC or APA for recent changes and specific information regarding the examination and material.

Materials contained within this supplement relative to the DSM-5™ are paraphrased or credit is applied.

Scenarios – Practice Format

The 37 online scenarios are designed according to a Practice Format similar to the design utilized by the National Board for Certified Counselors (NBCC) for the National Clinical Mental Health Counseling

examination. These scenarios follow the standard protocol used to identify a mental health disorder for a simulated client case. Many of the 37 scenarios will provide adequate data to make only a single diagnosis; however several will provide data that point to dual or multiple diagnoses.

In most cases, these scenarios will utilize a process which begins with the client's initial statement of current problem or chief complaint. The counselor, having accepted or been assigned the case, must then ask appropriate questions and gather the information necessary to formulate a diagnosis. Sufficient information will be available to help the counselor make a provisional diagnosis. The next steps will be making recommendations regarding gathering additional diagnostic information for, if necessary, formulating treatment procedures, and initiating referrals.

For many of the simulations, the questions have been standardized in the form of information deriving questions, methods or procedures to acquire additional and/or necessary information to form a provisional diagnosis, recommended treatment, methods to monitor treatment, and finally to consider referral or case closure. Consider the following examples:

> During the first session, what information would be important to assess in order to formulate a provisional DSM-5™ diagnosis?
>
> In completing the initial evaluation interview, what referrals would the counselor make?
>
> Based on the information gathered in A and B, what provisional DSM-5™ diagnosis is indicated?
>
> What techniques, therapies and/or strategies would be useful during the sessions?
>
> What information would be beneficial in monitoring the client's progress?
>
> In preparing for treatment termination, what recommendation(s) would a counselor make?

For the first two questions, if you make the right selection there is sufficient information to make a correct diagnosis. When you reach 'the provisional diagnosis question' that is a STOP question. The purpose of a STOP question is for you to make the correct provisional before being permitted to respond to the final three or more questions for the case. For some scenarios you may be instructed to find a second or third diagnosis before going forward to the next question. A recommended treatment question usually follows the diagnosis question. When dual or multiple diagnoses are identified, unless a specific diagnosis is requested, the treatment question should be answered with treatments for all identified diagnoses.

Sample Scenario

The design of this procedure is to replicate what actually takes place in clinical practice. That is, the counselor has to acquire diagnostic information in a building block fashion to make a correct provisional diagnosis, request additional testing, make referrals, and proceed with treatment.

In the *Scenario List* available online once you log in to your account, note that *Scenario - Mary Jones* is a sample that can be used to become familiar with the design and process of the online scenarios.

Note that Section Two contains the *Disorder Overview*, which is the information portion of the Supplement. Information is limited for many of the disorders but includes a definition of the disorder, interviewing strategies, assessment or diagnostic information, recommended treatment, instrumentation, a few commonly used medications, and references.

How to Approach the Scenarios

Because there are many different health providers, many of whom are trained at different levels, it will be important to approach these scenarios as though the counselor is trained at the master's level of education, completed a practicum/internship program successfully, and has limited work experience. In addition, many states are "practice" states, meaning a counselor is not allowed to practice beyond the limitations of his or her training. For the NCMHCE examination, even though the examinee may not be trained in certain treatments or instrumentation, one should answer all questions in terms of best practice, not whether or not the examinee is trained in that treatment technique or using certain instruments.

Be mindful that when answering the different questions the preferred response may be one in which the person taking this examination may not be trained to provide. This may be in the different phases of the scenario such as the intake, referrals, and treatment. The examination is requesting one's knowledge in terms of best practice not selecting answers based upon the qualifications of the examinee (degree level, M.S., Ph.D.). An example may be to select the MMPI-2 as the best instrument of choice even though the examinee has not been trained to administer or interpret the MMPI-2.

The NCMHCE is seeking your acquired knowledge. If the MMPI-2 contains the scale of the diagnosis under consideration it should be selected. The examination is not determining if the examinee is qualified to administer the MMPI-2 or that the examinee is ethical or unethical in making that selection.

The word "provisional" is used to convey that the diagnosis made by the counselor is subject to be confirmed by a clinician trained in this assessment such as a psychiatrist making a diagnosis for the purpose of prescribing medications. In the treatment section, not all therapeutic recommendations will be within the capability or training of every counselor. For example, if a recommendation might be hypnotherapy, that might be a good choice for the client or a hypnotherapist but not for a professional counselor untrained in hypnotherapy.

None-the-less, making such a choice would be appropriate if the examinee believes it or evidence exists in the literature that this choice should be made for the correct response.

In reading many of the valued answers, you will recognize many references to specific medications. But the authors' intent is not to train you in how to identify, use, or monitor medications. It is unlikely

the NCMHCE will ask you for this knowledge but it has been included as general information since many clients have been poorly informed and may ask questions about the psychoactive medications they have been prescribed.

As the counselor considers which treatments or psychotherapeutic modalities should be recommended, a number of factors need to be considered: pertinent diagnoses; short term and long term treatment goals; time limitations imposed by insurance, EAP, or managed care companies; nature of the relationship between counselor and client, cost effectiveness, who is the client and client commitment; and most beneficial therapeutic modalities based on research findings. Although common sense dictates the fact that specific treatments follow specific diagnoses, there are conflicting data regarding what therapies are most effective for specific diagnoses. The authors have utilized the literature as best as possible, however, to report the results of outcome studies and therapies believed to be most effective and helpful. The authors have found cognitive behavioral therapy to be frequently cited as an effective approach for many disorders, particularly when there are clearly defined goals although short and long term goals may vary, depending on the nature of the diagnosis and desired treatment results. The examinee must also take into account that, while most insurance companies, EAP, and managed care approve limited numbers of sessions, some treatments require a longer duration to effect change.

National Board for Certified Counselors (NBCC)

The National Board for Certified Counselors (NBCC) sponsors the National Clinical Mental Health Counseling Examination (NCMHCE; http://www.nbcc.org/NCMHCE) for certifying counselors. Those preparing to take the NCMHCE should visit this Website for any changes made by NBCC. Testing time for the Clinical Simulation Examination (CSE) is four hours. READ THE INSTRUCTIONS VERY CAREFULLY. Be sure you have a clear understanding regarding the image pen, answers surfacing, asterisks (1 or 2), how many answers to select, scoring procedures and the problem-solving scenario. Today most states administer the computer online version of the NCMHCE.

The NCMHCE Exam

The NCMHCE consists of 10 clinical mental health counseling cases. Some states use both the National Counselor Examination (NCE) and the National Clinical Mental Health Counseling Examination (NCMHCE) for the cognitive requirement for licensure. Case scenarios are presented with five to eight topical segments during the journey of psychotherapy (behaviors) which are components of client care. The assessment behaviors begin with a question such as "what information would be important to assess in order to formulate a provisional DSM-5™ diagnosis" followed by a number of options/answers. Further investigation may extend beyond inquiring about symptomology of various disorders to include questions about specific instruments considered helpful to acquire or validate

symptomology or diagnoses. Subsequent questions may focus on experts who should be consulted and other parties who might be involved. For example if the examinee is asked to interview or provide counseling for a student who has been identified with a conduct disorder the examinee will have to consider whether or not a consultation/conference should be requested. If so, it follows that additional questions will include such things as who should comprise the consultation group and should the parents be asked to attend? Information in the scenario will help answer such questions and also suggest if and when it would be appropriate for others to attend, i.e. the school counselor, the teacher who made the referral to the counselor, curriculum coordinator, school social worker, and perhaps the principal of the school.

The NCMHCE examination process begins with the meeting between a client and a counselor and concludes with termination, discharge and follow-up. It is possible the scenario begins with a telephone call for a scheduled session. It emphasizes evaluation and assessment (interviewing/mental status evaluation, cultural sensitivity, ethics), diagnosis and treatment planning (goal formation, techniques/strategies), monitoring client progress (assessing progress), referral (community resources), supervision and consultation along with sound ethical behavior (code of ethics) encompassing the entire scope of clinical practice. Counselor tasks may include charting, requests for release of information, client rights, agency policy, insurance company communication and an assortment of other duties the counselor performs in addition to best client care.

The NBCC practice booklet does not appear to adhere to a strict set of questions for each of the two parts (Information-Gathering - IG and Decision-Making - DM) with the exception of acquiring information for and making a provisional diagnosis. This indicates to those preparing for the NCMHCE that questions can be geared to any client session and can include the necessary tools, strategies, theories, treatment procedures, in-session dialogue or dilemmas, ethics and consultation necessary to provide good client care.

Those who are preparing for the exam can expect it to exemplify the full scope of a counseling practice. Of specific clinical interest will be the evaluation and treatment of clients presenting with some form of a cognitive disorder (learning, memory, etc.), substance use, psychosis, mood disturbances, anxiety, avoidance behavior, school-relational problems, physical complaints and social and personality problems.

Evaluating a client with one of those disorders means investigating cognitive, emotional, and behavioral symptoms by obtaining a complete history (present, past, social, family, medical, and occupational), performing a mental status examination, and often recommending further diagnostic testing and consultations while paying attention to ethical/legal issues. After making a diagnosis (es) a thoughtful treatment plan can be proposed or constructed.

Each scenario is much like the NCMHCE in that it includes questions related either to Information Gathering (IG – usually 2-4 questions) or Decision-Making (DM - usually 4 or more questions). IG includes questions such as, "What information would be important to make a diagnosis?" or "What information would be beneficial to monitor the client's progress?" DM includes questions such as,

"After completing your evaluation, what recommendations would you make?" or "What is a recommended treatment?"

The examinee should envision that the scenario and first question might resemble an initial interview unless otherwise instructed. Morrison (1993) has delineated percentages of times devoted by an interviewer to specific tasks, as follows: chief complaint(s) (15%), specific symptoms - suicidal ideation or behavior, substance use, history of violence (30%), medical history (15%), personal, social and character pathology (25%), mental status evaluation (10%) and diagnosis and treatment discussion (5%). Although all of the options might provide some information the efficient interviewer will want to maximize time deriving the most important information to establish a provisional diagnosis.

The clinical interview **is a systematized method of** deriving pertinent information that includes several different categories such as client education, family background, physical and psychological (mental) health, social involvements and client identification (age, gender, etc.). Most importantly, however, the interview must address the client's reason for seeking help which includes primary symptoms, predisposing factors, and possible destructive or self-destructive behaviors including substance abuse.

The interviewer's questions may be organized systematically or they may be more open-ended. In some cases the interviewer would best follow the client's leads while not forgetting the task of utilizing the history of the client's presentation, motivation, and predispositions, which are those pieces of information that suggest that certain disorders need in-depth investigation including issues related to medical, family, and social histories.

It is not to suggest that by selecting these choices you will necessarily gain all of the information you would like to obtain, but rather it can demonstrate that you have background information which may be helpful during the entire phase of counseling.

Predisposition may also be discovered in a family history of substance use, mood disorders, tics, and eating disorders. This does not mean that because any of these disorders were to be found in the family history they would necessarily be the cause of the disorder; rather it may be that this person grew up in a type of surrounding that predisposed them to such disorders.

For this reason, choosing family history may gain positive points for the test taker in some scenarios but negative points in others.

It is recommended to order the choices before making any during the examination.

Strategy for taking the examination:

It is important for the examinee to review the procedures for taking the test in the preparation guide for the 10 "Clinical Simulation Examinations" (CSE; NBCC, 2013). It is especially important to follow the directions as to whether one or more than one answer is required and to pay attention to the words "select as many," which appears in the first set of questions requesting the acquisition of important data. The scoring system for these questions assigns varying values for the answers ranging from +3 to –3. Answers scored +3 are considered essential, while those with lower valuation are less essential and yield lower points. If answers contribute little or nothing to the specific request the score may be zero. The authors will use a zero at different times because the answer may be acceptable but much lower on the list. In addition, the scenario choices are likely to be fewer or different than the choices for the NCMHCE even though certain choices may be preferable for the test. Points may even be taken away (-1, -2, -3) if they are detrimental to the process (excessively expensive, unnecessary time spent, worse symptoms or trigger a suicide attempt). NBCC may in revealing an answer use wording such as minimally acceptable. This may suggest the answer receives some points but not the maximum.

Please be mindful these instructions are subject to change as NBCC deems to make changes.

When a question is answered correctly, it will provide information that will enable the examinee to move to subsequent questions more easily. Thus, correct answers in the initial portion of IG will help the test taker establish a correct provisional diagnosis. Correct information will provide a foundation for subsequent questions related to instrument selection, appropriate ethics, proper referrals, monitoring, and specific treatments.

Unlike the actual NCMHCE our scenarios for some responses will provide a zero (0) value. The meaning attached to a zero is that this response may be positive in a different list of responses for a particular question. When the zero is assigned it is our view that other choices (options) are higher on the priority list.

Although the simulator modifies the test conditions to enhance learning, it is important to be aware of the real test conditions. In some states, the examinee will be asked to use a latent image pen to mark the correct answers and irrelevant or inappropriate answers will not only be devoid of helpful information but may also be given a negative score. In most states the NCMHCE is administered on-line similar to this one.

In the actual test situation, you cannot undo what you have marked. For each question select one choice at a time and read that response before making a second choice. You can

mark more than one choice, but keep in mind that more answers might result in either a more positive or more negative score.

The Arthur-Brende scenario format (six traditional questions) is similar to the actual NCMHCE, but be aware that the NCMHCE may contain more than six questions per scenario and recent information suggests five-eight questions per scenario. The reason for more questions appearing than during past years is that the NCMHCE has expanded on the knowledge and behavior required of the counselor to work with different disorders.

What may appear to be different in our scenarios compared to the actual examination will be questions regarding ethics, group process and dynamics, and specific instruments. Our simulations do address these same constructs and behaviors, but are often embedded in the traditional six questions. One example of this embedding may appear in the treatment section when hypnosis is one of the suggested treatment options. Choosing this option may not be appropriate because of ethical issues pertaining to training and boundaries. Ethical issues are also pertinent when it comes to the examinee's knowledge about informed procedures, release of information, court subpoena, Buckley Amendment, HIPAA, record keeping, consultation requests, and confidentiality/privilege.

Another way in which our scenarios are different than the actual NCMHCE is in the amount of information received. When you select an answer you will receive more information in the form of sentences than you will find on the NCMHCE. **The NCMHCE answers are much briefer.** If you purchased NBCC's packet you will see fewer sentences, some of which are very brief and very short such as 'not indicated'. We also provided shorter answers when we first started approximately 10 years ago but customers wanted more information so we decided to move toward a more educational approach in format questions but we also chose to be more tutorial with our answers. As a result our scenarios are likely to be more detailed than you will find on the actual examination.

In addition we have provided discussion boxes that contained our reasoning for our choices. The discussion boxes appear with the diagnosis and treatment. Frequently within the discussion box information may appear to contradict the scenario. It is not our intention to provide contradictory information rather to make suggestions that may be helpful under other situations.

The discussion boxes will not be found in the actual examination.

When group treatment becomes an option, the examinee should know that some group treatments are contraindicated for certain disorders, some are recommended for other disorders (psychoeducation, process, support), and the composition and length of group treatment may vary depending on goals of the treatment.

The training format for the diagnosis may also be different: where the Arthur-Brende Scenarios use the STOP question which is intended for the preparer to take time to study why a certain disorder choice was incorrect, this may or may not be the situation for the NCMHCE.

In summary an approach to the scenarios may be:

Question 1. Interview for symptoms
This question is a request for symptom gathering to formulate a tentative diagnosis.

In doing so using a clinical interview can be helpful if the assessor uses discipline to order or sequence his/her questions to ask only those options that are likely to produce symptoms. I have suggested to consultees that it is good to identify those clinical words (key words the client shares in the scenario such as 'tired, fatigues, sad, down, loss of interest, memory failing, etc.). These are the words that should form the basis along with those derived from good choices.

Frequently, an interviewer asks the client when the issue first started (time dimension) and what took place when they noticed the issue (discontinued going to bridge group, stopped playing piano, spent even more money, no longer read, etc.). These statements may be good for treatment, monitoring, and discharge but not for symptom gathering.

Perhaps some of these findings can be written down for later use.

I recommend that the examinee, after reading the scenario and identifying the key words, see how many options are available.

If for example there are six options, select the best answer to derive a symptom and write it down on the piece of paper. Then ask "Why did I ask that question?" or "What do I expect?" Is there a link between the probe and a knowledge base from the literature or clinical practice. If one can answer that question with a supportive reason write the choice down on the piece of paper and look for a second option using the same format or strategy. Can you connect your choice with something in the scenario, predispositions, or validated questions found in the literature?

Draw a line under your first two choices and ask yourself, "If I select a third answer, what would it be?" and write it under the line.

Now, reread the scenario and if you did not think of something else select your first choice.

If the choice is scored positive, you will learn something that can be added to what you have found in the scenario.

You may now be forming diagnosis in one or more classifications (mood disorder, anxiety disorder). Start your processing for a calculated data choice for a diagnosis.

If the first choice scored positive and you learn nothing to reorder the next two letters, select the second choice. Again, if positive you will learn more. You may now, with the scenario data and first two choices, be fairly confident of a diagnosis. Now you are asking should I select the third option.

A possible idea to consider might be that if you have sat across from the disorder being considered, you will know if the third option is a good choice.

Trust your acquired learning and experiences. If you have not counseled the disorder in question it might be 'less is more'. If you select an answer when you have a felt uncertainty, it may be best to leave it if you have had two or more positive answers before any 'not indicated' responses.

Question 2: Collateral services
This question is designed to determine if we use our collateral services wisely. This is the rule in/rule out decision. It might be wise to consider cost effectiveness and efficiency when making these choices.

An area for review is instrumentations. The type of question, "What instrument would be helpful to gain additional information?" does not say what diagnostic tool so instruments like Beck Depression Inventory or Beck Anxiety Scale, SASSI and other short screeners seem to be good choices if the disorder is the same as that instrument taps.

It is our opinion in an introductory licensure examination that request for psychopharmacology or treatment recommendations are best not made before a diagnosis is confirmed.

There may be situations where those recommendations would be made but is our thought not for the NCMHCE scenarios. Referring to a physician or psychiatrist would be dependent upon gathered information such as a need for medical information (predispositions) or follow-up for medication because of a lack of compliance.

Question 3: Diagnosis
This is a STOP question that requires the correct diagnosis before moving to the next question. It could be that the examination may request differential diagnoses that were considered for a rule in/out. The DSM-5™ recommends recording procedure(s) for each disorder. It is unknown if the intensity, medical, and stressors are to follow diagnosis(es). The DSM-5™ recommends that all diagnoses that meet full criterion are to be included with the presenting disorder. The primary diagnosis is to be the treated disorder, although there are exceptions.

Question 4: Treatment, technique, and strategy
It is our opinion that high point choices will be those treatments (theories) that have effectiveness or efficacy studies in the literature such as CBT for many diagnosis and DBT for borderline. These treatments have research studies in the literature to support outcome based results for certain disorders.

A second line of choices for this question or perhaps value will be those treatments that provide immediate relief. Managed care or insurance companies approve a limited number of sessions thus the process of therapy can be accelerated or begin clients on the road to recovery but perhaps not a cure per se.

This frees up the examinee to select other therapies known to be helpful such as psychotherapy, supportive therapy, and solution-focused therapy. Since this question frequently states, "Select as many as you feel appropriate." and includes techniques it is important to select certain techniques that are matched to the disorder or to treatment goals. This can be a time to use techniques that are connected to activities the client was previously involved with but stopped during that time period of the distress. An example might be recommending bibliotherapy if the person was an avid reader before the stressful issue was brought to therapy.

If one of the questions has requested best short-term goals, then match a technique with one of the goals.

An example might be the client indicated they stopped going to church or a social club because of the anxiety in social interaction.

Perhaps a recommendation of stress relaxation techniques, breath inhalation, muscle relaxation, or even in vivo exercises would be beneficial.

Question 5: Monitoring
As in the last example of a request for short term goals and techniques, monitoring can be some form of behavioral count or involvement. Dependent upon the disorder specific monitoring tools may be helpful such as screeners (instruments), rating scales, self-reports, and physiological measures (blood pressure, heart rate, pulse, galvanic response).

Question 6: Discharge
Besides recommendations such as self-help groups and journaling, one can also consider for discharge the tasks of reviewing the goals and change.

Assessment information:

1. Read carefully as identifying information is provided in the clinical case scenario. Usually you will know the age, gender and, at times, educational background, counseling setting, and the environmental setting, i.e. work and family.
2. Sensitivity to culture and race is critical because biases are known to exist throughout the literature from assessment to treatment. Family communication, philosophical and practical issues related to treatment varies with encounters with mental health services. Chavira, Grilo, Shea, et al. (2003) in researching Caucasians, African Americans, Asian Americans, and Hispanic Americans that ethnicity data in diagnosing reflects differencing in rates for four personality dysfunctions. Important information for the clinician is to be aware of how the individual perceives a problem, expresses a problem, the interaction between the clinician and the client, family philosophies regarding mental illness, and if the person decides to seek treatment. It is recommended that each preparer review the ACA Code of Ethics section on diversity.
3. Initially focus on the chief complaint(s). Read for clues in the scenario that will help you select the more important options. Some directional information will guide the questioning. Be alert to trigger words or phrases, such as "sleep," "appetite," "mood," "health," "concentration", "fatigue', "sudden change in behavior", 'memory', and "duration of symptoms."
4. Select responses that will provide answers related to the DSM-5™ disorders. Recognize the importance of acquiring information regarding frequency, intensity and time frame of symptoms related to the chief complaint.

5. Pursue causative factors for the chief complaint(s). For example, if a client has memory loss, ask about accidents, falls, depression, and health problems i.e., ("mini-strokes", etc.).

6. It is important for some disorders to be aware of medical conditions that appear to be associated with a diagnosis. The medical condition may not be the cause but often is a condition at the same time. This information may suggest the counselor utilize appropriate referrals to gain best client care or to validate information. A list of these associations will be found at the conclusion of these suggestions.

7. The literature findings suggest that there are family predispositions with certain disorders. Predisposition may be for history taking regarding medical, mental, family, work, social, and risk behaviors. An example may be to select family history because one or more family members have or had the same condition or disorder. Frequently, clues may be found in the scenario to warrant 'family history' to be an important data gathering.

   Some examples may be alcoholism, mood disorders, eating disorders, tics, etc. Frequently, clues may be found in the scenario to warrant 'family history' to be an important probe in data gathering. It is our opinion the family inquiry, as a selection, moves up the list of choices. A partial list will follow the family, social, and medical associations.

8. The mental status examination (MSE) often confirms diagnostic questions pertaining to behavior, memory (short-term, intermediate and long-term), affect, and cognitive functioning.

9. Positive scores (+1, +2, +3) will follow pertinent answers pertaining to duration and intensity of symptoms with higher values reflecting greater importance.

10. Diagnostic instruments that assess for disorders that are statistically valid and reliable have been used to corroborate interviewer's data gathering of symptoms. Some instruments that have few items (time and cost concerns) may be good for monitoring client improvement. They may also be good choices depending on the wording of the question. The question might state a diagnostic instrument or it might state what instrument would be helpful. The first request is for an instrument validated as a diagnostic instrument such as the MMPI-2 while the second question indicated 'helpful' like the Beck Depression Inventory (short in items but readily utilized). For diagnostic assessment some instruments for mood disorders might be the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Beck Depression Inventory (BDI), Burns Anxiety Inventory, and for personality disorders perhaps the Millon Clinical Multiaxial Inventory-III. Monitoring for client improvement, the clinician might consider using the Beck Depression Inventory (BDI), Burns Anxiety Inventory or the SASSI. The BDI contains 21 self-report items measuring the severity of depression in adults and adolescents. It assesses symptoms for depression contained in the DSM-5™. It is inexpensive and can be administered and scored by the master level trained counselor. The instrument scale direction and cut-off scores have not been required.

11. The provisional diagnosis question is a STOP question. STOP means the correct provisional diagnosis must be made before the examinee is permitted to progress to the next question.

The following questions are based on the correct provisional diagnosis. If one were to proceed to the next question with the incorrect provisional diagnosis answers would likely be incorrect for treatment, to monitor and to refer. The NCMHCE has a different approach to the STOP question than this computer training set of scenarios.

12. This training manual as you move to later scenarios will be asking for dual diagnoses. If you select one correct diagnosis you will be instructed to find a second or even third before proceeding to the next question. The NCMHCE may ask for a dual diagnosis but likely only one or two, if that, for each examination. It is advisable to become familiar with the use of specified, unspecified and V-codes with different diagnoses. Be sure to read NBCCs web site for any up-to-date changes.

13. The next question is usually requesting recommended treatment. Sometimes more than one treatment is valued. When dual diagnoses are confirmed the treatment question can be approached as a clinician might. That is, prioritizing the immediate need (safety, medication) and decisions about which disorder may be given treatment priority. If this is not the case do not select a treatment for one disorder that may not be at least somewhat helpful for the other. These types of questions are found in the later scenarios.

14. For recommended treatments, strategies, and techniques for different disorders in the scenarios it is recommended that one become familiar with literature citing evidenced based research. It was recommended by psychologists that at a minimum of two independent randomized control trials for effectiveness be conducted. More recently the field has expanded this requirement to include levels of evidence. For a more in-depth understanding of effectiveness or efficacy studies consult Trinder and Reynolds (2000). One example of a research article reporting this concept and research was conducted by Simon Gowers (2006). In his study cognitive behavior therapy (CBT) and eating disorders he cites results of this sort. A controlled clinical trial refers to a study that meets the criteria for research in which the treatment or technique is exposed to rigorous research criteria. This type of research usually involves comparing a control group with a particular therapy or intervention or comparing a technique/ treatment with a different technique/treatment. Levitt, Hoffman, Grisham and Barlow (2001) cite several controlled clinical effectiveness trail studies using CBT with panic disorder in 8-12 treatment sessions. We have made an effort to include this type of recommendation in our manual as well as the on-line scenarios.

15. In addition to treatments that meet evidence-based studies consider treatment selections that provide immediate relief. Due to the limited number of sessions clients receive (insurance, finances, managed care, cost effectiveness, transportation) affecting change for improved conditions are to be considered.

Medical Associations with Psychological Disorders

Counselors are not physicians so are not expected to diagnose a physical problem. Limited medical information is provided in order that when the interviewer is acquiring information either in the interview or information located in the chart of a medical nature there may be an associated psychological issue to explore or a referral that should be made to a medical practitioner or other professionals.

Because the mind and body are closely intertwined, medical symptoms may reflect psychiatric conditions, physical symptoms can mimic psychiatric disorders or reflect DSM- 5™ diagnoses, and medication side-effects can be manifested as psychiatric symptoms. Non-medical professionals are not expected to memorize specific medications for the NCMHCE but, rather, should learn to appreciate when a referral should be made to a medical professional (typically a psychiatrist or in some cases a primary care provider) for possible medication initiation or modification for medication side-effects. This requires asking the client if he or she has any new or unpleasant emotional or physical symptoms. While the following list of examples is not fully inclusive, consider the following examples:

'Heart Attack' vs. Panic Attack
Symptoms of a panic attack often include chest pain or 'tightness', shortness of breath, rapid pulse, and extreme apprehension; BUT a normal medical evaluation, normal electrocardiogram, and absence of abnormal lab findings rules out a heart attack.

Gastrointestinal and Varied Pain Complaints vs. Somatization Symptom Disorder
Symptoms of somatization symptom disorder may include gastrointestinal complaints such as vomiting, abdominal pain, nausea, bloating, diarrhea, intolerance of several different foods, non-specific pain in back, joints, and pelvis; BUT the absence of objective medical and laboratory findings rules out a specific medical diagnosis.

Hypochondriasis, Sleep Disorder and Non-specific Somatic Symptom Disorder Complaints and Chronic Post-traumatic Stress Disorder
Post-traumatic stress disorder is often overlooked by physicians, whose patients, particularly women previously abused as children, seek medical attention for physical symptoms such as pelvic and abdominal pain, gastro-esophageal reflux disease, non-cardiac chest pain, gastrointestinal (GI) symptoms, and irritable bowel syndrome.

Cancer vs. Hypochondriasis
Symptoms of hypochondriacs include a variety of physical complaints and/or preoccupation with minor physical abnormalities, such as a small sore or cough which is thought to be evidence of a serious disease or feared disorder BUT no objective medical abnormality can be found.

Multiple Sclerosis vs. Conversion Disorder
Symptoms of multiple sclerosis, an auto-immune demyelinization disorder, may include difficulty swallowing, deafness, double vision, weakness, difficulty walking, or paralysis. Conversion disorder should be considered when one of these symptoms develops suddenly in a patient with a history of psychological disorder and/or psychological trauma. Multiple sclerosis should be suspected when symptoms recur 30 days or more later but are different because demyelinization occurs in a different anatomical location. Objective evidence of demyelinization is sometimes made by a MRI.

Evidence of immunoglobulins in the cerebrospinal fluid is found in 75% to 85% of cases and other tests may be used to detect the presence of antibodies associated with demyelinization.

Lyme Disease vs. Mood Disorders
Symptoms of chronic and/or recurrent anxiety and mood disorders have been associated with Lyme disease, the most common tick-borne disease in the Northern Hemisphere. Early manifestations of infection include fever, headache, fatigue, and a characteristic skin rash. Untreated Lyme disease can become a chronic disorder lasting for years, manifested by a variety of physical and emotional complaints including memory and sleep disturbances, depression, anxiety, and bipolar disorder.

Substance withdrawal symptoms vs. Anxiety Disorder
Symptoms of both disorders include sweating, rapid pulse, tremors, insomnia, gastrointestinal complaints, and occasionally transient hallucinations. These symptoms can occur after sudden withdrawal from alcohol, narcotics, marijuana, anxiolytics, and some muscle relaxants. In addition, some patients discontinuing short-acting anti-depressants such as Paxil and Effexor have had similar withdrawal symptoms.

Substance Use Disorders
These may be limited to neurological symptoms such as learning problems, loss of coordination, and involuntary movements. Symptoms may also include depressed mood, apathy, and behavior disorders.

Diabetes and Bipolar Disorders (Hirschfeld, Young, & McElroy, 2003)
People with bipolar disorder are three times more likely at risk to develop diabetes mellitus symptoms than are members of the general population (Hirschfeld, et al, 1999; Krishman, 2005; Kupfer, 2005; & Regenold, et al, 2003). Dunner (2004) reported a 6.6% association with bipolar disorder and diabetes mellitus in a study conducted in Canada.

Eating Disorders
Eating disorders are linked with adult onset of type 2 diabetes mellitus, hperlipidaemias, cardiovascular diseases, several cancers, and sleep apnea (Brewerton, 1999).

Sleep-Wake Disorder (central sleep apnea disorder, circadian rhythm sleep-wake disorder, night terror disorder) vs. Sleep Disorders Secondary to another disorder (conditions such as depressive disorder and PTSD).
A diagnosis of a serious primary sleep disorder may require a sleep study such as a polysomnogram, multiple sleep latency tests, and multiple wake tests.

Depressive Disorder Due to Another Medical Condition vs. Primary Depressive Disorder with Medical Symptoms.
Twenty five per cent of chronically ill individuals develop a secondary depression and five per cent of those diagnosed with major depressive disorder subsequently are found to have another medical illness which caused their depression.

Organic Mood Syndromes vs. Medical Illnesses Causing Mood Disturbances:
Endocrine conditions such as thyroid disorders (hypothyroid and "apathetic" hyperthyroidism) parathyroid disorders (hyper- and hypo-), adrenal disorders (Cushing's or Addison's diseases), eurosyphilisnism, and diabetes mellitus.

Bipolar disorder rapid cycling has been linked to thyroid abnormalities (Gyulai, Baurer, Baurer et al., 2003; Oomen, Schipperijn, & Drexhage, 1996).

Chronic medical conditions such as cancer (especially pancreatic and other gastrointestinal malignancies), porphyria, an inherited condition caused by a buildup of chemicals called porphyrins in the body causing psychiatric symptoms and chronic pain. Uremia and chronic renal diseases causing fatigue, nausea, vomiting, cold, bone pain, itch, shortness of breath, and seizures.

Cardiopulmonary disease and cardiac conditions such as myocardial infarction and stroke.

Neurological disorders such as multiple sclerosis, migraine, various forms of epilepsy, encephalitis, brain tumors, migraines, narcolepsy, multiple sclerosis, Huntington's disease, Parkinson's disease, dementias (including Alzheimer's neurological disorder), progressive eurosyphili palsy, Fahr's syndrome, hydrocephalus, and Wilson's disease.

Auto-immune diseases such as rheumatoid arthritis, Sjogren's arteritis, temporal arteritis, multiple sclerosis, and systemic lupus erythematosus.

Infections: Tuberculosis, acquired immune deficiency syndrome (AIDS), eurosyphilis, mononucleosis, pneumonia (viral and bacterial).

Vitamin and mineral deficiencies:

B12 (mood swings, psychosis, insomnia, learning difficulties); D (depression, SAD, psychosis); C (depression, anxiety, insomnia, fatigue); Folate (neural tube defects in the unborn, peripheral neuropathy, weakness); Niacin B3 (fatigue, depression, memory loss, confusion); Thiamine B-1 (Wernicke's encephalopathy, Korsakoff's psychosis); Magnesium (anxiety, insomnia, irritability, confusion).

Mood Disorders Caused by Drug and Medication Side-effects:
Corticosteroids (including Prednisone and Cortisone)

may cause changes in mood and cognition, are generally dose related, and can precipitate psychosis, hypomania, mania, depression, cognitive and memory problems.

Interferon (treatment for hepatitis C – has caused major depression in 23% of patients).

Anti-hypertensive: Reserpine, beta blockers (particularly Propranolol and Metoprolol), Angiotensin-converting enzyme (ACE) inhibitors, Clonidine.

Antibiotics – Penicillin, cephalosporins, Quinolones such as Ciprofloxin and Ofloxacin, chloramphenicol, and Isoniazid. The chronic use of broad spectrum antibiotics (and excessive ingestion of meat products associated with antibiotic use) has been found to disturb probiotic bacteria in the intestinal tract. A small number of medical practitioners have written articles indicating their conviction that disturbed intestinal flora has caused a rising number of mental disorders in western nations. Their recommendation is to reduce sugar intake and take probiotics to restore normal intestinal flora. (Gucciardi, Anthony, Antibiotics Could be to Blame for Skyrocketing Mental Illness Rates, Activist Post, Oct 2011)

Anti-viral agents and HIV drugs may cause depression.

Anabolic androgenic steroids are associated with mood and behavior changes.

Cold preparations which combine antihistamines and decongestants—such as phenylpropanolamine, azatadine, loratadine, ephedrine, phenylephrine, pseudoephedrine, and naphazoline—can cause an atropine-like psychosis that typically manifests as confusion, disorientation, agitation, hallucinations, and memory problems. Decongestants can cause dangerously high levels of norepinephrine when combined with monoamine oxidase inhibitors (MAOIs). Ephedrine can induce restlessness, dysphoria, irritability, anxiety, and insomnia.

Medications for reflux disease (omeprazole and lansoprazole) and H2 receptor antagonists (famotidine, nizatidine, ranitidine, and cimetidine) have been reported to cause serious neuropsychiatric complications—including mental confusion, agitation, depression, and hallucinations—mainly in geriatric patients with impaired hepatic-renal function.

Opioid antagonists such as naloxone and naltrexone can potentially induce dysphoria, fatigue, sleep disturbances, suicidality, hallucinations and delirium.

Anti-migraine medications such as sumatriptan have been associated with fatigue, anxiety and panic disorder.

Ondansetron, used for antiemetic therapy, has been associated with anxiety.

Isotretinoin—a retinoid used for severe acne—can cause severe depression and suicidal behavior.

Aminophylline and salbutamol are associated with agitation, insomnia, euphoria, and delirium.

Methotrexate is known to cause personality changes, irritability, and delirium.

Family Predispositions

Some disorders appear to continue to be prominent in family members. The authors are not suggesting that the family members are causative agents for the continuation of the disorder rather to be mindful during the interview knowing this information may be helpful in conducting a differential diagnosis or confirming a diagnosis. A partial list is presented:

1. **Tourette's Syndrome**
   Comorbidity: Predisposition: Relatives of client's with Tourette's have a higher incidence of tics, OCD, and ADHD. A higher rate is also noted in monozygotic twins. Data suggests that tics are to be found in maternal and paternal family members (Kenney, Kuo, & Jimenez-Shahed, 2008)

2. **Eating Disorders**
   Striegel-Moore and Bulik (2007) and Bulik, Devlin, et al. (2003) cite evidence that there is a genetic link in family and environmental elements for anorexia nervosa, bulimia nervosa, and BED. They cite seven studies from 1983 to the present linking genetic components to familial transmission of eating disorders.

3. **Tics**
   Kaplan and Sadock (1998) comment on twin studies, adoption studies that support a genetic etiology for Tourette's disorder. Tourette's disorder and chronic motor or tic disorder tend to run in same families. Their research suggests that son's of mothers with Tourette's disorder is at high risk for this disorder. A relation is also found between Tourette's disorder and attention-deficit/hyperactivity disorder and also with obsessive-compulsive disorder (Kenny, Kuo, U Jimenez-Shahed, 2008).

4. **Alcohol**
   A genetic predisposition to alcohol researched in family studies, twin studies, adoption studies, ethnic differences and biological risks support risk factors for alcoholism (Pandy, 1990). Pandy points out the identification of high-risk individuals often have a genetically predisposition to alcoholism. His work suggests biochemical traits of two categories. These categories are alcohol abuse (state markers) and vulnerability to alcoholism (trait markers). This research references Goodwin's work in the evidence of familial nature of alcoholism. The Institute of Medicine in 1987 published a report that alcoholism rate is significantly higher in relatives of alcoholics than in those relatives of nonalcoholics. The rate this study cited was that 40% of alcoholics have an alcoholic parent. Alcoholics coming from a family of alcoholics tend to start drinking earlier in life. Pandy indicates predisposition is not an easy question to answer as both genetic and environmental factors are involved.

5. **ADHD**
   Chromosome 11 are risk factors. Twin and family studies indicate marked genetic contributions to the development of ADHD. The estimates are 60% to 92% (Althof, Rettew, & Hudziak, 2003).

Instrumentation

This section will focus on the instruments that may be used for screening, monitoring and assessing (diagnosing) behaviors. It is our opinion that screening instruments are more likely used to derive a rough estimate of possible directions the assessor takes during the interview. Screening instruments often are short and provide direct questions in a self-report form. The instruments listed in this section for screening are not all defined as screeners in the manual. Those that are considered screeners will be identified. Screening is a rapid and rough estimate (Domino, 2000). It is a process of collecting data to decide whether more intensive assessment is necessary. This is an initial stage in which a particular decision is sorted out from the general population. (Salvia, Ysseldyke & Bolt, 2007). An individual has a certain characteristic or does not have a certain characteristic.

A screening assessment is a relatively brief evaluation intended to identify individuals who are at risk for developing certain disorders or disabilities. Screening can be done to determine readiness for certain interventions.

Diagnostic assessment is a detailed evaluation of an individual's strengths and weaknesses in several areas including cognitive, affective, emotional, social functioning and behavioral. This type of assessment is to determine a level or degree of functioning or disorder. Decisions based on assessment should not be viewed as definitive and should be revised with new information (Sattler, 2008). It is our opinion instruments identified as diagnostic qualities would be selected for a section of the NCMHCE where additional information is sought to validate or invalidate the data derived during the interview. It would be helpful to be aware of instruments that assess DSM-5™ disorders. There are several ways and methods to monitor client improvement. We are unaware of any instruments that are specifically identified for monitoring improvement. Nevertheless it is possible that instruments that have a few questions or even screeners might be used for this purpose. Monitoring can take the form of duration, latency, frequency, amplitude (intensity) of certain behaviors.

The order of these instruments is not to suggest they are the best. These instruments and inventories are those likely to be used in the practice of screening, monitoring and supporting a diagnosis. No attempt is made to provide detailed information regarding validity, reliability, norms and technical data. Rather identifying the purpose of the instrument and scales measured. For some instruments additional information may be provided.

Although the surveys are dated 1988 and 1989 the following instruments were ranked according to frequency of use in mental health centers (mh), counseling psychologist (cp), and adolescents (a). It is recommended in preparing for the NCMHCE to become familiar with the instrument purpose, scales

and population age. The number following the letters represents the ranking in frequency in use. The use of these instruments for assessing, screening or monitoring purposes should also be considered.

1. Minnesota Multiphasic Personality Inventory (MH1, CP1, A6)
2. Bender Gestalt (MH3. CP5, A3)
3. Beck Depression Inventory (MH12, A11)
4. Wechsler Adult Intelligence Scale-R (MH2, CP6)
5. Wechsler Intelligence Scales (A2)
6. Sentence Completion (MH6, CP4, A 4)
7. Rorschach Inkblot Test (MH8, CP10.5, A2)
8. Thematic Apperception Test (MH10, CP9, A4)
9. Millon Clinical Multiaxial Inventory (I & II) (MH19, A12)
10. MacAndrew Alcoholism Scale (A13)
11. Children's depression Inventory (MH30)
12. Symptom Checklist-90R (MH29)

To review the entire list of instruments locate each list from the following source (Aiken,1997, Archer, Maruish, Imhof, & Piotrowski, 1991,Piotrowski & Keller, 1989, Watkins, Campbell & McGregor, 1988).

1. Neuropsychology II (NEPSY-II)

The NEPSY-II is to assess neuropsychological development in preschool and school-age children, 3-16 years of age. It is useful for aiding in diagnoses and intervention planning for particular disorders.

The NEPSY-II is useful for general assessment, diagnostic assessment, selective assessment and a full assessment in a neuropsychological examination.

Domains: Attention and executive functioning, language, memory and learning, sensorimotor, social perception, and visual-spatial processing.

Disorders: Academic, social, and behavioral difficulties. Subtest scores are useful in suggesting or supporting a diagnosis for attention-deficit/hyperactive disorder (ADHD), pervasive developmental disorder (e.g., autism spectrum disorder), language disorder, mathematics disorder, and reading disorder.

Recommendation: Prior to the administration of the NEPSY-II Korkman, Kirk and Kemp (2007) recommend data gathering for developmental, medical, social, and educational history and current level of performance in school, genetic risk factors and the environment in which the child is living along with the demands placed on the child in the domicile (p. 3).

2. Bender Gestalt II (Bender Visual-Motor Gestalt Test)

Purpose and use:
The Bender Gestalt Visual-Motor Gestalt Test measures visual-motor integration skills in children and adults from 4 to 85 (Branningan & Decker, 2003). The instrument is used in educational, psychological and neuropsychological assessment. The Bender Gestalt II is a clinical tool for measuring visual motor behavior.

The Bender has been used for the identification of mental retardation (intellectual disability), disabilities, reading difficulties, personality dynamics, and diagnosis of organic brain abnormality, psychotic dysfunction, anxiety states, psychosomatic conditions, sexual disturbances, cultural differences, and psychoneurotic conditions, characterological defects including alcoholism, malingering and physiological alterations (Toler, 1968, p. 222).

Scoring:
There are several methods to score the Bender-Gestalt II such as the Pascal-Sutell, Hain, Koppitz Developmental, Brannigan and Brunner, Hutt Adaptation¸ and Canter's Background Interference (Canter, 1996).

Interpretation:
The majority of interpretations are directed at organic brain pathology.

3. Minnesota Multiphasic Personality Inventory-2

Purpose:
Psychopathology and normal/abnormal function, (18 years and older)

Validity Scales:
Include lie, infrequency, and correction.

Clinical Scales:
Include hypochondriasis, depression, hysteria, psychopathic deviate, paranoia, psychasthenia, schizophrenia, hypomania, social introversion-introversion, masculinity- femininity, Harris- Lingoes subscale¸ MacAndrews addiction scale-revised, malingering scale; Wiggins scale (social desirability).

4. Minnesota Multiphasic Personality Inventory-Adolescent

Purpose and Use:
Original research in behavior with the MMPI-A was conducted with borderline, depressed mood, eating disorders, homicidal behavior, manifest aggression, victimization by incest and sexual abuse, sleeping problems, physical disabilities, and schizophrenia. The MMPI-A has been researched in psychiatric settings, medical problems, alcohol and drug treatment centers and in correctional juvenile programs (Butchner, Williams, Graham, Archer, Tellegen, Ben-Porath, Kaemmer, 1992).

Clinical Scales:
Hypochondriasis (Hs)

Depression (D)

Hysteria (Hy)

Psychopathic Deviate (Pd)

Masculinity-Femininity (MF)

Paranoia (Pa)

Psychasthenia (Pt)

Schizophrenia (Sc)

Hypomania (Ha)

Social Introversion (Si)

5. Millon Clinical Multiaxial Inventory (MCMII-III)

Purpose:
The MCMII-III provides support for the opinions of mental health professionals in clinical counseling, medical, forensic, and other settings. It was designed to measure personality traits and psychopathology and used for clinical decision making. There are 24 clinical scales clustered into four groups: personality scales, severe personality scales, clinical syndrome scales, and severe clinical scales.

Scales:
Clinical scales: Anxiety, Somatoform, Bipolar: Manic, Dysthymia, Alcohol Dependence, Drug Dependence, Post-traumatic Stress Disorder, Thought Disorder (Schizophrenia, Schizophreniform), Major Depression, and Delusional Disorder.

Personality:
Schizoid Personality, Avoidant Personality, Depressive Personality, Dependent Personality, Histrionic Personality, Narcissistic Personality, Antisocial Personality, Sadistic Personality (Aggressive), Compulsive Personality, Negativistic Personality (Passive-Aggressive), Self-Defeating Personality (Masochistic).

Severe:
Schizotypal, Borderline, and Paranoid.

Interpretation:
Millon and Davis (1996) state that the transaction between personality disorders and stressors produce a diagnosis (DSM-IV-TR). The assessor is to interview for a separation in moderate versus

severe personality scales. A correlation of .66 was found between Narcissistic scale of the MCMII-III and the Narcissistic Personality Inventory (Torgersen & Alnaes, 1990).

6. Beck Depression Inventory (BDI-II)

Purpose:
The BDI-II is a 21 item self-report inventory that measures the severity of depression in adults and adolescents (13 and older). The inventory is composed of symptoms intended to assess the criteria for diagnosing depressive disorders. It is not an instrument strictly for diagnosing clinical depression rather according to the authors can be used for assisting in diagnosing disorders from panic disorder to schizophrenia.

The 21 depressive symptoms are mood (sadness), pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusations, suicidal ideas, crying, irritability, social withdrawal, indecisiveness, body image, work difficulty, insomnia, fatigability, loss of appetite, weight loss, somatic preoccupation, and loss of libido (Beck, Steer, & Brown, 1996, p. 2).

Interpretation:
A total raw score of 63 points and scores of 20-28 are considered moderate and 29-63 severe.

7. SCL-90-R

Purpose and Use:
The use of the SCL-90-R is to screen and integrate data into the interview. Frequently the client has provided stimuli of distress (why in counseling), unsure why they are there, and indicate a desire to free the self of the burden. The SCL-90-R elicits information regarding psychological distress and psychopathology. Caseness is based on the number of symptoms endorsed by the respondent.

SCL-90-R Scales

Somatization (SOM)

Obsessive-Compulsive (O-C)

Interpersonal Sensitivity (I-S)

Depression (DEP)

Anxiety (ANX)

Hostility (HOS)

Phobic anxiety (PHOB)

Paranoid Ideation (PAR)

Psychoticism (PSY)

Global Severity Index (GSI)

Positive Symptom Distress Index (PSDI)

Positive Symptom Total (PST)

Interpretation:
KEEP IN MIND these markers are to be considered PRESUMPIVE or IMPRESSIONISTIC regarding the characteristic of a disease or pathological condition. It is not possible to make an accurate clinical diagnosis on a single-at-point in time assessment. The GSI is the most sensitive single numeric indicator of the respondent's psychological status. Caseness is considered when a GSI's T score is ≥ 63 or if any two dimension T scores are ≥ 63 and is considered a positive risk or a case.

Populations studied with the SCL-90-R
Eating Disorders-(bulimic) Psychopharmacology outcome-sensitive to drug vs. placebo-anxiety and depressive disorders, stress, suicidal behavior, somatization, interpersonal sensitivity, paranoid ideation, and psychotism, sleep disorders, drug and alcohol abuse, physical and sexual abuse, and sexual dysfunction.

8. Substance Abuse Subtle Screening Inventory (SASSI-3)

Purpose:
Structured, self-report and screens for substance dependent disorder.

Scales:
Obvious attributes (OAT) problematic behavior associated with clinical abuse and personality characteristics associated with substance dependent (impulsiveness, low frustration tolerance, and self-pity. High scores reflect a client's tendency to be detached from their feelings and to have relatively little insight into the basis and causes of their problems.

Subtle Attribute SATs scores higher than OAT the client may deny the need for intensive treatment. Risk Prediction Scales (RPS)-predictive validity Face Valid Alcohol-FAC-12 items and Face Valid Other Drug (FVOD-14 items) Symptoms (SYM) - Acknowledges specific problems associated with substance misuse Subtle attributes (SAT) Defensiveness (DEF)

9. The Structured Clinical Interview (SCID-I) and SCID-II

Description:
A set of questions to be used in conjunction with the Bipolar Spectrum Diagnostic Scale.

SCID-II was originally developed during the time of DSM-III-R and utilized for personality disorders while the SCID-I was for clinical disorders such as those identified by the DSM-IV-TR. There is also a

children's interview (DISC-2; Hodges, 1994).

Scales:
Mood episodes, psychotic symptoms, psychotic disorders, mood disorders, substance use disorders, anxiety, adjustment disorders.

10. Bipolar Spectrum Diagnostic Scale (BSDS)

Description: A narrative based self-report developed by Dr. Robert Pies and revised by Dr. S. Nassir Ghaemi in 2005. The results are designed to determine the presence or absence of bipolar disorder. There are two separate parts. The first part is a story of positive statements in which the individual checks off whether or not he/she believes the statement is true for them. The second part of the instrument is a single multiple choice question asking the individual to rate how well the story represents them overall (Ghaemi, etc., 2005).

11. Mood Disorder Questionnaire (MDQ)-SCREENING

Description: The MDQ is a single report. It is an easy to use screening tool for the detection of bipolar I disorder. Dr. Robert M. A. Hirschfeld (2000) along with team members developed the tool. The MDQ has 5 questions and each number is divided into a number of questions such as 13 for the first question. The authors indicate the MDQ is not used for monitoring for improvement (Hirschfeld, 2002).

12. The Drug Abuse Screening Test (DAST) and Short Michigan Alcoholism Test (SMAST)

The DAST is often used by doctors and counselors to determine if an individual is reflecting symptoms of an addict. The SMAST attempts to identify individuals with drinking problems. The DAST has 28 items requiring the respondent to answer yes or no. A score of five or less indicates a normal score while 6 or higher indicates a drug problem.

13. CAGE

The CAGE is used to screen for alcoholism during the intake interview. There are four questions: C for cutting down on alcohol intake, A for annoyance over criticism about alcohol, G for guilt about drinking behavior, and E for drinking in the morning to relieve withdrawal anxiety. Answering yes to two or three questions is considered a high alcohol suspicion Index.

14. The Dissociative Experiences Scale (DES)

The DES is a self-report screening instrument for the identification of clients at high risk for dissociative disorders. The DES is used in tandem by using the Structured Clinical Interview (SCID-D). The SCID-D is

the first diagnostic instrument developed for the assessment of five dissociative symptom areas (Steinberg, Rounsaville, & Cicchetti, 1991).

Instruments for Children and Adolescents

Intelligence:

Stanford-Binet Intelligence Scale, 5th edition
The Stanford-Binet age range spans 2 to 85+. The scales include Fluid Reasoning, Knowledge, Quantitative Reasoning, Visual/Spatial Reasoning, Working Memory and overall verbal, non-verbal and total intelligence quotient.

The Wechsler Intelligence Scales WISC-IV and WPPSI-III
The Wechsler WISC-IV age range is 6 to 16 years and 11 months while the WPPSI-III is 2 years, 6 months to 7 years, 3 months of age. Both instruments have 7 verbal scales and 7 performance scales.

Children's Depression Inventory (CDI 2; Kovacs & MHS Staff, 2011)
The Children's Depression Inventory is a self-rated scales for parents about their children. The purpose is to identify depressive symptoms in children from 7 to 17. It can also be used as an adjunct in diagnosing for clinical depression. Four diagnostic categories of depression are scaled in the CDI2. These categories are major depressive disorder (MDD), dysthymic disorder (DD), depressive disorder not otherwise specified (NOS) and adjustment disorder with depressed mood.

Revised Children's Manifest Anxiety Scale (RCMAS-2; Reynolds & Richmond, 2009)
The RCMAS-2 is a questionnaire and one of the most widely used in anxiety research. This questionnaire is used to assess the level and nature of anxiety in children 6 to 19 years of age. The major scales are worry, defensiveness, physiological anxiety and social anxiety.

Achenbach System of Empirically Based Assessment (ASEBA) (Achenbach & Rescorila, 2001)
The ASEBA assesses for ages 6 to 18. Specific scales measured are Competence and Adaptive includes activities that are academic, social-working and school behaving. Empirically –based scales are anxious/depressed, withdrawn/depressed, somatic complaints, social problem, thought problems, Rule-breaking behavior, aggressive behavior, internalizing, externalizing and total problems. DSM-oriented scales are affective, anxiety, somatic, ADH, oppositional defiant and conduct problems.

Behavior Rating Inventory of Executive Function (BRIEF; Gioia, Isquith, Guy & Kenworthy, 2000)
The BRIEF covers the broad age range of 5 to 18 and areas of learning disabilities, attentional disorders, traumatic brain injuries, lead exposure, pervasive developmental disorders, depression, and other neurological, psychiatric and medical conditions.

Behavior Assessment System for Children (2nd ed) (Reynolds & Kamphaus, 2004)
This instrument can be used to evaluate the behavior and self-perceptions of children. There are two

self-report scales, one for teachers and one for parents, a self-report scale (personality), structured developmental history and a form for recording classroom behavior.

Conners 3 (Parent, Teacher and Adolescent forms)
Many counselors have used the Revised Connors' Parent and Teacher Rating Scales (CPSR and CTRS-R). The 2008 form Conners 3 is in current use and has three versions—parent, teacher and adolescent self-report. Each version has a short and long form. There are three screening tools available composed of a 12-item ADHD Index. The Connor forms are frequently used by pediatricians in their practice.

Purpose:
The purpose of the Conners 3 is to screen and assess behavior problems and is a clinical tool for obtaining parental, teacher and adolescent reports of childhood behavior problems. The areas of concern include the scales within the forms.

The Parent form contains 108 items while the Teacher form contains 113 items. These forms are typically used with parents, caregivers and teachers when comprehensive information is needed.

The Conners 3 covers the age range of 6 to 18. The major assessment is ADHD and related issues using a teacher, parent and self-report forms. Scales include inattention, hyperactivity/impulsivity, executive function and learning problems, aggression, peer relations, family relations, conduct disorder, oppositional defiant, anxiety, depression, schoolwork/grades, home life, strengths and skills,

Factors:
Attention deficit hyperactive disorder (ADHD) and late disorders.

The CPRSR and CTRSR are often used in combination to provide observations of the child within the home environment and the school.

Differential Diagnosis

Psychiatrists and those trained to conduct a differential diagnosis utilize a decision tree or symptoms tracking. Symptom gathering begins with clinical features such as those in the presenting complaint and those symptoms acquired during the assessment interview. A differential diagnosis is a systematic method of diagnosing a disorder. Diagnosis is derived from Greek words. The "dia" refers to by and "gnosis" refers to knowledge.

The professional conducting the interview and conducting an assessment measures the current condition of the client against what is considered "normal". The degree of departure from the "normal" is to determine the severity of the condition and a resultant diagnosis. The professional uses a causal analysis of symptoms from several methods with reasoning compared to the structure of the DSM-5™.

The diagnosis is based on accumulated symptoms derived from the interview, assessment instruments (tests), collateral services and environmental factors. Once a list is determined, the list is narrowed

down and the process is referred to as a differential diagnosis. The interviewer begins the process of either confirming or ruling out (r/o) the disorders. A referral for additional data to correctly consider or rule-out a diagnosis may be the next step since it is possible this diagnosis may not be the correct one.

Many disorders have co-existing symptoms or co-occurrence with a wide number of disorders. Co-occurrence refers to a shared symptom list or two disorders with similar symptoms. This co-occurrence may be referred to as comorbidity although there is some controversy in the use of this term.

Below is a partial list of diagnoses where disorders share similar symptoms and a differential diagnosis may be required. For example, Hill and Spengler (1997) describe the assessment of a severely depressed person who can appear cognitively impaired, by using the clinical interview and a neurological examination. The evaluation process includes creating comparative lists for normal and abnormal conditions, using symptomology diagnostic criteria found in the DSM-5™. The counselor evaluates orientation, memory, and severity and consistency of cognitive impairment (mental status examination).

Dementia and Cognition: "impairment in short-and long-term memory with impairment in abstract thinking, impaired judgment, other disturbances of higher cortical function, or personality change" (APA, 2000, pp. 152, 157). An older client with dementia will attempt to answer questions about orientation and often does so incorrectly. This client frequently will deny any difficulties with awareness because individuals with dementia typically underestimate or deny the degree of difficulties.

Mood and Affect: Both depressed and demented clients can exhibit behaviors that typify depression. Dementia clients often look like they are depressed although they can also exhibit emotional labiality. Those who are severely depressed usually do not experience wide mood fluctuations.

A depressed client when responding to questions about orientation may appear to have a deficit or impairment and will need assistance from the interviewer, but can usually respond with this help.

You are encouraged to read the Hill and Spengler article for more about depressed and/or dementia differential diagnosis.

Disorder, Comorbidity, Treatment Planning and Instrumentation

You will need to have some basic preliminary information about techniques or treatment approaches recognized to be helpful for the assigned diagnosis. Be knowledgeable about the ethics pertaining to the use of particular techniques or treatment approaches (C.6.e). Informed procedures and client rights are central to the implementation of any treatment under the ACA Code of Ethics. Treatment questions frequently ask about therapies, alternative treatments, techniques, and/or strategies known to be effective for many of the diagnostic disorders.

The recommendations for treatment and instrumentations have been compiled from research articles and the work of Seligman and Reichenberg (2012). For treatment, the preferred treatments or treatments of choice are usually listed first followed by other treatments found in the literature for that disorder. Instruments listed are for assessment purposes and occasionally one will be cited for monitoring. This treatment and instrumentations list is not comprehensive for the many disorders. At the conclusion of treatments and instrumentations is a brief definition for the different therapies and acronyms.

The ACA Code of Ethics makes reference as to what the counselor is to do when using treatments that have literature support and what to do when the treatment does not have literature support (ACA, 2005).

All page numbers in the comorbidity section refer to the DSM-5™ (APA 2013).

Disorder:
Intellectual Disability

Comorbidity:
ADHD, depressive and bipolar disorders, anxiety disorders, Autism spectrum, stereotypic movement disorders, impulse-control disorders, and major neurocognitive disorders (p. 40).

Treatment:
(SIB) Behavior modification is treatment of choice (for self-injury), parent training, and community based treatment and individual psychotherapy

Instrumentation:
Wechsler Intelligence Test and Stanford-Binet Intelligence Scales

Disorder:
Autism Spectrum Disorder (combined the DSM-IV disorders into one spectrum; autistic disorder, aspergers disorder, childhood disintegrative disorder, pervasive developmental disorder, NOS)

Comorbidity:
Specific learning difficulties, developmental coordination disorders, medical conditions (epilepsy, sleep problems, constipation, avoidant-restrictive food intake disorders (p. 59)

Treatment:
Behavioral (no best treatment is currently found in the literature), floor technique, The Pervasive Development Pivotal Response Training (PRI)

Instrumentation:
Childhood Autism Rating Scale (CARS; Scholper, Reichler, DeVelis & Daly, 1991) is the most widely used. Disorders Screening Test II (Siegel, 1999), Individual Education Plan (IEP). The Social Communication Questionnaire, Taylor and Jasper's Social Skills Inventory (Maurice, Green, & Foxx, 1996) (eye contact,

taking turns, initiating greetings, answering social questions, employing empathy, asking questions, relating to peers)

Disorder:
Attention Deficit Hyperactive Disorder

Comorbidity:
Oppositional defiant disorder, conduct disorder, disruptive mood dysregulation disorder, specific learning disorder, anxiety disorders, major depressive disorder, intermittent explosive disorder (p. 65)

Adults: Intermittent explosive disorder, substance use disorder, antisocial personality disorder, obsessive-compulsive disorder, tic disorders, and autism spectrum (APA, 2005).

Treatment:
Stimulant medications, parent training, counseling, behavioral targeted classroom intervention, social skills, interferes with functioning in social, academic, and occupational domains

Instrumentation:
Achenbach Child Behavior Checklist is most commonly used as well as the Behavior Assessment System for Children, 2nd edition, Conners's Rating Scale-Revised (1996) and Conners's Teacher Rating Scales-Revised

Disorder:
Conduct Disorder (CD)

Comorbidity:
Antisocial personality disorder, specific learning disorders, anxiety disorders, depressive or bipolar disorders, substance-related disorders, academic achievement especially reading and verbal skills (p. 485).

Treatment:
Problem-Solving Skill (PSST) dysregulation, impulsivity social skills, anger management, parent management.

Instrumentation:
Achenbach Child Behavior Checklist is most commonly used as well as the Behavior Assessment System for Children, 2nd edition, Conners' Teacher Rating Scales-Revised

Disorder:
Oppositional Defiant (OD)

Comorbidity:
Conduct disorder, ADHD, anxiety disorders, major depressive disorder, substance use disorder (p. 466)

Treatment:
Problem-solving skills training (PSST)-cognitive, behavioral, individual therapy

Instrumentation:
Achenbach Child Behavior Checklist is most commonly used as well as the Behavior Assessment System for Children, 2nd edition, Conners' Teacher Rating Scales-Revised

Disorder:
Separation Anxiety (SAD)

Comorbidity:
GAD, specific phobia and for adults (phobias, PTSD, panic disorder, generalized anxiety disorder, social anxiety disorder, agoraphobia, OCD, and personality disorders (p. 195)

Treatment:
Exposure therapy-highly effective, cognitive-behavioral most effective, Coping Cat model (manual)

Instrumentation:
Child's Depression Inventory (ages 7-17), The Washington University Schedule for Affective Disorders and Schizophrenia for school age children. Young Mania Rating Scale (YMRS) distinguishes between bipolar and other disorders.

Disorder:
Bipolar I

Comorbidity:
Anxiety disorders, panic attacks, social anxiety disorder, ADHD, disruptive, impulse-control disorder, conduct disorder, intermittent explosive disorder, oppositional defiant disorder, substance use disorder (p. 132)

Treatment:
CBT, Interpersonal therapy, combination family focused and CBT, psychoeducation, other treatment recommended - DBT has some support

Instrumentation:
Child's Depression Inventory (ages 7-17), The Washington University Schedule for Affective Disorders and Schizophrenia for school age children. Young Mania Rating Scale (YMRS) (distinguishes between bipolar and other disorders.)

Disorder:
PTSD

Comorbidity:
Depressive, bipolar, anxiety and substance use disorders (p. 280)

Treatment:
CBT, exposure therapy, emotion focused cognitive-behavioral, trauma focused CBT (sexually abused children)

Instrumentation:
Trauma Symptom Checklist for Children, Beck Anxiety Inventory (neurophysiological, subjective, panic related and autonomic)

Adult & Children Mood Disorders

Disorder:
Adjustment Disorder (6 types)

Comorbidity:
Most mental disorders and medical disorders (p. 289)

Treatment:
Little research available for choice of therapy, a crisis-intervention model - relieving acute symptoms, brief psychodynamic psychotherapy

Instrumentation:
No specific instruments for assessment other than the SCAD

Disorder:
Major Depressive Disorder

Comorbidity:
Substance related disorders, panic disorder, OCD, anorexia nervosa, bulimia nervosa, borderline personality disorder (p. 168)

Treatment:
CBT, low level of social functioning perform best with interpersonal psychotherapy (Seligman & Reichman, 2010). Newer therapies are: Behavioral Activation Therapy (BAT; Martell, Dimidjian, & Herman-Dunn, 2010), CBT-I (I-insomnia), Mindfulness, exercise, Vagus nerve therapy

Instrumentation:
Beck Depression Inventory, Hamilton Rating Scale, SCID

Disorder:
Persistent Depressive Disorder (dysthymic disorder)

Comorbidity
Anxiety disorders and substance use disorders (p. 171)

Treatment:
Cognitive-behavioral therapy, interpersonal therapy, social skills, assertiveness & decision-making

Instrumentation:
Beck Depression Inventory, Steen Happiness Index

Disorder:
Bipolar Disorders

Comorbidity:
Panic attack, social anxiety, ADHD, conduct disorder, impulse control disorder, substance use disorder, intermittent explosive disorder, oppositional defiant disorder (APA, 2005)

Treatment:
Medication first line, family focused psycho-educational treatment, social rhythm therapy, and cognitive-behavioral therapy, group therapy during recovery

Combination treatment:
Family focused therapy (FFT), IPT with social rhythm therapy, and CBT. Other treatments helpful include day treatment, group therapy, self-help groups, electroconvulsive therapy, and Vagus nerve stimulation.

Instrumentation
The Structured Clinical Interview (SCID) can be used to validate, The Treatment Attitudes Questionnaire (limited research, better for planning). Bipolar II use the Hypomania Checklist 32 (HCL-32).

Disorder:
Cyclothymic Disorder

Comorbidity:
Substance-related and sleep disorders (children-ADHD; p. 141)

Treatment:
Two years experiencing numerous episodes of hypomania and mild to moderate depression (one year for children, two for adults). Treatments proven to be helpful are IPT, FFT, regulating sleep, circadian rhythms, and social rhythm. Supplements may be career counseling and interpersonal skill development. Group counseling may be useful. First degree relatives of people with cyclothymic disorder have increased incidences of bipolar disorders, childhood history of being hypersensitive, hyperactive, and moody. Children with parents who have bipolar disorders are more likely to exhibit cyclothymic disorder compared with other children. Little research, regulate sleep, circadian rhythms and social rhythms thus, interpersonal and social rhythm therapy (IPSRT), family focused therapy (FFT), and cognitive-behavioral therapy.

Instrumentation:
Hypomanic Checklist (HCL32) has been used to differentiate between unipolar depression and depression with hypomania symptoms (Angstet al., 2005).

Anxiety Disorders

Treatment:
Cognitive-behavioral therapy, exposure therapy, acceptance-based therapy (interoceptive exposure, mindfulness meditation, SIT, DBT, and ACT target thoughts). Group therapy, cultural factors-ethnic identity, gender roles, acculturation play in clinical presentation, assessment and treatment. Eye contact, verbal and nonverbal communication, personal space, and verbal cues, tone/ volume may vary from culture to culture. Coping styles vary - African-Americans tend to use gratitude and religiosity more frequently than Europeans.

Ethnicity:
According to the literature, panic disorder co-exists with sleep paralysis more frequently in African-Americans (60%) than Caucasians (8%).

Cambodian populations. Of 89 Cambodian refugee patients with Panic Disorder, surveyed at two psychiatric clinics, 53 (60%) currently suffered panic disorder. Among the 53 patients suffering panic disorder, the most common panic attack subtypes during the previous month were the following: “sore neck” (51%), orthostatic dizziness (49%), gastro-intestinal distress (26%), and effort induced (21%). (Hinton, D, Phalnarith Ba, Sonith Peou, and Khin Um, Gen Hosp Psychiatry. 2000 Nov–Dec; 22(6): 437–444).

Hispanic patients (ataque de nervios) may experience uncontrollable behaviors such as physical or verbal aggression, crying, shouting (Paniagua, 2001).

Instrumentation:
Beck Anxiety Inventory more commonly utilized-4 categories of anxiety symptoms are neurophysiological, subjective, panic related, and autonomic (Beck & Steer, 1990). Anxiety Disorders Interview Schedule (Brown, et al, 1994), Structured Clinical

Disorder:
Panic Disorder

Comorbidity:
Anxiety disorders, agoraphobia, major depression, bipolar disorder, mild alcohol use disorders (p. 213)

Treatment:
Cognitive-behavioral therapy treatment of choice; panic control therapy (PCT), new treatments include ACT, SFIT and some support for family and group therapy, graduated and pacing exposure can be helpful.

Instrumentation:
ADVIS (Brown et al.,1994) measures avoidance, severity of panic and panic related symptoms, Burns Anxiety Inventory

Disorder:
Phobias

Comorbidity:
See specific phobias

Treatment:
Exposure-based are empirically validated and considered effective. May include exposure as relaxation training, breathing retraining and paradoxical intention.

Instrumentation:
Beck Anxiety Inventory and Burns Anxiety Inventory assess for differences in phobias and delusional fears.

Disorder:
Agoraphobia

Comorbidity:
Anxiety disorders, panic disorder, social anxiety disorder, depressive disorders, major depressive disorder, PTSD, and alcohol use disorder (p. 221)

Treatment:
Panic control therapy (PCT) is well documented. Newer therapies, but not necessarily validated, are sensation-focused intensive treatment (SFIT) and ACT shows promise.

Instrumentation:
Beck Anxiety Inventory, Mobility Inventory for Agoraphobia, Agoraphobic Cognition Questionnaire

Disorder:
Social Anxiety Disorder

Comorbidity:
Anxiety disorders, major depressive disorders, and substance use disorders (p. 208)

Treatment:
Cognitive therapy with exposure is most commonly recommended. Cognitive-behavioral group therapy (CBGT) has empirical support (Hofmann & Barlow, 2002). Other treatments recommended are exposure alone, cognitive restructuring alone, exposure combined with cognitive restructuring, social skills training, and relaxation, homework and role playing, mindfulness, attention training, self-efficacy interventions and interpersonal therapy all show promise.

Instrumentation:
Fear of Negative Evaluation and Social Interaction Anxiety Scale (SIAS), Achenbach System of Empirically Based Assessment (ASEBA)-assesses for social problems (ages 6-18), Revised Children's Manifest Anxiety Scale (RCMAS-2) measures for social anxiety (ages 6-19).

Disorder:
Obsessive-Compulsive

Comorbidity:
Panic disorder, social anxiety disorder, GAD, specific phobia, bipolar disorder, tic, body dysmorphic disorder, trichotillomania excoriation and possibly schizophrenia or schizoaffective disorder (p. 242)

Treatment:
Exposure and response prevention therapy is first choice. Other treatments found to be helpful are cognitive approaches that focus on thinking (Head & Gross, 2008), checking family (children and adolescents), ACT more research needed.

Instrumentation:
Yale-Brown Obsessive Compulsive Scale (Y-BOCS) one of most useful, Obsessive-Compulsive Inventory-Revised, (OCI-R; Foa et al., 2002). The OCI-R has 18 items with 6 subscales (washing, ordering, hoarding, obsessing and neutralizing (Franklin, Ledley, & Foa, 2008)

Disorder:
PTSD

Comorbidity:
Depressive, bipolar, anxiety and substance use disorders (p. 280)

Treatment:
Prolonged exposure therapy (Foa, Keane, Friedman & Cohen, 2009) considered the best therapy treatment of choice based on research, cognitive processing therapy (CPT) designed for survivors of sexual assault and traumatic brain injury-PTSD, anxiety management training. Other treatments sometimes used in therapy include EMDR, group and family therapy, stress inoculation training

Instrumentation:
The Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990), The PTSD Checklist (Blanchard, et al., 1996). For Children: K-SADS PTSD section, Child Behavior Checklist (Achenbach, 1991), Childhood Trauma Questionnaire (Bernstein et al., 1994), Psychometric Evaluation of the Children's Impact of Traumatic Events Scale-Revised (Chaffin & Shultz, 2001)

Disorder:
Generalized Anxiety Disorder (GAD)

Comorbidity:
Anxiety disorder, unipolar disorder (APA, 2000)

Treatment:
Cognitive-behavioral therapy (cognitive restructuring) is most frequently used, behavior therapy, affective therapy (AWARE) although less effective than cognitive and behavioral therapies, and ACT.

Instrumentation:
Beck Anxiety Inventory, The Penn State Worry Questionnaire Anxiety Disorders Interview Schedule (Brown, et al., 1994)

Disorder:
Alcohol-related (USE)

Comorbidity:
Bipolar disorders, schizophrenia, antisocial personality disorder (p. 496)

Treatment:
Combined behavior interventions - motivation enhancement, cognitive therapy, social skills training, cognitive restructuring, relaxation training, stress management, 12-Step, Family therapy

Instrumentation:
Screeners: Rapid Alcohol Problems Screen (RAPS4), Michigan Alcoholism Screening Test (MAST), CAGE (Screening for Alcohol Abuse), Alcohol Use Disorders Identification Test (AUDIT)

Disorder:
Feeding and Eating Disorders

Comorbidity:
Social phobia, OCD, generalized anxiety disorder (Kaye, Bulik, Thornton, Barbarich, & Masters) and PTSD and schizophrenia (Blinder, Cumella, & Sanathara, 2006).

Treatment:
Multidisciplinary approach, cognitive-behavioral therapy, DBT for BED, active comparison group therapy (ACGT)

Instrumentation:
Questionnaire on Eating and Weight Patterns-Revised (QEWP-R, Yanovski, 1993), Eating Disorder Examination Questionnaire (Fairburn & Cooper, 1993)

Disorder:
Anorexia Nervosa

Comorbidity:
Bipolar, depressive and anxiety disorders, alcohol use disorder (p. 344)

Treatment:
Multidisciplinary approach, cognitive-behavioral therapy, DBT, group therapy, transdiagnostic approach, interpersonal psychotherapy and family therapy.

Instrumentation:
Questionnaire on Eating and Weight Patterns-Revised (QEWP-R)

Disorder:
Bulimia Nervosa

Comorbidity:
Depressive symptoms, bipolar nervosa, depressive

Treatment:
Manualized based CBT treatment is preferred and DBT for BED.

Instrumentation:
DBT, CBT, Focus on therapeutic alliance, reducing negative affect, modifying eating behaviors, identifying situations that trigger behavior (Maine, Davis, & Sloane, 2008), Eating Disorder Inventory (EDI) (Garner, D., Olmstead, M., & Polivy, J. (1983)

Sexual Dysfunctions

Disorder:
Femal Sexual Interest/Arousal Disorder

Comorbidity:
Depression, thyroid problems, anxiety, urinary incontinence and other medical problems, arthritis, irritable bowel disease (p. 436)

Treatment:
Medication, couples and group therapy can be appropriate, 12-Step Program modeled after alcoholics anonymous, sex addicts anonymous, sexual compulsives anonymous and sex and love addicts

Instrumentation:
The Sexual Interest and Desire Inventory-Female (SIDI-F), The Sexual Opinion Survey (SOS; White, et al., 1977), Sexual Dysfunction Scale (McCabe, 1998), Sexual Desire Inventory (Spector, et al., 1996) and the Early Sexual Experiences Checklist (Miller, et al., 1991) used to detect unwanted sexual experiences before age 16. Interview for Sexual Functioning (DISF, DeRogatis 1997) in 5 domains (sexual fantasy and cognition, sexual behavior and experiences, orgasm, sexual drive, and sexual arousal).

Dissociative Disorders

Disorder:
Dissociative Identity Disorder

Comorbidity:
PTSD, depressive disorders, avoidant and borderline personality disorders, conversion disorder, somatic symptom disorder, eating disorders, substance-related disorders, OCD, sleep disorders (p. 298)

Treatment:
No recommendations

Instrumentation
No recommendations, includes social role, gender identification, sexuality and body

Sleep-Wake Disorders

Disorder:
Sleep-Wake disorders include insomnia, hypersomnolence, narcolepsy, breathing-related sleep disorder, circadian rhythm, non-rapid eye movement (NREM), rapid eye movement (REM), nightmare disorder, restless leg syndrome (RLS), and substance/medication-induced sleep disorder.

Comorbidity or co-existing:
Depressive and anxiety disorders. King (2014b) listed other co-existing conditions to include autism, ADHD, panic and other related disorders, OCD, adjustment disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, elimination disorders, amphetamine or other stimulant use disorders, neurocognitive disorders and persistent complex bereavement (p. 12).

Voinescu, Szentagotai, and David (2012) found in their study the symptom of inattention in ADHD was associated with insomnia and together with sleep and circadian disorder.

Treatment:
Psychopharmacology, CBT, bright light therapy, sleep education, sleep hygiene, sleep restriction, stimulus control, cognitive restructuring, paradoxical intension, relaxation and relaxation therapy.

Cognitive-behavioral therapy for insomnia is gaining support because of the relationship between depression and sleep disorders. CBT-I behavioral treatment, relaxation therapy including progressive relaxation, biofeedback, cognitive thought stopping have been found to be helpful. Positional therapy (head elevated) can be recommended for sleep apnea.

Instrumentation:
Level 2 Sleep Disturbance Patient-Reported Outcome Measurement Information System (PROMIS) Short Form (psychiatry.org/practie/dsm/dsm5/online-assessment-measures), Epworth Sleepiness Scale (Johns, 1991), Sleep Disorders Questionnaire (Violani, et al. 2004), Sleep Condition Indicator (Espie, 2011), The Composite Scale of Morningness (Smith et al. 1989), Sleep timing Questionnaire (Monk et al. 2003), Sleep History Questionnarie (Edinger, 1987), Sleep Disturbance Questionnaire (Espie, Brooks, & Lindsey, 1989), Sleep Impairment Index (Morin, 1993), Pittsburgh Sleep Quality Index (Buysse, Reynolds, Monk, Berman, & Kuper, 1989). A recent Semi-structured clinical interview, laboratory analysis, sleep log or diary are components of the different questionnaires with the exception of polysomnography.

Physical and psychological factors

Disorder:
Somatization Symptom Disorder (Briquet's syndrome)

Comorbidity:
Medical issues, anxiety and depressive disorders (p. 314)

Treatment:
Affective cognitive-behavioral therapy (ACBT), group and family therapy (rare disorder)(forms include conversion, pain, hypochondriasis, and body dysmorphic). Treatment will vary depending upon form; example IPT-P and CBT for pain or HRT for skin scratching and picking.

Instrumentation:
Anxiety Disorders Interview Schedule (ADIS-IV-L; DiNardo et al., 1994)

Disorder:
Factitious Disorders

Comorbidity:
None provided in the DSM-5

Treatment:
No therapies known to be effective, stress management

Instrumentation:
Clinical interview

Disorder:
Delirium

Comorbidity:
None provided in the DSM-5. Differential diagnosis includes acute stress disorder, malingering and factitious disorder, other neurocognitive disorders (p. 601)

Treatment:
Medical and neurological assessment, psychotherapy and medication (slow the process), eliminate casual factors; medications causing side-effects, metabolic disorders, etc.

Instrumentation:
None provided, Mental Status Examination and neurology

Disorder:
Major or minor neurocognitive disorder (Dementia)

Comorbidity:
Age related diseases and delirium (p. 610)

Treatment:
Support for caregivers

Instrumentation:
Comprehensive medical and neurological assessment

Personality Disorders (Clusters A, B, & C)

Borderline, paranoid and schizotypical most dysfunctional (Millon & Grossman, 2007) obsessive-compulsive, dependent, histrionic, narcissistic and avoidant typically least dysfunctional.

Treatment:
Psychodynamic, cognitive-behavioral, DBT, mindfulness, mentalization-focused, schema therapy (Young, 1999)

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Cluster A: Appear Odd or Eccentric

Disorder:
Paranoid

Treatment:
Little effectiveness studies available, individual treatment preferred, cognitive therapy, group therapy rarely recommended

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical In Interview

Disorder:
Schizoid

Treatment:
Schema therapy (Young, 1999), behavioral techniques such as social and communication skills

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder:
Schizotypal

Treatment:
Supportive, lengthy and slow, cognitive therapy, behavior therapy for speech patterns

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Cluster B: Appear Dramatic, Emotional or Erratic

Disorder:
Antisocial

Treatment:
Individual therapy, with a structured and active approach to therapy is recommended, some support for reality based approach for anger management, substance use disorders, and social skills training, mentalization-based therapy and schema therapy hold promise. Behavior, reality and cognitive approaches are helpful.

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder:
Borderline

Treatment:
DBT, mentalization-based therapy, transference-focused therapy, schema-focused CBT, supportive psychotherapy, STEPP group therapy. Group therapy can be more effective than individual therapy (Farrell, et al, 2009). Psychodynamic Psychotherapy has one study equal to DBT.

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical In Interview

Disorder:
Histrionic

Treatment:
Long term individual psychotherapy, cognitive-behavioral therapy as the treatment of choice, group therapy can be helpful (feedback)

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder:
Narcissistic

Treatment:
Psychoanalytic (anger, envy, self-sufficiency), cognitive-behavioral, group therapy if all members are narcissistic and can tolerate the exposure and negative feedback.

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Cluster C: Appear Anxious or Fearful

Disorder:
Avoidant

Treatment:
Randomized and control trials effective for psychodynamic psychotherapy (Gottdiener, 2006). Little empirical evidence available; behavioral interventions, schema- focused therapy, group therapy, and family therapy may be helpful.

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder:
Dependent

Treatment:
Psychodynamic, cognitive-behavioral therapy, schema therapy can be helpful

Instrumentation:
Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder:
Obsessive-Compulsive

Treatment:
Randomized and control trials effective for psychodynamic psychotherapy (Gottdiener, 2006). Little evidence available for cognitive and behavioral therapies.

Instrumentation:
Dysfunctional Thought Record (active log), Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Reality Impairment

Disorder:
Psychotic

Treatment:
Schizophrenia , schizophrenoform, delusional, schizoaffective - randomized and control trials indicate behavior and psychosocial therapies are preferred for schizophrenia (Gottdiener, 2006) along with antipsychotic medications.

Instrumentation:
Positive and Negative Syndromes Scales (PANSS; Kay, Fiszbein, & Opler, 1987), Structured Interview for Psychotic Symptoms (SIPS; Miller et al., 1999)

Disorder:
Dissociative DID

Treatment:
There is limited recommendations for treatment, with the exception of individual therapy and medication.

Instrumentation:
Cambridge Depersonalization Scale (Sierra & Berrios, 2000), Structured Clinical Interview for Depersonalization and Derealization Spectrum

Disorder:
Schizophrenia

Treatment:
Medication and psychosocial intervention; behavior therapy, skills training, social support, and group therapy can be helpful in providing information.

Instrumentation:
Positive and Negative Syndromes Scale (PANSS, Kay et al., 1987), Structured Interview for Psychotic Symptoms (SIPP; Miller, et al., 1999)

Disorder:
Schizoaffective

Treatment:
Evidence not available for treatment

Treatment Definition

Acceptance Commitment Therapy (ACT):
(interoceptive exposure, mindfulness meditation, DBT, ACT). These therapies target thoughts and combine acceptance, compassion and commitments to goals. ACT targets acceptance of thoughts, choosing goals that the honors and taking steps that are action oriented. The therapy purpose is help clients understand how they have become entrapped in their thoughts and the focus is on relational

frame theory. A core skill learned is how to recognize and stop self-perpetuating and self-defeating emotional, cognitive, and behavioral avoidance routines (Seligman & Reichenberg, 2012).

Affective Therapy:
Beck and Emery use a five stage process (AWARE, accept feelings, watch the anxiety, act with the anxiety rather than fight it in dysfunctional ways, repeat the steps, expect the best).

Behavior Activation Therapy (BAT):
Emotions result in behaviors resulting in rumination and avoidant behavior. The focus is on behavior activation without cognitive change. The focus is on problem solving, long-term change and completion of goal. Depression helps to overcome the urge to escape or engage in avoidance behaviors.

Cognitive Processing Therapy (CPT):
Resick and Schnicke are the developers of CPT. CPT combines exposure therapy, anxiety management training and cognitive restructuring. CPT is considered to be helpful in treating rape victims and survivors of sexual assaults. This is a 12 session structured model where exposure is combined with cognitive restructuring. Caution is exercised to not re-expose the client to the trauma when exposure is utilized as a part of the treatment.

Dialectical Behavior Therapy (DBT):
Marsha Linehan-her theory development started with suicide and eventually toward borderline personality disorder. The theory includes support, insight and Eastern philosophy. It is further based on CBT. Client work is with eating disorders, antisocial and borderline personality and substance use comorbid with borderline personality disorder.

Eye Movement Desensitization Response (EMDR):
EMDR pairs visual stimulation, kinesthetic stimulation/auditory stimulation with a focus on the traumatic memories.

Mentalization-based Therapy (MBT):
MBT is a psychodynamic approach and central to the therapy is attachment theory. It is a manualized approach. The goal is to assist clients to understand their own and other's mental states, faulty thinking about relationship problems which triggers abandonment fears and to reduce impulsivity, self-harming and suicidal behaviors (Bateman & Fonagy, 2008).

Mindfulness-based Therapies:
These therapies are based on the present moment, mediation and relaxation techniques. Mindfulness-bases stress-reduction (MBSR) is the work of Jon Kabat-Zinn (1990) and is designed to prevent future recurrence of depression in clients who have recovered from an episode of depression (Seligman & Reichenberg, 2012). Clients become aware of their thoughts, feelings, and bodily sensations and to learn to accept them without judgment. The client becomes capable of thoughts in the moment and let them pass.

Panic Control Theory (PCT):
A cognitive behavioral approach that focuses addressing mistaken beliefs people have about the meaning of physical sensations (Craske & Barlow, 2008). The approach is psychoeducation, relaxation, cognitive restructuring, and interoceptive exposure exercises shown to reduce panic attacks.

Pivotal Response Training (PRI):
This is a home based behavioral intervention. Early work was with autism targeting motivation and initiation. Parents are trained to intervene while at home with their child. As such improvement is noted in communication skills, decreased disruption behaviors and increased generalization of treatment gains (Koegel et al., 2010). An approach similar in working with parents is Floor Time (Greenspan).

Polyvagal Theory: Vagus Nerve Therapy (VNS):
A device is implanted in the chest and sends electrical impulses to the vagus nerve that will activate the brain that leads to improve in mood (Feder, 2006). Stephen Porges developed the neurophysiological foundation of emotions, attachment, communication and self-regulation (Porges, 2011).

Prolonged Exposure Therapy:
This therapy is the creation of Dr. Edna Foa and is frequently recommended for anxiety and depression disorders and specifically for PTSD. The goal is to decrease distress regarding a trauma. The client approaches thoughts, feelings and situations that are being avoided because of the distress. The client is exposed to repeated thoughts, feelings, and situations in order to reduce the control the client has allowed due to the distress. The therapy includes education, breathing-relaxing exercises, real life practice through vivo experiencing thus reducing gradually the distress and more control, and talk during the therapy regarding the trauma.

Rapid Resolution Therapy:
The client is asked to describe the traumatic experience while intending to remain emotionally connected to what is actually happening. The therapist explains that he or she will also intend to remain emotionally connected to what is happening, and will help the client if necessary. The therapist and client are collaborating on a project and both are into which is an improved quality of life. The idea is to overcome the intrusive, sensorimotor elements of the trauma.

This is to be a transformation of the traumatic memory into a personal narrative in which the trauma is experienced as a historical event that is a part of the person's autobiography. The purpose is to tell the story of a shocking event without re-experiencing it. The client is to remain emotionally present and that the traumatic experience is not happening.

Referral and monitoring progress:
Monitoring is the process of observing changes in thought, feelings and behavior of client undergoing change treatment. Monitoring can take many different forms often in direct relation to what the client is experiencing or the disorder. Monitoring is tracking of specific client changes of treatment goals by

the client and counselor through record-keeping, regular goal assessment reporting and with the client and counselor observations via self-reports, surveys, or behavioral reports. Improvement information should be measurable, achievable, relevant and time-bound.

Schema Therapy:
Schema therapy focuses on organized patterns of behavior, cognition, and feelings reflecting childhood states. The schemas are abandonment, anger/impulsivity, primitive parent, and detached protector (patterns in childhood). The therapist probes for four environmental contributors to the themes and maladaptive behaviors (unstable or unsafe home environment, overly punitive parents, emotional negation or deprivation, and an environment where the child's needs are subjugated to the needs of the parents (Rafaeli et al., 2011).

Sensation-Focused Intensive Treatment (SFIT):
This approach is to combine treatments for panic and avoidance in an intensive self-study format over eight consecutive days. Treatment includes exposure to the most feared situations without teaching techniques for reducing the anxiety.

Transference-focused Therapy:
This therapy addresses common symptoms found across many disorders such as eating disorders, alcohol, and substance disorders with anger, emotional dysregulation and impulsivity as three such symptoms. The focus is on integrated anger as the core for borderline pathology. Transference is utilized to unintegrated anger into a whole object relationship rather than to split off into unrealistic positive or negative objects.

A client may be experiencing difficulties in expressing his/herself socially in the form of interpersonal verbal communication. Monitoring may take the form of observing that a client is meeting and talking with others. Monitoring observations can be behavior demonstrated or through self-monitoring. The specific change behavior monitored is dependent upon the treatment goals. For someone experiencing agoraphobia improvement behaviors may be attending a social functioning, going shopping, mailing a letter, a behavior whereby the client comes into contact with people. Self-reports are often a means to determine improvement. The client reports tasks accomplished. Self-reports from young clients are sometimes in question and may need validating observations from adults. A person experiencing an alcohol disorder will count the days of sobriety, attending AA meetings, meeting with a sponsor and meet specific objectives of the 12-Step program. Relapse is another way to measure improvement and in this case it would be considered a lack of improvement.

Self-help programs like AA, Al-Anon, Alateen, NA, grief recovery groups, rape support groups, spiritually sponsored programs, and other support groups have been important community resources for individuals who desire ongoing support or follow-up after having completed treatment programs for addictive behaviors.

Short screening instruments can be used to monitor improvement. An example might be someone experiencing a depression disorder. The Beck Depression Inventory (BDI) can be administered at the initiation of treatment or during intake assessment and administered at a later time. The BDI is short

and inexpensive and can be used to support self-reports, behaviors observed by the client or family members and mood charting by the counselor.

Physiological instruments are used by medical professionals in a variety of ways for different disorders in specialized laboratories, hospitals, emergency rooms, or the private offices of medical specialists. Physiological indicators may include EKG, blood pressure, respiratory parameters, EEG, EMG, alcohol screening, body movements, body temperature, perspiration, eye movements, CFF and electrodermal activities, and neuroimaging. Individuals with chest pain and palpitations experiencing panic attacks are evaluated with EKGs, sphygmomanometers and measurements of cardiac enzymes. Individuals with nightmares and sleep disorders are evaluated in sleep laboratories. Individuals with movement disorders, seizures, muscle weakness or loss of coordination are evaluated with EEGs, specialized exams, or EMGs. Individuals with chronic pain are measured with dolorimeters. Individuals with changes in cognition may be evaluated with neuroimaging including procedures like CT Scans, MRIs, Functional MRIs (fMRIs), Pet Scans, and SPECT. Imaging is particularly useful to evaluate for the possibility of space occupying lesions but, as yet, is not useful for making psychiatric diagnoses. The fMRI is increasingly found to be an effective tool for diagnosing central nervous system disease and is extremely sensitive to early changes in the brain resulting from ischemia such as that which follows stroke.

PET scanning is used for diagnosing brain tumors, strokes, and neuron-damaging diseases which cause dementia. SPECT scanning is similar to PET and is particularly well-suited for epilepsy imaging, provides a "snapshot" of cerebral blood flow, and is increasingly used to differentiate disease processes which produce dementia.

Be aware of recognized community resources such as self-help programs like AA, Al-Anon, Alateen, NA, Grief Recovery Groups, Rape Support Groups, spiritually sponsored programs, and other support groups known to have a good prognosis for sustaining the progress obtained through treatment.

Recognize the possibility of a relapse and make plans for handling such behaviors.

Medication

Be alert to medication issues. Even though the prescribing psychiatrist may not be working with the counselor it is important to establish good communication (with the client's permission). The counselor needs to be aware of medication issues, indications/contraindications, and possible side-effects. He/she may see the client more regularly than the psychiatrist or prescribing physician and should be alert to issues such as non-compliance or complaints pertaining to medication effects. Non-compliance with prescribed medication should not be ignored, and the counselor should encourage the client to revisit his or her prescribing physician. If there are serious medication side effects, a telephone call to the attending physician may be indicated.

In summary, the evaluation process includes a number of important aspects. The counselor must make an empathic contact with the client and begins a process of gathering information, to include: What is (are) the chief complaint(s)? When did each begin? What may have caused the symptom(s)? How long

(history) has each symptom gone on? Has the symptom(s) gotten worse? What alleviates or makes the symptoms worse?

After gathering information and establishing the diagnostic possibilities, the counselor next makes decisions about additional data gathering options (further testing or referrals to clinical specialists who can provide more information). After that, decisions will be made about the most effective therapy and additional referrals, if warranted, to other professionals or specialized treatments.

Supervision

Supervision in clinical settings is a triadic process involving a relationship (supervisor and therapist) about a relationship (therapist and client; Fiscalini, 1997). Supervision, which can be either individual and/or group that include evaluation, ethical and legal considerations, supervision models, relationships influenced by cultural and developmental differences, feedback, knowledge acquisition, client care, standards, triadic and dyadic processing, interventions and research.

Bernard and Goodyear (2009, p. 7) define supervision as an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. The intervention characterizing this supervisor-supervisee relationship tends to be on-going and comprises a number of elements: It is evaluative and hierarchical, extends over time, has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitors the quality of professional services offered to the clients being evaluated and/or treated and serves as a gatekeeper for those who are to enter the counseling profession.

A supervision course for practitioners has not been a required course in the curriculum of most master degree counseling programs although all trainees are recipients of supervision. Accredited doctoral programs, however, do require a didactic course about supervision as well as a supervised supervision experience (practicum) for the graduates. (The NCMHCE may place an examinee in the role of the supervisor for the supervisee.) As a result some information will be shared regarding the supervision theories or models and the role of the supervisor. It is recommended that each person preparing for the NCMHCE review supervision standards to be found on-line for the American Counseling Education and Supervision (ACES), and the American Mental Health Counseling Association (AMHCA). In addition it is recommended that individuals preparing for the NCMHCE also review supervision sections within the code of ethics for NBCC, ACA, and AMHCA in order to become aware of dilemmas often encountered in counseling and processed in supervision. In addition, if one has not been trained in supervision it would be helpful for that individual to think about possible questions that might be encountered during the process of a therapy case. Further preparation should include reviewing codes of ethics derived from the ethics and standards as well as ethical violations found in the ETHICAL GUIDELINES FOR COUNSELING SUPERVISORS processed by ACA. [See online: ACA.ACES (Client Welfare and Rights, Supervisory Role, and Program Administration Role)].

Supervision is a process in which the supervisor assists the counselor through teaching, counseling and consultation while continuing to respect boundaries. Supervisory teaching may involve sharing information and assisting the supervisee to differentiate thoughts, feelings and behaviors apart from the client. The supervisor may share information or stimulate the supervisee to examine client-counselor interactions. Supervisory teaching also includes drawing attention to supervisee variables that may be interfering with the client case. A major difference between therapy and supervision is the responsibility of evaluation.

There is also a difference between supervision and consultation in-so-far as consultation is usually a one-time experience when the counselor requests a seasoned professional to help the client better understand how to process through a difficult case (skill level). Teaching, counseling and consultations are specific roles yet overlap in supervision.

Feiner (1994) specifies the roles of a supervisor as formative, normative and restorative while Bernard and Goodyear (2009) define the task of the supervisor as facilitating professional development and improving client care.

Although the supervisor has an unequal relationship with the trainee due to the administrative nature of the role, his or her clinical acumen is of utmost importance since it includes being aware of and processing the supervisee's defensiveness and 'counter-transference' toward the supervisor as well as the trainee's personal 'issues' that could be projected into the counseling process.

Supervision contracts between supervisors and supervisees should include learning goals, expectations, agency policy, risk behaviors, length and frequency of supervision, and summative evaluations. Haynes, Corey and Moulton (2003) suggest that a supervisor- supervisee contract should include purposes and goals for supervision, frequency, duration and structure of meetings, roles and responsibilities for supervisor and supervisee, description of supervisor background, experience, and areas of expertise, model and method of supervision, documentation responsibilities, evaluations methods, feedback, commitments to follow all applicable agencies policies, professional licensing statutes, and ethical standards, agreement to follow healthy boundaries with clients, function within the boundaries of competence, provide informed consent to clients, reporting procedures for legal, ethical and emergency situations, confidentiality policy and statement of responsibility regarding multicultural issues (p. 198). The contract is essential when a counselor begins the search for an on-going supervisor.

Ethical considerations and issues for supervision may include due process, informed consent with clients, supervision, supervisees, multiple relationships and multiple relationships between supervisees and clients, preventing supervisee transgressions, preventing supervisor transgressions, competence, monitoring supervisee competence, and confidentiality. Legal issues include malpractice, duty to warn, direct liability and vicarious liability, and preventing claims of malpractice. Direct liability is the direct negligence of supervisory practices and is likely to include allowing supervisee to practice outside scope of practice, not providing sufficient time for supervision, lack of emergency coverage and procedures, not providing a supervisory contract, lack of appropriate assessment of supervisee, lack of sufficient monitoring of practice and documentation, lack of

consistent feedback, and violation of professional boundaries in the supervisory relationship (Haynes, Corey & Mouton, 3002, p. 190).

Models

Most clinicians are recipients of supervisors who adhere to a supervision model of choice. Some of these models include psychodynamic, developmental, and social models.

Psychodynamic models include psychodynamic, person-centered, cognitive-behavioral, systemic and constructivist (narrative and solution-focused).

Developmental models include the Integrated Developmental Model (IDM), Process Developmental-reflective practice (Loganbill, Hardy, & Delworth, 1982), Events-Based and Life Span Model.

Social Role models include discrimination, Hawkins and Shohets' approach (2000), and the Holloway Systems Approach Supervision (SAS; 1995).

During supervision the supervisor and supervisee may be discussing parallel processes and isomorphism, triangles, working alliances, goals and expectations and specific counselor behaviors (expert and referent powers), self-disclosure, attachment style, effective practice (supervisor evaluations), supervisee's resistance, shame, anxiety, performance, transference, countertransference, and ethnicity.

Performance evaluation by a supervisor of a supervisee may include the use of process notes and case notes, audiotapes, written critiques, transcripts, interpersonal process recall, and live observation (bug in the ear, monitoring, walk-in, phone-ins, interactive television).

Possible questions:
The NBCC website identified three sub-scores for information gathering and decision-making one of which includes Administration, Consultation and Supervision.

Some possible supervision questions may appear similar to the following:

Question:
A supervisee is seeking a supervision relationship with a particular supervisor. The supervisor would state that the supervisee would commit and agree to which of the following: (select as many as you consider important)

a. Share the treatment plan with the client
b. Adhere to all policies of the counseling agency
c. 3,000 hours of clinical experience
d. 30 continuing updating hours each year
e. Reveal all personal information about yourself.

f. Meet over dinner to discuss particulars about the situation.

Answers: a, b

Question:
A supervisor is describing a supervision contract to a supervisee. According to the AMHCA standards the contract is to include the following:

a. Frequency, location, length and duration of supervision meetings
b. Type of notes
c. Supervision models and expectations
d. Fee structure
e. Liability and fiduciary responsibility of the supervisor
f. The evaluation process, instruments used and frequency of evaluation
g. Therapy techniques required for treatment
h. Emergency and critical incident procedures

Answers: a, c, e, f, h

Group Supervision

Group supervision has many of the same purposes as individual supervision. The group composition is 4-8 supervisees coming together to present and receive assistance with cases. The supervisor is to monitor the quality of the therapeutic work and understanding of a counselor's responsibilities during the therapeutic processes. Some advantages of group supervision are economics of time, cost, and expertise, vicarious learning, breath of client exposure, feedback with greater quantity and diversity, greater quality, comprehensive picture of the client and supervisee, learning supervision skills, normalizing experiences and mirroring interventions (Bernard & Goodyear, 2009).

Group supervisors need to be accomplished counselors as well as have a working knowledge of group process and dynamics. It is important the supervisor is aware of the advantages and disadvantages of homogeneity versus heterogeneity of supervisee's levels of experience.

Question:
The counselor has recently come from a counseling agency where individual supervision was the agency policy. This agency has group supervision and in consultation with the group supervisor the supervisee asked what might be the advantages of group supervision. Select as many as you consider appropriate.

a. Confidentiality
b. Economics of time, costs, and expertise

c. Vicarious learning

d. Breath of client exposure

e. Group phenomena issues

f. Isomorphic

g. Feedback of greater quality

Answers: b, c, d, g

Explanations:

a. No. Confidentiality is less secure, especially the privacy of fellow supervisees.

b. Yes. Time, costs and expertise are considered advantages especially when compared to individual supervision.

c. Yes. Vicarious learning through observing other counselor supervisee's present case conceptualizations, techniques utilized and issues related to ethics.

d. Yes. A broader range of clients are presented in group supervision thus an encounter with a breath of client exposure.

e. No. Supervisee competition, scapegoating and group dynamics may impede focusing on client care.

f. No. Group supervision focuses on individual counseling thus the opposite of the supervision does not mirror the treatment.

g. Yes. Supervisors with increasing therapy work and supervision experiences become experts in providing succinct responses to case presentations. The quality of experiences is often through understandable language employed by fellow supervises.

Question:
The counselor during individual supervision told the supervisor that s/he was stuck and wanted to know how to get unstuck with a particular client. What suggestions might the supervisor provide? (Select as many as you consider relevant.)

a. Develop a descriptive metaphor

b. Develop a theoretical orientation

c. Develop homework for the client

d. Request the client to take a different perspective

e. Consider a referral to another counselor

f. This is a situation that calls for case consultation

Answers: a, b

Question:
During individual supervision and prior to the client's termination the counselor was charged by the supervisor as how he/she evaluated effectiveness. The supervisee requested the supervisor to provide what feedback he/she could provide. What methods might the supervisor utilize to provide one form of feedback? (Select the best answer)

a. Bug in the ear (BITE)
b. Ask the client
c. In Vivo
d. Phone ins
e. Client relapse
f. Employ an empirical study

Answer: f

Question:
For eight weeks the counselor provided a client with psychoeducation and supportive therapy. During the eighth week the client told the counselor that he thought whatever the counselor was doing was not helpful. The counselor in an effort to be helpful to the client asked the supervisor what he might recommend. (Select as many as you consider helpful)

a. Provide the client the truth that there is no therapy for Alzheimer's
b. Seek consultation from a hypnotherapist
c. Try CBT
d. Continue psychoeducation and supportive therapy
e. Ask the client

Answer: d, e

Question:
The counselor decided to seek supervision for a client's treatment. In selecting a supervisor the counselor would want to consider which of the following?

a. Supervisor experience
b. Supervisor is listed on the approved supervisor registry
c. Supervisor is within 5-15 minute travel time
d. Supervisor theoretical orientation
e. Supervisor training

Answers: e

Explanations:

a. This would be helpful.

b. This would be helpful, however, is not required by law or ethics.

c. Not indicated

d. This could be helpful but not necessarily a determining selection factor for this case.

e. Training would provide the counselor with the knowledge that the supervisor would have a developed supervision contract stating the scope of supervision, role of a supervisor, methods and theoretical orientation for supervision, client counseling experiences, expectations for supervision and insurance coverage.

Question:
Supervision is sought before treatment for social phobia. The supervisor asked the supervisee what target behaviors should be considered for this treatment? (Select as many as you consider appropriate)

a. Controlling adrenalin-mediated stress reactions

b. Anger

c. Behavioral laboratory

d. Selective mutism

e. Facial hyperhidrosis

f. Self-esteem

g. Internal critical script

h. Sympathectomy

i. Sugar intake

Answers: a, e, f, g, i

Explanations:

a. Yes. It can be helpful to provide anxiety-disordered individuals education about the mind-body connection, including the role of the limbic system and the adrenalin-mediated fight, flight, and freeze reactions to stress. In addition, it can be useful to train such individual's techniques such as relaxation training or biofeedback training to control the physiological components of stress.

b. No. Anger is often associated with clients experiencing social anxiety or phobia. If anger surfaces during session work supervision for assistance in technique or process is available.

c. No. This is a form of pro-active teaching and treatment and not a target behavior. During treatment it would be helpful for clients to practice learning how to recognize and accept the physiological symptom of blushing caused by increased blood flow in the face and head and

possibly learn to control this symptom. For those unable to control it, the goal might be to teach them how to accept or make friends with the blushing.

d. No. This is not recommended unless inability to talk is apparent during the interview. In cases where mutism is an issue, parents should learn about 'enabling' by finishing your child's sentences, creating and avoiding over-dependence, empowering initiative to speak, avoiding pleading or forcing speech, attentive listening, learning patience.

e. Yes, this is a concern surfaced and present in many situations where others are involved. During treatment it could be helpful for clients to practice learning how to recognize and accept the physiological symptom of hyperhidrosis (increased sweating) caused by the adrenalin response to stress and possibly learn to control or modify it.

f. Yes. Self-esteem issues are always very important to deal with in therapy when resolving social anxieties.

g. Yes. During the counseling negative self-talk, which reflects the presence of an internal critical script, can be an area for the cognitive component of the phobia. It would be important to determine if the client deliberately uses avoidance behaviors and is perfectionistic.

h. No. The sympathetic nerve is an integral part of the sympathetic nervous system, which controls the "fight or flight" response to danger. When activated, the sympathetic nervous system speeds up the heart rate, increases the rate of respiration, causes blood vessels to constrict, and diverts blood away from the digestive tract and skin, and towards muscles. Sweating also increases as a side effect of adrenalin production. Collectively, these changes are known as the stress response, and enable the body to fight danger or escape from it. A sympathectomy is a surgical procedure in which a portion of the sympathetic nerve which runs parallel to the spine inside the chest is severed or cauterized. It can be a treatment for certain blood vessel disorders, hyperhidrosis (excessive sweating), and Raynaud's phenomenon (constriction of circulation in the ears, nose, toes, or fingers to constrict more than normal in cold temperatures), but is not a treatment for stress disorders.

i. Yes. Studies of the effects of sugar on behavior reveal that some children and adults are sugar-sensitive, meaning their behavior, attention span, and learning ability deteriorates in proportion to the amount of junk sugar they consume. Sugar promotes sugar 'highs', particularly in children who tend to be more sensitive than adults. A study comparing the sugar response in children and adults showed that the adrenalin levels in children remained ten times higher than normal for up to five hours after a test dose of sugar

In summary it is recommended to review the ACA Code of Ethics to become aware of different tasks and duties of a counselor. Specifically review Sections F.2., F.3., and F.4. and F.5. Counselor Supervision Competence, Supervisory Relationships, Supervisor Responsibilities and Counseling Supervision Evaluation, Remediation and Endorsement. In addition Section D.2. Consultation.

There are numerous supervision questions that can be posed when reviewing the ethical code. Some ideas may be gathered from the following (ACA, 2005):

1. Records (A.1.b.): required by law, timely documentation, documentation is accurately placed in the chart, client progress, services provided, and errors in the record

2. Client records not to be kept. Wheeler (2013), a licensed attorney recommends that the counselor should not comply with this type of request (Standard A.1.b, ACA, 2005).

3. Client requests their counseling records. Wheeler (2013) recommends based on HIPAA regulations that copies may be given to the client but not the original records. There is a difference in copies and originals. If under a subpoena consult with your attorney for release.
4. Informed Consent (A.2.a.): review in writing and verbally with client rights and responsibilities and regarding process and counselor
5. Information needed (A.2.b.): purposes, goals, techniques, procedures, limitations, potential risks and benefits of services, counselor qualifications, credentials, relevant experiences, confidentiality, records, continuation of services regarding death or incapacities, implication of diagnosis, use of tests and reports, fees and billing.
6. Fees (A.10.b.): financial status of clients, locality, comparable services
7. Treatment teams (B.3.b.): Client is informed of teams' existence, composition, information shared and purposes of sharing information.
8. Scientific Bases for Treatment Modalities (C.6.e.): Use techniques and procedures grounded in theory and have empirical support. Those techniques and procedures used are to be defined as unproven and to explain potential risk as well as ethical considerations.
9. Understanding Consultees (D.2.b.): clear understanding of problem definition, goals for change, predicted consequences of the intervention.
10. Proper Diagnosis (E.5.a.): Assessment techniques to determine client care-locus of treatment, type of treatment, recommended follow-up.

Ethics

Questions involving ethical responses and decision-making for the counselor can occur at any time during client care. The authors decided to standardize six questions for many of the clinical cases. Nevertheless, the reader should review the American Counseling Association (ACA) Ethical Code. Care should be exercised in the use of DSM-5™ labels when the validity of the data to make an assessment remains scant. An ethical approach to this dilemma is to conduct another assessment at a later time and see if the assessment matches.

Standards

The AMHCA standard of practice for supervisors' requirements is knowledge and skill based. Knowledge standards criteria include (brief) evidenced-based clinical theory and interventions, understanding client population and working knowledge of supervision models; understanding roles, functions and responsibilities of supervisors including liability, communicating expectations and

nature of relationships; understanding appropriate professional development activities, supervisory relationships related to issues, cultural issues; understanding and defining legal and ethical issues (laws, licensure, rules and code of ethics); understanding evaluation processes; and understanding knowledge of industry recognized financial management processes, record keeping, and transmission of records.

Skills standards for the AMHCA emphasize understanding client populations and demonstrating clinical interventions with cultural and clinical contexts; developing, maintaining and explaining supervision contracts; demonstrating and modeling clear boundaries and appropriate balance between consultation and training; and demonstrating the ability to analyze and evaluate skills and performance.

Client Rights (HIPAA, FERPA)

Health Insurance Portability and Accountability Act (HIPAA)

Health Insurance Portability and Accountability Act (HIPAA) Health Insurance Portability and Accountability Act (HIPAA; Public Law 104-191) was enacted in 1996 and fully implemented in 2005 to safeguard and ensure health care providers and patients (physical and mental health care) uniform standards to protect information privacy. Any third party transmission of patient information must meet the statutes for HIPAA. Entity refers to treatment, payment and health care operations. In cases of emergency, providers may sometimes disclose information to exercise a clinical judgment (Retrieved 9-14, 2011 http://www.omh.ny.gov/omhweb/hipaa/phi_protection.html)

Wheeler (2013) indicated that the Office for Civil Rights published compliance areas that are pertinent to counselors and federal laws. These compliance areas are patient privacy, HIPAA and you, and examining compliance with the HIPAA privacy rule.

The Privacy Rule was finalized in 2003 and applies to 'covered entities' such as organizations and individuals that transmit patient information electronically, in paper form or provided orally. The covered entity includes health and mental health plans and written client signed releases of information. The Privacy Rule covers all records that are held or information disclosed to a covered entity. The interpretation for this rule is that counselors are to provide to the client a written explanation of how the counselor will use, keep and disclose his/her health information. A procedure is to exist so that the client may make amendments or execute changes in the record as well as gain access to his/her records. In addition, the counselor is to have an established privacy procedure as to who has access to the client records. Client consent is to be obtained for the release of information regarding treatment, payment and health care operations purposes as well as transmission of client information to financial institutions. Exceptions are noted in the document whereby information may be released during times of an emergency. Even when clients provide permission to release information, the minimum amount is covered under the "Minimum Necessary" rule. The "Minimum

Necessary" rule allows the health provider to use, to request, or to disclose to others only necessary patient information to fulfill the intended purpose. Each provider is to consult other privacy federal laws when a disclosure is under consideration. The Privacy Rule may be secured at Web site: http://www.hhs.gov/ocr/hipaa.

The typical information a 'covered entity' protects or uses is: (1) treatment, payment, or health care operations; (2) upon the individual's agreement in certain limited circumstances (after an opportunity to agree or object); (3) disclosure to the individual; (4) pursuant to an authorization from an individual; or (5) as permitted or required by HIPAA for government or other purposes (45 C.F.R. & 164.502[b]).

A privacy officer is to be established in a counseling office. This officer is to train employees how to handle confidential information, ensure procedures are in place to protect, and ensure that proper forms are used by health personnel.

Psychotherapy notes are covered under 45 C.F.R. & 164.508(a) (2) and stipulates that an authorization is to be obtained for use or disclosure of psychotherapy notes. The psychotherapy notes should be located in a separate file from the rest of the patient's record. HIPAA's rationale is that psychotherapy notes are not a part of the health record and not intended to be shared with anyone (Remley & Hurley, 2010). The client is to provide a release before any notes are transmitted elsewhere. There are exceptions for psychotherapy notes that include: (a) use by the counselor of psychotherapy notes for providing treatment, payment, or health care operations; (b) training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family , or individual counseling; (c) use or disclosure by the covered entity to defend a legal action or to other proceedings brought by the individual; (d) use with respect to the oversight of the originator of the psychotherapy notes, such as peer review and (e) disclosures required by law (445.CFR & 164.512(j), certain disclosures about decedents (45 CFR & 512(g) and disclosures to avert a serious threat to health or safety. 45 CFR & 164.512(j)(Remar & Bounds, Rogers & Hardin, 2011, pp 12-13).

In summary complying with HIPAA procedures health providers are to adopt written policies and procedures, train employees, designate a privacy officer, designate a contact person, and maintain documentation (Leslie, 2002).

Family Educational Rights and Privacy Act (FERPA)

This act, created in 1974, was previously referred to as the Buckley Amendment. The act and specifications affect all public and private parochial educational institutions that receive federal funds. If a school system has a health based center, it may be subject to HIPAA requirements regarding student health records. FERPA indicates that parents of minor students (18 or older or in college) have the right to inspect the records and to challenge information contained within the file and to have written authorization obtained before any education records are transferred to any third party (US Department of Education, 2008). Parents or guardians may receive copies of the student records

without the permission of the student (Remely & Hurley, 2010). This does not include case notes if retained as separate from the student file and not made available to anyone else.

Study Suggestions

1. It is the opinion of the authors that those preparing to take the NCMHCE need not memorize all of the symptoms for each mental disorder. Nevertheless, the more you know the better you will be able to select or rule out a disorder.
2. It is suspected that you will not be held accountable for specific medications or the technical names of drugs. Information about medications in this manual may seem excessive to some but are intended to reinforce that aspect of treatment and monitoring. More than likely examinees will be expected to know which type of client exhibiting which disorder is likely to be prescribed medications.
3. Several interview surveys and instruments are listed within each of the chapters. They are included as a reminder that some may be utilized for assessment and/or monitoring client progress.
4. It is standard practice during the initial interview for mental health evaluators to inquire about the physical health of their clients (medical assessment), which often includes asking them to complete intake forms on which basic medical information is requested. The authors designed many case scenarios in which there may not be a specific question in Section A that requests medical information. In those cases, the test taker should consider the possibility that a medical concern might surface from one of the other questions in Section A. If that happens, a referral might be made in Section B to secure medical information that may be helpful in making a diagnosis. For example a client suffering from a sleep disorder could have a secondary sleep problem based on another mental disorder. The latter possibility would require further medical evaluation. In other cases, the mental health evaluator will not realize until later that additional medical information should be requested because of clues that emerge in the answer sections of some of the case scenarios. In such cases an additional probe would be necessary to request further medical information and/or evaluation.
5. Many of the scenarios include a request for psychiatric consultation. A request occurring in Section B would be either for diagnostic purposes - establishing or confirming a difficult diagnosis - or for initiating psychoactive medications when the client's psychiatric condition is severe enough to warrant immediate intervention. Be aware, however, that ordinarily a psychiatric consultation for the purpose of starting patients on psychoactive medications would only take place after the diagnosis has been established - during the treatment phase of the NCMHCE.
6. Obtaining a family history is important in the scenario's assessment phase to help make diagnoses for those conditions having a genetic predisposition. These include mood disorders,

particularly bipolar disorder, schizophrenia, anxiety disorders, ADHD, eating disorders, alcoholism, and substance dependency.

7. The scenario's treatment phase is meant to define those treatments, psychotherapies, and alternative treatments demonstrated to be most appropriate and helpful for symptom remission for specific diagnoses. The choice of treatment is also affected by the duration allowed or required to achieve the desired results, availability of trained and experienced therapists, and a supportive treatment setting appropriate for chronic illnesses and personality disorders. Psychodynamic therapies typically require longer treatment duration and may be most appropriate for skilled therapists whose clients have sufficient resources including a supportive environment, motivation, and cognitive capacity.
8. Review the ACA Code of Ethics Section C.6.e. Scientific Bases for Treatment Modalities regarding obligations to the client.

2 SELECTED DSM-5™ DISORDERS

Disorders Usually First Diagnosed In Infancy, Childhood or Adolescence

The DSM-5™ contains 20 categories of disorders. The disorders are arranged sequentially in each chapter according to a life span approach with disorders first experienced in childhood to disorders experienced in older adults. Posttraumatic Stress Disorder in preschool children is covered under Posttraumatic Stress Disorder with criteria for children under six. Temper dysregulation disorder with dysphoria was changed to disruptive mood dysregulation disorder. Learning disabilities combined three into one.

For the purpose of the NCMHCE supplement a number of disorders will be selected based on occurring with a higher frequency in the population.

In terms of children the following disorders are to be found in neurodevelopmental disorders.

1. Intellectual Disabilities
2. Specific Learning Disorders
3. Communication Disorders (Learning Disorders, Speech Sound Disorders, Child On-set Fluency Disorder, Social Communication Disorder)
4. Pervasive Developmental Disorders (Autism Spectrum Disorder)
5. Motor Disorders
6. Attention-Deficit/Hyperactivity Disorder
7. Oppositional Defiant Disorder
8. Conduct Disorder
9. Disruptive Mood Dysregulation Disorder
10. Feeding and Eating Disorders of Infancy or Early Childhood
11. Binge Eating Disorder
12. Tic Disorders (Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, Provisional Tic Disorder)

13. Elimination Disorders
14. Reactive Attachment Disorder
15. Separation Anxiety Disorder
16. Disinhibited Social Engagement Disorder

Although a number of psychiatric conditions occur during childhood, this preparation manual (supplement) for the National Clinical Mental Health Examination (NCMHE) will only address attention-deficit/ hyperactivity (ADHD), oppositional defiant (OD), separation anxiety, and conduct disorders (CD). A brief amount of information regarding definition, assessment, and treatment will be provided regarding tics, Tourette's syndrome, and learning disorders with substance abuse when comorbidity is present with ADHD, OD, and CD. Among those guidelines that can be used to assess these psychiatric conditions are the published parameters established by The American Academy of Child and Adolescent Psychiatry (AACAP, 1995).

Neurodevelopmental Disorders

Intellectual Disabilities

The American Association for Mental Retardation (AAMR), American Psychological Association (APA) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5™, DSM IV-TR) offer similar, yet subtly different definitions of intellectual disabilities. The DSM-IV-TR (APA, 2000) defines intellectual disabilities according to the essential feature of a sub-average intellectual functioning (IQ < 70) with onset before age 18 accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: use of community resources, self-direction, functional living, functional academic skills, communication, self-care, social/interpersonal skills, work, leisure, health, and safety (p. 41). One criticism made by Greenspan (1999) was that mental retardation is assessed by one factor, that of an intelligence quotient (IQ) score. He suggested the definition should include terms less injurious such as: deficits in social, practical and academic intelligence; decreased diagnostic reliance on standardized test scores and greater reliance on clinical and consensual judgment; assumption of an underlying biological etiology; ongoing need for supports and protections; and recognition that vulnerability to potential exploitation and manipulation is a universal feature of the disorder (p. 6).

The panel for the DSM-5™ attended to the single assessment indicator and added adaptive behavior. Rather than a single score on an intelligence instrument (<70) a second measure is to be applied, adaptive functioning. The IQ of 70 or less was maintained; however, all other IQ numbers were dropped. The assessment includes additional domains to include conceptual, social, and practical. Finally the name changed from mental retardation to intellectual disability based on the rational that mental retardation was an injurious and outdated term.

No single etiology for intellectual disabilities exists in the literature. However, a few predisposing factors such as heredity, early alterations in embryonic development, pregnancy and perinatal problems, general medical conditions acquired in infancy or childhood, developmental and environmental influences are suggested (APA, 2000).

Definition and Interview:

The assessment for intellectual disability involves individual testing, observations and data–gathering from significant individuals who know the client. The amount of impairment in intellectual functioning is coded by term, adaptive functioning, and intelligence range. That is, an individual experiencing mild intellectual functioning could be assessed on a standardized individual intelligence measure such as the Wechsler Intelligence Scale for Children to be functioning less than 70 or two standard deviations below the mean. Intellectual functioning involves reasoning, abstract thought, and cognitive efficiency. The assessment of an intelligence quotient in one of the above ranges also must be accompanied by a significant impairment in adaptive functioning.

Adaptive functioning is defined by how well the individual is able to cope with the demands of daily living and standards of personal independence and social responsibility. Taken into consideration is the age level and socio-cultural background, and community setting. Gathering data for the adaptive assessment can be achieved through the use of standard instruments as well as interviews with individuals who have interactions and observations regarding the individual being assessed. In most cases, retarded children should also be interviewed and/or observed.

Specifically, "the conceptual domain involves competence in memory, language, reading, writing, math reasoning, and acquisition of practical knowledge, problem solving, and judgment in novel situations. Social domain involves awareness of others, thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. Practical domain involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization among others" (APA, 2013, p. 37).

In assessing a differential diagnosis, the interviewer should be aware and knowledgeable regarding learning disorders, communication disorders, pervasive developmental disorders, dementia, and borderline intellectual functioning. Intellectual disability is categorized as a personality diagnosis and may be accompanied by another diagnosis if it is associated with a psychiatric condition or a personality diagnosis if it is associated with a medical condition, which is fairly common with intellectual disabled children.

Incidence:

It is estimated that approximately 1% of the population has intellectual disability (APA, 2000, 2013). The percentage may vary according to the different definitions and severity of the client conditions utilized in the studies for prevalence. The DSM-IV indicates that approximately 85% of those individuals assessed intellectual disability fall in the range for mild retardation (APA, 1994), most of which are appropriate for interviewing. The DSM-5™ cites severely affected clients prevalence to be approximately 6 per 1,000 (APA, 2013).

Diagnostic Information:
Testing results reflect a significantly sub-average intellectual functioning with an IQ of approximately 70 or below on an individually administered IQ test. There are noticeable deficits or impairments in at least one or more of the following daily life activities: communication, self-care, home living, interpersonal relationships, academic skills, health, self-direction, leisure, and safety (APA, 1994, 2013). All symptoms must have an onset during the developmental period (prior to 18).

Instrumentation:
Any assessment should be matched with the characteristics of the person. The characteristics should include age of the person, mode of communication, and motor and visual-spatial capabilities. There are a number of norm-referenced instruments of intellectual functioning to determine global estimates of cognitive abilities. Some of these are:

1. Stanford-Binet Intelligence Scale: Fourth Edition (Laurent, Swerdlik, & Rybum, 1992)
2. Wechsler Intelligence Scales [Wechsler, 1974, 1991, 1992, 2003 (WISC-IV)]
3. Test of Nonverbal Intelligence (Brown, Sherbenou, & Dollar, 1982)

Adaptive behaviors are two sets of skills necessary to perform successfully in their environment. The first set involves personal skill development, which include self-care, home living, work, and recreation. The second set of skills involves social competence, which are skills needed to interact with others. Some of these norm-referenced instruments are:

1. Vineland Adaptive Behavior Scales (Sparrow, Balla, & Ciccetti, 1984)
2. Scale of Independent Behavior (Bruininks, Woodcock, Weatherman, & Hill, 1984)
3. AACAP practice parameters (AACP, Official Action, 1995)

Attention Deficit Hyperactivity Disorder

A number of changes in the definition of attention-deficit/hyperactivity disorder (ADHD) have been included in the DSM-IV (APA, 1994) and persist in the DSM-IV-TR (APA, 2000). The current approach to understanding this syndrome is to consider two symptom domains: inattentive and hyperactivity / impulsivity. The combined type is classified as a specifier. Attention-deficit/hyperactivity is defined as a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development and interferes with functioning in inattention and hyperactivity and impulsivity (Criterion A, APA, 2013, p. 60) Criterion A (inattention requires six or more symptoms from a list of nine and persists for a period of six months. Six or more of a similar list exists for hyperactivity and impulsivity for the same six months. A client age 17 or older need only meet five symptoms (APA, 2013). Criterion C requires that the behavior is noted in two or more settings (school, home, work, friends, or other activities). The symptoms are to be present prior to age 12.

For each subtype, a list of criteria is specified in the DSM-5™. Inattention is characterized by a variety of behaviors in which the client does not demonstrate the ability to remain at a task, to establish and maintain a task (goal establishment) and complete a task. Common to inattention is the inability to ignore irrelevant stimuli and become distracted from the task. From the menu provided in the DSM-5™, a frequent difficulty is developing and maintaining organizational skills and in focusing. Many inattentive types will begin a task, shift to something else and when redirected, will experience difficulty in accepting the instruction to do so. Hyperactivity is characterized by fidgetiness, restlessness, squirming, and excessive motor activities (e.g., running, climbing), and constant movement. Impulsivity is characterized as impatience, interrupting, blurting out answers before instructions or answers are given, and accident proneness.

Historically the etiology or causes of ADHD have varied from - a lack of moral control and a failure to adjust to environmental expectations of behavior to a neurological impairment (cerebral trauma), and more recently, to genetically-linked symptoms related to a neurological based disorder (Doyle, 2004; Wadsworth & Harper, 2007). More specifically, ADHD results from an under-responsive regulation of neurotransmitters, particularly Dopamine (Erk, 2000). The critical features relate to an inability to prioritize and implement four executive functions: (a) non-verbal working memory, (b) internalization of self-directed speech, (c) self-regulation of mood and arousal, and (d) reconstitution of the component parts of observed behaviors (Barkley, 1997).

Included as necessary for the diagnosis is an associated impairment in social, academic or occupational functioning. The symptoms must have lasted for six months prior to the assessment and have produced maladaptive behaviors, which are inconsistent with group developmental levels. In addition, symptoms typical of the impairment in children must have been present before seven years of age and have been present in two or more situations.

It has been reported that two thirds of children diagnosed with ADHD may have a concurrent clinical disorder to include oppositional defiant, conduct disorder, learning disorder, and pervasive developmental disorder (Biederman, Newcorn, & Sprich, 1991; Pliszka, 1998). Sinzig, Dopfner, and Lehmkuhl (2007), in their study with a German Methylphenidate Study Group, found that 4.9% of the children showed oppositional defiant disorder/conduct disorder symptoms. The overlap of these disorders with ADHD is well documented. Reeves et al. (1987) suggests that all children under age 12 diagnosed with conduct disorder and oppositional defiant disorder also meet the criteria for ADHD. Several authors have pointed out that children with ADHD are at risk for conduct disorder. A comorbidity rate for ADHD with ODD is 35%, 50% with CD, 15% to 75% with mood disorder, and 25% with anxiety disorder (Althof, Rettew, & Hudziak, 2003). It is no surprise that individuals with ADHD, CD, and ODD have a poorer prognosis when occurring together (Barkley, 1990). In addition, comorbid conditions also may be present, such as intellectual disability, disorders caused by genetic abnormalities, and anxiety or mood disorders provoked by environmental disruptions, (e.g., sexual abuse, assault, environmental disruption, and family death). The DSM-5™ refers to differential diagnosis occurring with or sharing comorbid symptoms are oppositional defiant disorder, intermittent explosive disorder, specific learning disorder, intellectual disability, autism spectrum disorder, reactive attachment disorder, anxiety disorders, depressive disorders, bipolar disorder,

disruptive mood dysregulation disorder, substance use disorders, personality disorders and neurocognitive disorders (APA, 2013).

Definition and Interview:
A diagnostic interview is a data gathering assessment whereby standardized cognitive instruments, behavioral checklists, rating scales, and interviews with individuals familiar with the client are used. It should be noted that it is common that observations gathered through checklists from school personnel and parents sometimes disagree (Barkley, 1990).

Two lists of criterion behaviors are provided for the subtypes (Inattention, hyperactivity and impulsivity) in the DSM-5™. A correct diagnosis is dependent upon a menu list in which 12 of 18 symptoms have to be present for a diagnosis of the combined type (specifier), and 6 of 9 criteria are to be met for inattention and for hyperactivity/impulsivity. Behaviors for inattention include failing to pay close attention to details, difficulty sustaining attention in play activities, a seemingly inability to listen, and difficulty organizing tasks. Hyperactivity criterion often include fidgeting with hands or feet, leaving a seat in a classroom, talking incessantly, and running about excessively. Impulsivity criteria behaviors are often blurting out answers, difficulty waiting his or her turn, and interrupting others (APA, 2013, p.60). It may be difficult for the person conducting the assessment to determine what is "often" when reacting to reports from others.

Although structured and semi-structured clinical interviews are available, Brown (2000) contended that many counselors utilize nonstandardized interviews. The Diagnostic Interview Schedule for Children (Shaffer, 1992) and the Semi-structured Clinical Interview for Children and Adolescents (McConaughy, 1996) have been considered effective tools when reviewing technical data (Edwards, Schultz, & Long, 1995).

Parent and teacher interviews are important sources of information for the person conducting the assessment. Rating scales are available to collect this data. In addition to securing parent and teacher information behavior, rating scales such as the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992), the Conners Rating Scales (1997), and the Child Behavior Checklist (Achenbach, 1991a, b) are good scales to assess for the problem and for adaptive behaviors. A detailed developmental history also is recommended. This history–taking will shed light upon the age of onset as well as any parental history of this disorder.

Another source of data collection can be secured from behavioral observations, such as classroom interactions. Brown (2000) indicated that these observations are useful in making interventions and recommendations.

Finally, psychological and psychoeducational assessments through the use of standardized instruments are common approaches. These approaches usually include intelligence tests, achievement tests, and specific achievement batteries designed to assess for attention deficits.

Many adults who come to counseling and later diagnosed with adult ADHD may not have previously treated for this disorder but have symptoms that have led to employment termination and substance abuse issues (Wadsworth & Harper, 2007). The interview for ADHD for adults necessitates asking the

individual to recall behaviors during early and middle school years, because the diagnosis requires onset in childhood. Comorbidity also can occur, as the adult may have another disorder at the time of the interview. Borland and Heckman (1976) found a high rate of anti-social personality, anxiety, and depressive disorders in their adult studies when compared to children with ADHD.

Incidence:
The DSM-5™ reports a prevalence rate of 5% in children and 2.5% in adults (APA, 2013). Greenhill (1998) indicated that ADHD in the United States is one of the most common childhood mental disorders. It is reported in the DSM-IV-TR that an estimated prevalence of attention-deficit hyperactivity/impulsivity is approximately 3% to 7% in school-age children (APA, 2000). Furthermore, an estimated 10% to 60% of children with ADHD continue to have the disorder as adults (Alpert et al., 1996).

Barkley (1990) indicates that at least 50% of children with ADHD may develop mood disorders; particularly bipolar spectrum disorders (Pavuluri et al., 2006). Hudziak et al. (1995) reports that ADHD has genetic elements. For example about 70% of children diagnosed with ADHD have parents either diagnosed with the disorder or who reveal some symptoms of ADHD. Wadsworth and Harper (2007) report the estimated percentage of adults with ADHD is 4.7% worldwide.

Diagnostic Information:
There has been an increasing incidence of behavioral and learning disorders among children and adolescents in the United States. These are most often diagnosed as symptoms of ADHD. Typically, beginning prior to age seven, symptoms appear more often in boys than girls and cause disruption in school and home. A developmentally inappropriate poor attention span and age-inappropriate features of hyperactivity and impulsivity characterize the disorder. It must be present for at least six months and interfere with academic or social functioning. Although the cause of such difficulties is frequently genetically based, they have also been associated with child abuse and neglect. Children in institutions are frequently overactive and have poor attention spans, but such symptoms disappear when these factors are removed. Predisposing factors to ADHD may include the child's temperament, genetic-familial elements, and the demands of society to adhere to a regimented way of behaving and performing. A low socio-economic standing does not seem to be a predisposing condition (Kaplan & Sadock, 1998).

Instrumentation:
Assessment for ADHD usually involves a battery of instruments that are cognitive, behavioral, and syndrome-specific. Cognitive assessment using intelligence and achievement tests for ADHD tends to reflect upon deficits in attention, cognitive control, memory, and global intelligence. Loge, Staton, and Beatty (1990) found ADHD children to score lower than controls in Full Scale IQ, information, arithmetic, digit span, block design, and coding on the WISC-R. Kaufman (1990) referred to the subtest deficits in arithmetic, coding, information, digit span, as the "ACID" profile frequently seen in children and adults with ADHD.

The following tests are considered to have good validity and reliability for such assessments:

1. Wechsler IQ test (WPPSI-R, WISC-III, WAIS-R; Wechsler, 1991)

2. WJ-R or WIAT (Wechsler Individual Achievement Test; Wechsler, 1992)

Behavioral assessment provides important sources of information for the evaluator; however, behavioral reports are known to be frequently inaccurate. Accuracy is affected by social desirability, halo effects, parent exasperation, and leniency errors. A number of rating scales, frequently parent and teacher forms, are available to assess ADHD. Some of these are:

1. Disruptive Behavior Disorders Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992)
2. Child Behavior Checklist (CBCL; Achenbach & Edelbroch, 1986)
3. Impairment Rating Scale (Pelham et al., 1996)
4. Conners Rating Scale-Revised (Conners, 1997)

A final measure for data gathering is the Continuous Performance Test (CPT). This type of test assesses attention, impulsivity, and distractibility using letters or numbers projected on a screen (Guevremont, DuPaul, & Barkley, 1990). This is a state-of-the art test, since it records the child's actual performance, rather than the reports of observers. It is important to remember that children tend to act out rather than verbalize psychiatric disorders such as depression or anxiety. Thus, children may appear to have ADHD per observers, but may actually have another diagnosis. Because a differential diagnosis is important a careful assessment includes instruments to rule out other disorders that may mimic ADHD.

When making the diagnosis of ADHD there should be evidence of six symptoms related to hyperactivity or inattention maladaptive behavior that have been present for at least six months. Comorbid disorders are: Oppositional defiant disorder, conduct disorder, learning, mood, and anxiety disorders (Spencer, Biederman & Wilens, 2004). Spencer, Biederman, Faraone et al. (2001) report that Tourette's syndrome and tic disorders are found in conjunction with ADHD.

Treatments:
The first step is to be sure the diagnosis is correct. Due to the symptoms and comorbidity with CD, ODD, mood disorders, anxiety disorders and other disorders a misdiagnosis brings on an ineffective or reduced treatment approach. A combined intervention of medication and counseling is the preferred treatment for ADHD symptoms (Montano, 2004; Weiss & Weiss, 2004). The focus of psychotherapy or counseling is empowering the client to take personal responsibility for his or her own behavior and learning to recognize the relationship between difficulties managing behavior and difficulties with focusing and cognitive functioning.

Weiss and Weiss (2004) recommend the following activities to be a part of the treatment plan for adult ADHD.

1. Education about ADHD
2. Attention management training
3. Behavioral management training

4. Social skills training
5. Stress management training
6. Anger management training, and
7. Problem-solving training

These authors caution counselors that insight therapies and non-directive therapies may not be as helpful as structured, directive therapies (medical, psychoeducation, behavioral intervention, cognitive restructuring, communication, social skills training, and family of origin exploration.)

Recent studies have focused on electroencephalographic (EEG) biofeedback (neurofeedback) in the treatment of attention-deficit hyperactivity disorder. These studies have reported improvement in attention and behavioral control and gains on tests of intelligence and academic achievement (Monastra, Lynn, Linden, Lubr, Gruzelier, & LaVaque, 2005). A review of this treatment reported that 75% of cases showed this improvement but continued studies are required.

Children

ADHD is one of the most effectively treated childhood disorders. Goldstein (1994, 1996) recommends a multimodal, multidisciplinary, and long-term approach as treatment. He recommended parent counseling and training, client education, individual and group counseling, social skills training, psychopharmacological medication and school intervention. Treatment involves using behavioral and pharmacologic treatments. A number of medications have been prescribed; however the stimulant methylphenidate (Ritalin) has been the pharmacologic intervention first used most frequently in the past with amphetamine-dextroamphetamine (Adderall) and extended release methylphenidate (Concerta) also becoming quite commonly prescribed with a response rate for children and adolescents reported to be 70% (Sinzig, Dopfner, Lehmkuh, et al., 2007; Spencer, Biederman, Wilens, & Faraone, 1996, 1998). Improvements have been recorded with children with both ADHD and tics using methylphenidate and clonidine (Johnson & Safranek, 2005).

ADHD symptoms occur in 5% of children in the United States. Physician visits by children with this disorder have been up 90% in response to a two-fold increase in this diagnosis being made over the past seven years. Although stimulants are used to treat the majority of children with ADHD, some disadvantages have been reported, such as the transitory nature of the effects, which cease when medication is not used, a failure rate of 30% to 40% and concerns about possible long-term safety (Rappley et al., 1999). Some professionals have been concerned about stimulants and have sought other treatments including electroenceplogram (EEG) neurofeedback training, a novel treatment approach, which some researchers claim is both effective and more enduring (Kirk, 2000; Lubar, Swartwood, Swartwood, & O'Donnel, 1995).

A home-based (behavioral intervention) five-step plan, which also can be used in the office, is a recommended treatment for ADHD, as follows:

1. Conduct an assessment and psychoeducation

2. Attention training
3. Reinforcement techniques
4. Maintenance and implementation of the plan to new situations
5. Follow-up (Kronenberger & Meyer, 1996)

School-based behavioral interventions also have been effective. These programs involve antecedent management techniques, contingency management, and token economies. Cognitive-behavioral interventions have been effective in teaching children self-talk, self-monitoring, and problem-solving strategies.

Adults

Treatment:
Spencer, Biederman, Wilens, and Faraone (1998) found in their studies that adults with ADHD were as responsive to the same or similar groups of stimulants as children and adolescents. Mattes, Boswell, and Oliver (1984) found the response rate for adults to be 25%. It is, however, not uncommon for physicians to prescribe anti-depressant medications, including Atomoxetine (strattera) rather than stimulants to treat for ADHD but find that patients with significant symptoms do not experience much improvement. Group counseling is recommended to encourage participants to share coping strategies and enhance socialization, thus reducing the stigma and isolation sometimes associated with ADHD. Methylphenidate (Ritalin) - including the long acting form of Ritalin (concerta) - and amphetamine – including the combination of dextroamphetamine and racemic amphetamine salts (Adderall) - are the most commonly prescribed medications for adults (Michelson, et al., 2003).

When medications are prescribed and taken, the counselor should monitor for any adverse effects such as insomnia, headache, and edginess for amphetamine compounds. For Atomoxetine (strattera) adverse effects may be gastrointestinal discomfort, more difficulty sleeping, sexual dysfunction in men (Michelson, et al., 2003), and mild increase in heart rate and blood pressure (Spencer, Biederman, Wilens, et al., 2003).

Monitoring
Self-reports and observations in overt behaviors are recommended. Betchen (2003) and Jackson and Farrugia (1997) provide a few examples suggesting that there be a reduction in:

1. Lengthy pauses in a speech pattern (inattentive)
2. Abrupt stop in speaking in the middle of a sentence
3. Forgetting what they are saying
4. Wandering into places forgetting the reason for going to that place
5. Requesting repeats of what was said to them or requested of them
6. Staring into space rather than focus on a person.

7. Interrupting others (impulsivity)
8. Wanting things immediately (impulsivity)
9. Not thinking about consequences (impulsivity)

Nicotine is reported to be associated with associative learning and the acquisition, maintenance, and relapse of drug use and abuse (Bevins & Palmatier, 2004). It has been utilized in treatment. Although it may be useful there are potentially serious side effects. Carmela, Reichel, Linkugel, and Bevins (2007) report that individuals diagnosed with ADHD are at increased risk to start smoking and will have much difficulty quitting.

Tic Disorder

All tic disorders (Tourette's, persistent motor or vocal tic, and provisional) are characterized in the DSM-5TM with onset before age 18 and as having their onset in childhood and are not due to the effects of medication or another medical condition (APA, 2013). The different tic disorders are described as follows:

1. Chronic tic disorder is typified by either single or multiple motor or phonic tics, but not both;
2. Transient tic disorder consists of multiple motor and/or phonic tics with duration of at least four weeks, but less than 12 months;
3. Tourette syndrome is diagnosed when both motor and phonic tics are present for more than a year;
4. Tic disorder (specified or unspecified) is characterized by the presence of tics that do not meet the criteria for any specific tic disorder.

Tics most commonly affect the face and head, upper and lower extremities, respiratory, and alimentary systems. Tics may take the form of grimacing, puckering the forehead, raising eyebrows, blinking eyelids, winking, wrinkling the nose, trembling nostrils, twitching mouth, displaying the teeth, biting the lips and other parts, extruding the tongue, protracting the lower jaw, nodding, jerking, shaking the head, twisting the neck, looking sideways, jerking hands or arms, plucking fingers, clenching fists, shrugging shoulders, shaking a foot or lower extremity, hiccupping, sighing, yawning, blowing, making sucking or smacking sounds, and clearing the throat. Obsessions, compulsions, attention difficulties, impulsivity, and personality problems often coincide.

Attention difficulties and irritability may precede the onset of tics. Treatment of tics may be necessary when they are severe enough to impair the patient or cause emotional disturbances. The use of medications is not recommended unless the symptoms are unusually severe and disabling. Behavioral techniques, particularly habit reversal treatment, have been effective in treating transient tics.

Instrument:

1. The Yale Global Tic Severity Scale (YGTSS: Leckman et al., 1980)

The scale measures for severity of motor and vocal tics (number, frequency, intensity, complexity, and interference)

Treatment:
The tic has been annoying and recommendations for this treatment would include habit reversal training, stress reduction, and psychoeducation concerning the influence that stress, anxiety and fatigue can have on symptoms. This education would coincide with education regarding the OCD symptoms.

Researchers have determined that comprehensive behavioral intervention (CBIT) for tic therapy has been helpful for 53% of children involved in this treatment (Piacentini, 2010). CBIT is based on habit reversal training that includes two concepts: tic awareness and competing-response training. Tic-awareness training teaches the individual how to monitor themselves for early indications (including the urge) that a tic is about to occur. Competing-response training teaches them how to engage in a voluntary behavior designed to be physically incompatible with the impending tic, thereby disrupting the cycle and decreasing the tic.

There are several different kinds of medication that can be prescribed to reduce the frequency and severity of tic symptoms. The effects of each kind of medication will vary from individual to individual, so there is no one best medication. For individuals with mild to moderate tic symptoms, guanfacine (Tenex) or clonidine (Catapres) is often prescribed. These are drugs that are often also prescribed to treat anxiety and panic. For individuals who have tic symptoms that fall in the moderate to severe range, neuroleptics are often prescribed, such as the newer atypical neuroleptic risperidone (Risperdal) or a traditional neuroleptic such as haloperidol (Haldol).

Tourette's Disorder

Tourette's disorder is a movement disorder usually seen in school-age children and manifested by the presence of tics. Tourette symptoms are involuntary, sudden, brief, intermittent, repetitive movements or sounds. Tics tend to be clonic (brief), dystonic (prolonged), and/or sustained. Kenney, Kuo, and Jimenez-Shahed (2008) provide examples of tics such as the simple motor (eye blinking, head jerking, nose twitching), complex motor (burping, copropraxia, head shaking, hitting, jumping, retching, smelling objects), and simple phonic (blowing, coughing, grunting, screaming, squeaking, sucking, throat clearing). Tics come and go over days, weeks, or months. Tourette clients may have multiple tic types. This syndrome can be associated with other disorders. For example, a child with Tourette's syndrome may have also been diagnosed with ADHD by age four and OCD by age seven.

Treatment:
The goal for treatment is to improve social functioning, self-esteem, and quality of life. Behavior therapy is recommended to improve social functioning, self-esteem, and reduce tics (Kenney, Juo, & Jimenez-Shahed, 2008). Behavioral therapies found to be effective for Tourettes and habituation are exposure and response prevention (ERP) and habit reversal (HR). Behavioral treatment targets reducing the physiological manifestation of anxiety such as heart rate and is based on the belief that tics are intentionally executed responses to relieve tension and associated unpleasant sensory

sensations (Verdellen, Hoogduin, Kato, Keijsers, Cath, & Hoijtink, 2008). Symptoms unresponsive to behavioral interventions may require pharmacological and even surgical procedures.

Adults with Tourette's syndrome, compared to children, require a greater focus on cognitive deficiencies than overt behavior symptoms displayed by children (Weiss & Weiss, 2004). Woods et al. (2002) suggest assessing functional impairment by observing the adult's ability to respond to sustained and divided attention, verbal fluency, complex information-processing, response inhibition, and verbal list learning. Continuous Performance Tasks (CPT) is helpful to assess sustained attention and response control.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia spectrum is defined by abnormalities in delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behaviors (catatonia) and negative symptoms.

Schizophrenia

Definition and Interview:
The DSM-5™ renamed the category of schizophrenia spectrum and other psychotic disorders to include schizotypal (personality) disorder, schizophrenia disorder, delusional disorder, brief psychotic disorder, schizophreniform disorder, and schizoaffective disorder. Subtypes have been eliminated from the DSM-5™ (APA, 2013). The definition and assessment remain pretty much unchanged from the DSM-IV-TR with the criteria exception consideration for bizarre delusions or hallucinations having been removed. Differentiating between bizarre and non bizarre delusions is of less importance during the assessment. Catatonia is no longer a subtype.

Schizophrenia is a significant mental illness causing dysfunction in social, academic, and occupational areas with onset and continuous disturbance duration persisting at least six months (Criterion C) in which there is at least one month of symptoms in Criterion A (page 99). Characteristic symptoms of schizophrenia must have two of the five characteristics and of the two include one of the first three characteristics; delusions, hallucinations, disorganized speech and during a one month period of time (APA, 2013). In the DSM-5™ in Criterion A for schizophrenia

regarding psychosis, the client can no longer meet the criterion with a single bizarre delusion but now requires two symptoms from the list of delusions, hallucinations or disorganized thinking (King, 2013).

1. Delusions
2. Hallucinations
3. Disorganized speech

4. Grossly disorganized or catatonic behavior
5. Negative symptoms (i.e., affective flattening, alogia, or avolition).

Patients with schizophrenia generally have two types of symptoms: positive and negative. Positive symptoms include the two most obvious signs of psychosis:

1. Hallucinations, most commonly auditory, i.e., hearing voices, noises, or music; visual, i.e., persons, lights, or things; and less frequently olfactory, gustatory, or tactile; and
2. Delusions, fixed false ideas, i.e., somatic, grandiose, religious, nihilistic, or persecutory.

These symptoms generally affect social and motor behavior quite adversely because of the resulting incapacitating "distortions of normal functioning" (Keith, 1997, p. 851). Negative symptoms are less obvious and resemble depression, yet they also can impair normal functioning because of avolition (loss of will), limited range of affect, anhedonia (loss of pleasure), or alogia (diminished cognitive capacity and fluency and content of speech). The APA (2000) describes the following criteria for diagnosing schizophrenia:

1. One of three of the following symptoms present for a significant amount of time over a one-month period: delusions, hallucinations, disorganized speech, and negative symptoms (Criterion A). One note of consideration is that if delusions are bizarre or hallucinations consist of two or more voices conversing, or one voice maintaining a running commentary on the person's thoughts or behaviors, only one of these is necessary to meet the diagnostic criteria for Criterion A. The new assessment considers a reduced importance in differentiating between bizarre and non-bizarre delusions because of a poor reliability with the differentiation.
2. Criterion B involves a social and/or occupational dimension, such as a significant disturbance in the quality and quantity of the individual's functioning at work, school, interpersonal relations, etc., or diminished self-care markedly lower than it was prior to the onset of the illness.
3. Criterion C considers the duration of the schizophrenic features. Continuous signs of positive and/or negative symptoms for a period of at least six months and one of the months has symptoms that meet Criterion A.
4. Criterion D involves ruling out schizoaffective and mood disorders. That is, no major depressive, manic, or mixed episodes should have occurred simultaneously with the active phase symptoms; but if they have occurred, these episodes should only have been for brief times relative to the active times.
5. Criterion E involves ruling out the possibility that the symptoms of schizophrenia are caused by the direct physiological effects of a substance or a general medical condition.
6. Criterion F pertains to a history of autism spectrum disorder or communication disorder of childhood onset, schizophrenia is assessed if delusions or hallucinations are present for a one month period (APA, 2013, p. 99).

Specifiers include first episode, (currently in acute episode, currently in partial remission, currently in full remission), multiple episodes (currently in acute episode, currently in partial remission, currently in full remission), and unspecified (APA, 2013, p. 100).

Incidence:
The most common of the psychotic disorders is schizophrenia (Meise & Fleishhacker, 1996; Robins, Helzer, & Weissman, 1984) with a worldwide prevalence of 1% (Andreasen, 1999; Keith, 1997). APA (2013) reports a prevalence rate approximating 0.3%-0.7%.

Andreasen reported that schizophrenia is one of the most important health problems worldwide, usually occurring in younger adults entering their early 20s. Morbidity is quite high (roughly 60% receive disability benefits within one year of onset) and the rate of suicide is around 10% (Andreasen & Black, 1991; Ho, Andreasen, & Flaum, 1997). Additionally, rates of employment for schizophrenics rarely exceed 20% (Keith, 1997).

Instrumentation:

1. Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978).
2. Brief Psychiatric Rating Scale (BPRS)
3. Repeatable Battery for the Assessment of Neuropsychological Status (RBANS; Randolph, 1998)

Treatment:
Schneider (1999) views schizophrenia as a cognitive impairment requiring treatment in an environment which provides adequate structure and sensory input. To be truly effective, caregivers for clients with schizophrenia must communicate clearly and simply. When clients seem to be hallucinating, caregivers should redirect them to concrete tasks. Supportive therapy is helpful, and confrontation and arguments should be avoided (Schneider). A client with schizophrenia, whose positive symptoms are adequately stabilized, can learn more effective coping mechanisms with the use of specific behavioral approaches, one of which has been referred to as the A-B-C's: (A) determine antecedents of the behavior, (B) clarify the problematic behavior itself, and (C) reinforce the consequences of the behavior.

Another important element of treatment is enhancing social functioning through affect recognition - addressing the failure of individuals with schizophrenia to recognize emotional cues necessary for interpersonal relationships. Training in emotion recognition using the micro-expression training tool (Ekman, 2003) has been shown to be useful (Russell, Chu, & Phillips, 2006).

Pharmacotherapy has provided substantial improvements in the treatment of both acute psychotic episodes and chronic schizophrenia. Psychiatrists make decisions about which medications to prescribe based on the type and severity of symptoms as well as the most favorable side-effect profile.

The older antipsychotics typified by such medications as chlorpromazine (Thorazine), which is the earliest of the Phenothiazine category of drugs dating back to the 1950s, and Haloperidol (Haldol), a more potent anti-psychotic drug dating back to the 1970s, block dopamine neurotransmitter activity

in the brain and are often accompanied by very uncomfortable motor movement side-effects. Haloperidol is still prescribed to control positive symptoms (i.e. hallucinations) but is being replaced by newer and more effective agents which act upon selective Dopamine and Serotonin neurotransmitters.

These are called atypical (or second generation) antipsychotics and include clozapine (Clozaril), risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), aripiprazole (Abilify), paliperidone (Invega) an active metabolite of Risperidone approved in 2009, and thee more recently approved antipschotics-asenapine (Saphris), iloperidone (Fanapt), and lurasidone (Latuda). Their anti-psychotic characteristics allow for control of positive symptoms such as hallucinations and delusions as well as negative symptoms like anhedonia, depression, and detached emotional responsivity while the older antipsychotics only controlled positive symptoms. Their ability to abate or reduce the severity of negative symptoms along with fewer side-effects when prescribed and monitored judiciously make them more desirable (Keith, 1997; Schneider, 1999).

The newer antipsychotic medications became available for use by American physicians primarily in the early 1990s although clozapine (Clozaril) was first approved by the FDA in 1989. Olanzapine (Zyprexa) was made available shortly thereafter and had many of the same characteristics of clozapine. Both of these medications were found to improve cognitive functioning in chronic schizophrenic patients (Chiaie, Salviati, Fiorentini, and Biondi, 2007; Mortimer, Joyce, Balasurbramaniam, et al., 2007) however the presence of excessive weight gain and Type II diabetes mellitus as potential serious side effects often precluded their usage.

Schizophrenic clients who are acutely agitated and become violent are generally treated with rapid acting antipsychotic medications. These include Haloperidol injections, lorazepeam (Ativan), ziprasidone (Geodon) intramuscular, olanzapine (Zyprexa Zydis) - oral radially disintegrating, and olanzapine (Zyprexa) intramuscular (Centorrino, Meyer, Ahl, et al., 2007), and aripiprazole (Abilify R) rapid acting intra-muscular injection.

The atypical antipsychotic medications prescribed at the most effective dose can control positive symptoms such as hallucinations and delusions and abate or reduce the severity of negative symptoms such as anhedonia, depression, and detached emotional responsivity and generally have fewer side-effects when prescribed and monitored judiciously (Keith, 1997; Schneider, 1999).

Recent clinical trial studies with quetiapine have proven effective for long-term usage in providing relief across all symptomatic domains. Clinical relief is noted in positive, negative, cognitive and mood domains as well as in prevents relapse, somatic concerns, anxiety, guilt feelings, depression and compliance to treatment (Kasper, 2004). Priebe, Roeder-Wanner and Kaiser (2000) reported treatment compliance regarding schizophrenic client's quality of life, changes in anxiety and depression.

Although most schizophrenic clients who have learned the importance of taking prescribed medications may be trusted to monitor them, not all will be compliant. Less responsible clients may discontinue medications and relapse. Thus it is vitally important that a less responsible client have the assistance of family members and professionals to monitor the appropriate usage of the medications and insure that he or she does not stop taking them.

For clients not compliant with oral medications, long-acting antipsychotic drugs are available in injectable form. Haloperidol (Haldol) and fluphenazine (Prolixin) are both older anti-psychotics that are still being prescribed by injection every two or four weeks and have proven to be quite useful. Risperdal Constanta, an atypical antipsychotic, has been the first of its class to become available for long-acting use when given by injection every two weeks.

The following injectable antipsychotics are now used for maintenance therapy: fluphenazine (Prolixin Decanoate) – 14 days duration; haloperidol (Haldol Decanoate) – 21 days duration; risperidone (Risperdal Constanta) – 14 days duration; olanzapine (Zyprexa Pamoate) – 30 days duration; paliperidone (Invega Sustenna) – 28 days duration; aripiprazole (Abilify Maintena) - 28 days duration.

Catatonia Associated With Another Mental Disorder (Catatonia Specifier)

Definition:
APA (2013) is no longer a subtype rather was reclassified as a separate specifier and can occur with other disorders. The assessment includes 12 characteristic symptoms, three of which need to be met for a diagnosis. Catatonia can be a specifier for depressive, bipolar, and psychotic disorders. According to APA (2000, 2013), the distinguishing features of catatonic specifier are psychomotor disturbances that may involve immobility or excessive mobility, peculiar movements, catalepsy, stupor, waxy flexibility, extreme negativism, agitation, stereotypy, mannerism, posturing, mutism, echolalia, or echopraxia. Excessive motor activity experienced by individuals with this subtype is purposeless and not provoked by external stimuli. Immobility, sometimes referred to as catatonic posturing, may include waxy flexibility, a condition in which one's limbs can be arranged by another person and continue to remain in whatever position is imposed (Bootzin & Acocella, 1988). Many catatonics alternate between periods of immobility and heightened motor activity (Bootzin & Acocella). Catatonia diagnostic criteria include the predominance of at least three of the following (APA, 2013):

1. Motoric immobility as evidenced by catalepsy (2) or stupor (1)
2. Excessive motor activity (3) - purposeless
3. Extreme negativism (5) - motiveless resistance to all instruction or mutism (4)
4. Peculiarities of voluntary movement, stereotyped movements (8), prominent mannerisms (7), or grimacing (10)
5. Echolalia (11) - senseless, parrot-like repetition of word or phrase spoken by another person or echopraxia (12), imitation of movements of another person (p. 119).

Schizophrenia and Other Disorders Associated with Psychotic Features or Symptomology

Several disorders are contained within the classification of schizophrenia and other psychotic disorders, as follows: schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional

disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to another medical condition, substance-induced psychotic disorder and psychotic disorder not otherwise specified (APA, 2000).

Psychosis is manifested by perceptual distortions, delusions, or hallucinations. Auditory are more common than visual, tactile, or olfactory. Psychotic symptoms also may include disorganized speech and behavior. Each of the psychotic disorders is characterized by varying etiological, age of onset, duration and symptomatic characteristics.

Delusional Disorder

Definition and Interview:
Delusions are generally regarded as illogical perceptions impervious to empirical disconfirmation (Hollon & Beck, 1994). The APA (1994, p. 397) defined delusional disorder as the occurrence of non-bizarre delusions that occur for at least one month. The DSM-5™ no longer defines delusional disorder with a requirement of a delusion being non-bizarre (APA, 2013). The definition and criteria stipulate the presence of one or more delusions with a duration of one month or longer.

Formerly called paranoia or paranoid disorder, delusional disorder specifiers consist of delusions of grandiosity, eroticism, jealousy, somatic, mixed type, and unspecified type which are different from delusions associated with either a mood disorder or schizophrenia. The assessor is to specify if the delusion is with bizarre content. These delusions are often not bizarre in nature as are commonly found in schizophrenic patients (i.e., being followed by the FBI or being controlled by extra-terrestrials). These individuals also lack other schizophrenic symptoms, such as hallucinations, flat affect, and other aspects of thought disorder. Paranoia may also be found in other mental states such as dementia or delirium.

The cause of delusional disorder is not known and is much rarer than schizophrenia. This diagnosis is relatively stable and may arise as a normal response to abnormal experiences in the environment or organic changes in the patient's central nervous system that may occur, such as in delirium or dementia. Many clients with delusional disorder are socially isolated and may develop a profound distrust of others. They typically use denial to avoid awareness of painful reality or their own feelings of anger and hostility, tending rather to project their resentment and anger onto someone else.

The delusions experienced by these patients may be associated with tactile hallucinations but auditory or visual hallucinations, while potentially present, are not prominent. Psychosocial functioning of individuals suffering from delusional disorder is not generally impaired aside from the direct impact of the delusion. In the differential diagnosis, schizophrenia, in comparison to delusional disorder, is more likely to include additional symptoms besides delusions such as auditory hallucinations, disordered speech, negative symptoms, and more social impairment. The parameter of non-bizarreness creates a challenge for distinction between the two diagnoses. By definition, delusions present in a delusional disorder patient are those that could conceivably occur (e.g., being poisoned, stalked, admired, or deceived).

There are a number of specifiers for delusional disorder although the jealous type may be most common. The various types include **erotomanic** (central theme that another person is in love with the individual), **grandiose** (the conviction of having some great but unrecognized talent), **jealous** (the perception that one's spouse is unfaithful, derived from incorrect inferences serving as "evidence"), **persecutory** (perception that one is being conspired against), **somatic** (involves bodily functions or sensations), mixed (no one theme predominates) mixed and unspecified (type cannot be identified).

Delusional disorder may be difficult to diagnose when cultural and religious factors are associated with the "delusions." Gender differences do not appear to exist but compared to clients with schizophrenia, there is an older age of onset with this disorder, and individuals are more frequently married.

Incidence:
Incident rates are difficult to discern; however, it is estimated that the population prevalence is approximately .03% (1% to 2% of inpatient admissions in mental health facilities), and the morbidity risk is probably around .05% to 1% due to its primarily late age onset (middle age or late adult life; APA, 2000, p. 326). APA (2013) cited a prevalence rate of 0.2% and the most frequent subtype is persecutory.

Treatment:
Relatively little is known about the treatment of delusional disorder; clients usually deny they have a problem and are difficult to keep in treatment (Opjordsmoen, 1991). Treatment for delusional disorders is hospitalization to rule out any medical related causes. In addition, a neurological assessment may be necessary for explanations for the admitting causes.

Medication may be helpful if the patients are willing to take it. Supportive counseling or therapy is the mainstay. The clinician must attempt to develop a trusting relationship. During assessment of the delusions, be sensitive to the degree in which the client's core delusions will be met with a wall of negativism, skepticism, denial, and projection (McGlashan & Kristal, 1995).

Bipolar and Related Disorders

Bipolar and related disorders are separated from the depressive disorders because they are a bridge or link between schizophrenia spectrum and psychotic and depressive disorders (symptoms). Disorders included in bipolar and related disorders are bipolar I, bipolar II, cyclothymic disorder, substance/ medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder (APA, 2013).

Bipolar Disorder

Defnition and Assessment:
Bipolar and related disorders and depressive disorders are now separate categories. A recent change for assessing is that there is more of an emphasis on activity and energy in addition to an elevated or expansive mood.

Bipolar disorders, type I and type II are considered repetitive and/or chronic disorders with type I being the most severe and potentially psychotic. Bipolar symptoms are typically cyclic in nature with depression preceding mania although there are times when the cycle begins with a manic episode, followed by depression. The diagnosis of bipolar disorder may not always be clear, particularly when a client seeks a doctor's help for depression, is prescribed an anti-depressant medication, but then experiences anxiety, rapid onset of energy, difficulty sleeping, and possibly a clear-cut manic episode. Such a response to anti-depressant treatment indicates the presence of bipolar disorder, mixed type. A proper assessment is to include the activity and energy level of the client in addition to the heightened and elevated mood symptoms.

It most often starts with depression, followed by mania. Most individuals suffer both depressive and manic episodes although 10% to 20% experience only manic ones. Most commonly, manic episodes have a rapid onset but sometimes they may slowly evolve over a few weeks. When treated aggressively, a manic episode can be controlled within days with appropriate first line treatment-most often consisting of mood stabilizing or anti-psychotic medications or both in combination. Untreated it can last three months. Manic episodes may reach psychotic proportions and be misdiagnosed as schizophrenia, while depressive episodes may also reach psychotic proportions — both of which may include delusions and hallucinations. About 40% to 50% of bipolar disorder clients may have a second manic episode within two years. Forty-five percent have more than one episode and 40% have a chronic disorder with a frequency that may even reach 30 episodes over a lifetime. The prognosis for clients with bipolar I disorder is worse than for those with major depressive disorder. The prognosis for individuals with bipolar II disorder is less severe but also warrants long-term treatment (Kaplan & Sadock, 1998).

Incidence:
APA (2013) reports a prevalence rate for a twelve month period, as reported in the DSM-IV-TR, to be 0.6%. Hirschfeld, Young and McElroy (2003) reported a lifetime prevalence of 3% to 6% for bipolar disorder. According to Kates and Craven (1998), 1% to 2% of the population will experience a manic episode during their lifetime, equally probable across the gender line. The first episode generally occurs in one's early 20s, although there is concern that adolescent cases of depression are often undiagnosed. Bipolar disorder occurs at much higher rates in individuals with a family history (parental) of the disorder. The APA (1994) reports a greater than 90% recurrence of manic episodes in individuals who have experienced a single episode. 60% to 70% of manic episodes tend to occur immediately before or after a depressive episode.

Definition and Interview:
Bipolar disorder is characterized by the occurrence of one or more manic episodes or mixed episodes

amid intermittent episodes of depression (APA, 1994; Kates & Craven, 1998). Individuals suffering from bipolar disorder usually recover completely between episodes and may be symptom free for years. However, a few individuals may have frequent mood swings that can occur more than four times in a year (i.e., rapid cycling) with little mood stability between episodes (Kates & Craven). A distinction is made between bipolar I and bipolar II disorders in which bipolar I clients may experience more severe manic and depressed swings while bipolar II clients experience less extreme swings with hypomanic rather than manic episodes, respectively (APA; Kates & Craven).

Bipolar I Disorder

The diagnosis of bipolar I disorder involves a manic episode which may be preceded by and followed by a hypomanic or major depressive disorder (APA, 2013, p. 123). There are ten specifiers and a number of potential features. There are four different bipolar I diagnoses (current or most recent episode of manic, current or recent episode of hypomanic, current or most recent episode depressed, and current or most recent episode unspecified) and two bipolar II diagnoses. Bipolar clients experience a decrease in psychosocial functioning, family discord, Criterion A for bipolar I diagnosis accounts for the state of the individual and is summarized by the following (APA, 2013, pp. 126):

Presence of only one manic episode and no past major depressive episodes

Currency of a hypomanic episode (less severe than manic episode and without psychotic features)

Currency of a manic episode

Currency of a mixed episode

Currency of a major depressive episode

Currency of an unspecified episode.

When the specifier with mixed features is assigned this requires the presence of 3 symptoms of another episode that does not overlap with the primary mood episode.

Criterion B addresses the history of previous types of episodes or the manic episode is not better accounted for by psychotic type disorders such as schizophrenia affective disorder, schizophrenia, schizophreniform disorder, delusional disorder or other specified or unspecified schizophrenia spectrum (p. 126). Criterion C involves the degree of intensity of the episode or rule out parameters if Criteria A and B are not better accounted for by other psychotic type disorders.

Bipolar disorder comorbidity is known to exist with anxiety (Fogarty, et al., 1994), substance abuse (Kessler, et al., 1994), eating disorders (Angst, 1998), paraphilia (Nelson, 2001), attention-deficit/ hyperactivity disorder (Hudson, Mangweth, Pope, et al., 2003), impulse-control disorders-gambling (Pallanti, Quercioli, Sood, & Hollander,2002), conduct disorders (Boyd, 1984), autism, Tourette's syndrome, migraines (Merikangas, Angst, & Isler, 1990; McCracken, McGough, Bhavik Shat, et al., 2002), diabetes (Regenold, Thapar, Marano, Gavirneni, et al., 2003), and obesity (Hirschfeld, Young, & McElroy,

2003; McElroy, Frye, Suppes, Dhavale, Keck, Leverich, Kirk, Denicoff, Nolen, Kupka, Grunze, Walden, & Post, 2002).

Bipolar II Disorder

Bipolar disorder, type II is characterized by at least one episode of hypomania (never a full manic episode) and at least one or more episodes of major depressive episode and at least one hypomanic episode. APA (2013) reports a 12-month prevalence rate of 0.8% for United States. Bipolar II disorder clients have a history of life-time hypomanic episodes with a majority of depressive episodes. Caution is to be exercised in the diagnosis of depressed clients who may have undiagnosed bipolar II disorder in the depressive phase. These clients are frequently diagnosed with unipolar depression (Amsterdam & Brunswick, 2003; Basco, Merlock, & McDonald, 2003).Amsterdam and Brunswick point out that many bipolar II clients receive an incorrect diagnosis. The issue of clinical concern is that the two disorders have recommended different treatments (Hirschfeld, & Vornik, 2005; Hirschfeld, Young, McElroy, & Ginsberg, 2003). Some studies report that when antidepressants are prescribed to a depressed bipolar II client, such medications can contribute to rapid cycling and a more rapid onset of manic episodes (Ghaemi, Boiman, & Goodwin, 2000).

Dilsaver and Akiskal (2005) recommend caution when assigning a diagnosis of major depressive disorder to Hispanic adolescents when observation over time would reveal bipolar disorder to be more accurate. Their research findings showed that half of females and nearly two-thirds of male adolescents were assigned major depressive disorder by a health triage team. Of concern is that an individual with bipolar disorder might find an antidepressant medication precipitating anxiety or a manic episode. For this reason, it is important for non-medical clinicians to make a careful assessment that includes a family history for possible bipolar disorder, before asking a medical consultant to consider prescribing anti-depressant medication.

The diagnostic criteria for a bipolar II disorder is for a recurring mood episode consisting of one or more major depressive episodes (lasts two weeks) and at least one hypomanic episode (at least four consecutive days). The mood episodes require that five or more symptoms for Criterion A to be met for at least two weeks and one of the two symptoms must be either a depressed mood or loss of interest (p. 133). The mood is to be most of the time, nearly every day, and can be derived from a subjective report.

Treatment:
While pharmacotherapy has been well established and is generally the treatment of choice (Markovitz & Klerman, 1991), practical recommendations regarding the structure of the environment appear to be most productive (Janowsky, El-Yousef, & Davis, 1974). Structured settings might include reducing stimuli by setting limits such as restraining the expression of intense feelings (e.g., anger, frustration). Family intervention using behavioral family treatment has showed promising results in relapse prevention in combination with pharmacotherapy (Goodwin & Jamison, 1990).

Fountoulakis, Vieta, Sanchez-Moreno, Kaprinis, Goikolea, and Kaprinis (2005) conducted a critical review of bipolar treatments which was updated three years later with recommendations that

separate treatments be provided for manic, hypomanic, mixed, and bipolar depression diagnoses (Fountoulakis, Grunze, Panagiotidis, & Kaprinis, 2008). Recent findings and rigorous studies are being conducted to support sleep therapy for depression treatment (Carey, 2013 a, b). Sleep psychology is a study area for the American Psychological Association as a specialty. The sleep therapy is referred to as cognitive behavioral therapy for insomnia or CBT-I. To date CBT-I has a 40% to 50% cure rate and seems to have staying power. CBT-I is a collection of complementary ideas (stimulus control, sleep restriction, sleep diary, common-sense advice) or three elements. A standard questionnaire is filled out, agree or disagree items.

Pharmacotherapy:
Pharmacotherapy is considered to be the most effective treatment to control and stabilize bipolar symptoms (Markovitz & Klerman, 1991). The first medication approved by the FDA for the treatment of bipolar disorder was Lithium (Fountoulakis, Grunze, Panagiotidis, & Kaprinis, 2008; Goodwin & Viea, 2005) which is still widely prescribed primarily as a maintenance medication to prevent recurring bipolar symptoms, bipolar depression, and has been demonstrated to reduce the risk of suicide. Lithium has not proved effective to treat acute manic episodes or to control agitated behavior and it has side-effect risks such as a mild tremor, hypothyroidism or goiter, and potentially fatal toxicity from over-dose or renal failure. During the past 1 1/2 decades the FDA has approved a number of other medications including the atypical antipsychotics clozaril, aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, asenapine, laurasidone, and several anticonvulsive drugs, particularly valproate, carbamazepine, and oxcarbazepine along with others less commonly prescribed such as lamotrogine, gabapentin and topiramate. Lamotrogine has been found to be most effective for treating bipolar depression. In addition, the FDA has approved Quetiapine and the Olanzapine/ fluoxetine combination for bipolar depression.

Manic patients suffering from psychotic symptoms and acute agitation may respond more quickly to selected anti-psychotics and/or anti-convulsants, particularly olanzapine and/or valproate (Centorrino, Meyers, Ahl, et al., 2007). Fountoulakis, Grunze, Molar, Grunze, and Broich (2006) cite research findings that indicate the non-use of antidepressants should be avoided in bipolar clients because they might trigger manic episodes, rapid cycling, anxiety attacks, or agitation.

Monitoring for possible emerging symptoms or medication side-effects should be on the counselor's therapeutic agenda. Patients on lithium are treated by physicians who typically check their patients' lithium (blood or serum) levels on a regular basis. Monitoring efforts by the counselor should include reminding the client to have lithium levels checked according to the prescribing physician's recommendation. The therapeutic lithium range is always maintained between .6 and 1 and when the level goes higher than 1 there is potential life-threatening toxicity, possibly caused by an excessive lithium dose or poor kidney functioning or renal failure. Mild adverse effects may include gastrointestinal discomfort, nausea, vertigo, muscle weakness and a dazed feeling. As levels increase above 1 mmol/L side-effects may include fine tremor of the hands, fatigue, thirst, excessive urination and thirst. Serum levels approaching 1.5 mmol/L may cause increased drowsiness, ataxia, ringing in the ears, and blurred vision. Levels exceeding 1.5 may cause seizures, somnolence, confusion, and even death. The presence of such serious side-effects from lithium indicate the need for immediate medical intervention. Other significant side effects of bipolar agents include weight gain (olanzapine,

quetiepine, valproate), thyroid toxicity (lithium), hair loss (valproate), muscle tremors (lithium), liver function abnormalities (valproate and carbamazepine), abnormal muscle movements and rigidity (some anti-psychotic medications) and thrombocytopenia (Carbamazepine).

Monitoring is also important because of the high incidence of relapse, most often caused by non-compliance with prescribed medications. It has been reported by Gitlin, Swendsen, Heller and Hammen (1995) that 37% of bipolar clients relapse within one year and that 73% will relapse within 5 years.

Psychotherapy supports the use of family-focused (Rea, Thompson, Miklowitz, Goldstein, Hwang, & Mintz, 2003) and family psychoeducational programs (Simoneau, Miklowitz, Richard, Saleem, & George, 1999).

Effective therapies include brief cognitive (Cochran, 1984), cognitive-behavioral (Basco, Merlock, & McDonald, 2003), psychoeducational, and interpersonal social rhythm therapies (APA, 2002; Frank, Swartz, & Kupfer, 2000).These interventions are important because they can assist in increasing medication adherence, reduce relapse rates, shorten recovery time from the depression, and improve the overall functioning of the client (Keck, 2006). Mood charting is also recommended in order to recognize subtle mood changes and symptoms, trigger recognition, warning signs for acute episodes, and overall monitoring of the treatment protocol (APA, 2002).

Cyclothymic Disorder

Cyclothymic disorder has a life time prevalence rate of 0.4% to 1% in the general population (APA, 2000, 2013). It is a chronic disorder characterized by fluctuating moods involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms for at least two years. These symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for manic or depressive episodes. Criterion B requires that for a two-year period of time the hypomanic and depressive periods have been present for at least half the time and the client has not been without the symptoms for more than two months at a time (APA, 2013).

Depressive Disorders

Depressive disorders include disruptive mood disorder, major depressive disorder, persistent depressive disorder (dysthymia previously), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder (APA, 2013).

Individuals suffering from depressive disorders can experience great distress. In some cases depressive disorders, particularly depressed mood, may be in response to stressful life events including losses and physical illnesses. Individuals with depressed mood experience loss of energy and interest, guilt feelings, concentration problems, loss of appetite, and sometimes thoughts of death. Depressive

disorders may also include symptoms of anxiety, obsessions, irritability, physical symptoms, and insomnia. Such changes nearly always result in impaired interpersonal, social, and occupational functioning.

Individuals with elevated mood (mania) tend to experience expansiveness, heightened sense of esteem, grandiosity, diminished sleep, pressured speech, and excessive energy. Individuals suffering from recurrent mood swings (previously called manic depressive illness) will receive a diagnosis of bipolar disorder. Bipolar disorders usually begin during the first half of life, usually before age 50, and tend to be recurring with episodes lasting an average of several months.

It is now known that depressive symptoms are caused by abnormalities in at least three neurotransmitters - serotonin, norepinephrine, and dopamine. The most frequently prescribed antidepressants are the SSRIs (Selective Serotonin Reuptake Inhibitors) or SNRIs (Serotonin & Norepinephrine Reuptake Inhibitors), which focus on raising low serotonin or low serotonin and norepinephrine levels in the brain in depressed persons. It is recommended that antidepressants be taken for six to 12 months for a first time depression but individuals who have a recurring depression should continue medications indefinitely to prevent relapse. Although antidepressant medications are the most common treatment for depressed individuals, psychotherapy has also been found to be effective – either alone or in combination with antidepressant medications. Electro-Convulsive Therapy (ECT) has also been used with moderately good results for treating depressed individuals unresponsive to other therapies and who are considered suicide risks. Another treatment which is administered only in specific centers is transcranial magnetic stimulation (TMS), a noninvasive method to treat depression which causes depolarization or hyperpolarization in brain neurons. When treating bipolar disorders, psychopharmacological approaches are essential. Manic episodes are treated with anti-psychotics and/or mood stabilizing medications, mixed bipolar symptoms are treated with mood stabilizers which are most often specific anti-convulsant medications. A depressed individual with undiagnosed bipolar disorder must be properly assessed before mediation is prescribed because a manic episode may be induced if an antidepressant medication is given without a concomitant mood stabilizer (Kaplan & Sadock, 1998).

Major Depressive Disorder

The diagnosis of major depressive disorder falls within depressive disorders and also includes disruptive mood dysregulation, persistent depressive disorder, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. Bipolar and related disorders have been removed from the depressive disorder category.

Depression, the most prevalent mood disorder, is a vast topic that has been researched and studied exhaustively in the fields of both psychology and medicine. Depression underlies many mental and physical disorders and disabilities and may lead to suicide (Keller, 1994). It is estimated that more than eight million Americans suffer from depression each year (Keller, 1994; Matheny & Riordan, 1992). Clients diagnosed with depression show symptoms of an inability to carry out normal activities,

frequent absenteeism at work, and experience social and cognitive dysfunction (Kessler et al., 2003). In the workplace, depression accounts for approximately 11% of all absenteeism and half of all days lost due to a mental disorder (Goff & Young, 1996). According to a study by Goff and Young, people with major depression have more difficulty with day-to-day functioning than those with chronic physical conditions, such as hypertension, diabetes and arthritis. These researchers have also reported that 40% of those who are high users of medical care suffer from depression.

Definition and Interview:
Goals of the diagnostic interview should include gaining information about the client in a number of symptomatic response areas consistent with criteria from the DSM-5™. The interviewer should be aware that there are primarily two kinds of depression that are generally considered in the professional literature: biological and psychological (reactionary).

Biological depression is a result of the dysregulation primarily of three classes of brain chemicals or neurotransmitters: dopamine, norepinephrine and serotonin. Reactionary depression is a temporary response to stressful life situations (see adjustment disorder with depressed mood). Each kind of depression predisposes the other. Therefore, it is often difficult to determine which type of depression may be present. Mays and Croake (1997) elaborated on theories of depression to include cognitive, psychosocial, interpersonal and system models that attempt to explain the affliction of depression.

While there are a number of theories that attempt to explain causation, regardless of type, several symptoms must be present to consider major depressive disorder as the correct diagnosis. One or the other of these symptoms include the presence of depressed mood or loss of interest or pleasure in just about all daily activities, plus at least four or more additional symptoms from a criterion list of nine that includes the following (APA, 2013, 1994):

1. Significant weight loss (5% of body weight in one month)
2. Insomnia or hypersomnia nearly every day
3. Psychomotor agitation or retardation (observable by others) nearly every day
4. Fatigue every day
5. Feeling of worthlessness or excessive inappropriate guilt nearly every day
6. Diminished ability to concentrate
7. Recurrent thoughts of death or of suicide
8. Depressed mood most of the day as indicated by subjective reports or observation by others
9. Loss of interest or pleasure (pp. 160-161).

The interviewer should also inquire about the duration of symptomology and observe presenting features of the individual (e.g., tearfulness, complaints of pain, and obsessive rumination). The diagnostician should also consider the degree of severity of the episode or disorder, with or without psychotic features, recurrence, remissions, and other features such as catatonia (marked psychomotor

disturbance), melancholia (loss of interest or pleasure in all or nearly all activities), atypicality, postpartum onset, cycling, and seasonal patterns.

While depression is a common psychological diagnosis, it often goes unrecognized and untreated. It has also been pointed out that major depression is more common with divorced, widowed or separated individuals than with married with persons (APA, 1994). This is unfortunate, according to Keller (1994), because the recovery rates for the first and second year when treated properly are 70% and 81%, respectively.

Incidence:
Depression rates for individuals of culture living in different countries are scarce. A prevalence rate for Mexicans is considered to be 4.9% (Burnam, et al., 1987). Mexican Americans born in Mexico have prevalence rates which are lower (3.3%) compared to Mexicans born in the United States. Slone, Norris, Murphy, et al. (2006) in a study of depression in four cities in Mexico found that the lifetime prevalence rates in Oaxaca, Guadalajara, Hermosillo and Merida was 12.8% and was lower than prevalence rates for the United States (17.1%). A factor contributing to the lower rate is the intact family structures that appear to be a resilient to depression (Vega, et al., 1998). Diminished ability to think, sleep disturbances, weight and appetite symptoms were the most prevalent for those with lifetime experiences with depression (Slone, et al., 2006).

Treatment:
How should depression be treated? Wexler and Cicchetti (1992) noted from a compilation of outcome studies that psychotherapy is as effective as pharmacotherapy and psychotherapy combined. They have proposed a case for initially using psychotherapy to avoid medication non-compliance, prescription costs, and potential side–effects. These findings should be interpreted with caution in regard to individuals suffering from more severe depression, symptoms which, in general, require pharmacotherapy to control (Matheny, Brack, McCarthy, & Penick, 1996; Wexler & Cicchetti, 1992). In the current managed care environment, the use of medication is emphasized and a significant percentage of depressed patients who are prescribed the newer and safer antidepressant medications will respond with generally good results.

Gilliam and Cottone (2005) support couple's therapy when one of the partners is diagnosed with a major depression and there is evidence of marital distress. They suggest that outcome effectiveness is better with couple therapy than individual therapy. The clinician may consider the 'matching hypothesis' (Beach & O'Leary, 1992) that marital discord is a predictor of poorer outcome for depression and cognitive dysfunction predicts a poorer outcome for couple therapy to treat depression. The authors do suggest that additional research is needed concerning couple therapy for depression.

Persistent Depressive Disorder (PDD)

Dysthymic disorder is renamed persistent depressive disorder in the DSM-5™ (APA, 2013). Persistent depressive disorder includes a specifier and was combined with persistent major depressive disorder.

PDD is a chronic disorder characterized by the presence of a depressed mood that lasts most of the day and is present on most days for at least two years. The depressed mood can be reported by the client or observed by others. Most typical features of the disorder are feelings of inadequacy, guilt, irritability, sad or in the dumps, and anger; withdrawal from society; loss of interest; and inactivity and lack of productivity. The term dysthymic (persistent depressive disorder), which means ill-humored, was introduced in 1980 and changed to dysthymic disorder in the DSM-IV and to persistent depressive disorder in the DSM-5™. Previous terms were neurotic depression or depressive neurosis. It commonly affects the general population at a level of 3% to 5 %, and is very common in general psychiatric clinics where it affects one-half to one-third of all clients. PDD frequently co-exists with other mental disorders, particularly major depressive disorder, anxiety disorders, substance abuse and some personality disorders (Kaplan & Sadock, 1998).

Definition and Interview:
PDD refers to a prevalent form of sub-threshold depressive pathology characterized by features such as morosity, introversion, low-energy, low-drive, low self-esteem, anhedonia, eating and sleeping disturbances, a pessimistic outlook, suicidal ideation and/or an inability to have fun (Akiskal, 1983; Bootzin & Acocella, 1988; Brunello et al., 1999). Although comorbidity with panic, social anxiety, phobia and alcohol use disorders has been described, the most significant association is with major depressive episodes. Family history is replete with affective disorders, including bipolar disorders. Genetically predisposed individuals may suffer childhood onset mood swings, both spontaneously and upon psychological challenge in as many as 30% of sufferers (Brunello et al., 1999).

According to the APA (2000) the essential difference between major depressive disorder and PDD is that major depressive disorder is more discrete and severe, while PDD is characterized as a chronically depressed mood with diminished self-esteem that occurs for most of the day, for more days than not, for at least two years. The absence of suicidal thoughts seems to distinguish dysthymic disorder from that of major depressive disorder, while symptom-free episodes occurring longer than two months would rule out the diagnosis of dysthymic disorder. Major depressive episodes may be "super-imposed" (p. 346) on the existing dysthymic, creating the scenario for a double depression diagnosis.

Diagnostic features for persistent depressive disorder for Criterion A is characterized by being depressed in mood for most of the day for at least two years, Criterion B meeting two or more from the list of six, and Criterion D a major depressive disorder continuously present for two years (p. 168). Criterion B includes:

1. Poor appetite
2. Insomnia or hypersomnia
3. Low energy
4. Low self-esteem
5. Poor concentration
6. Feelings of hopelessness (p. 168)

Incidence:
The lifetime prevalence of dysthymic disorder is about 6% and is two to three times more likely to occur in women than men. In children, gender prevalence rates seem to be equal (APA, 2000, p. 378-379). APA (2013) reports a prevalence rate of 0.5% for PDD and 1.5% for major depressive disorder.

Treatment:
While research on treating dysthymic has been sparse, Klerman, et al. (1994) acknowledged the value of interpersonal therapy while Markovit and Klerman (1991) noted cognitive therapy to be an effective treatment approach. With the advent of effective anti-depressant medications there has been more attention paid to the logical benefit of combining psychotherapy with medications. Few trials have been conducted to support the efficacy of adjunctive medication (Klerman, et al., 1994). However, Ravindrum, et al. (1999), reported that cognitive therapy was no better than placebo and that treatment with an SSRI antidepressant, with or without cognitive group therapy, reduced the functional impairment of depression. Other researchers comparing the effectiveness of psychotherapy with anti-depressant medication have shown that psychological interventions, particularly cognitive–behavioral therapy, are at least as effective as medication in the treatment of depression when outcome is assessed with patient-rated measures and long-term follow-up is considered (Antonuccio, Danton & DeNelsky, 1995). A study of the effectiveness of psychotherapy combined with the anti-depressant Nefazedone was found to be superior to either intervention alone in 681 patients with chronic depression who reportedly had an 85% response rate over a three month period (Keller et al., 2000). Nefazedone is now rarely prescribed since several cases of irreversible liver toxicity were reported in 2003.

Antidepressants from different classes, specific to either/or noradrenergic, serotonergic, or dopaminergic mechanisms of action, have been shown to be effective against dysthymic in an average of 65% of cases (Brunello, et al., 1999). The antidepressant medications include several groups. The tricyclics, which act on two neurotransmitters serotonin and norepinephrine, include (amitriptyline (Elavil), doxepin (Sinequan), imipramine (Tofranil), desipramine (Norpramin), clomipramine (Anafranil) and nortriptyline (Aventyl, Pamelor) and have been effectively used to treat depression for many years. Unfortunately their somewhat adverse side effect profile has reduced acceptance by many patients. Similarly, MAO inhibitors (MAOIs) (Emsam (selegiline), Marplan (isocarboxazid), Nardil (phenelzine), and Parnate (tranylcypromine), which act by inhibiting the activity of monoamine oxidase may cause potential serious side-effects. The biological effect of MAOIs is to prevent the breakdown of monoamine neurotransmitters (serotonin, melatonin, epinephrine, norepinephrine, and dopamine) so that they increase within the circulation. Individuals who consume foods containing tyramine (found in cheese) or foods containing tryptophan, or certain red wines are at risk to suffer a hypertensive crisis caused by excessive amounts of norepinephrine suddenly flooding circulation. However, the recently introduced Selegiline transdermal system introduces a MAO inhibitor into the system via the skin so that this potential crisis is averted, promising no significant side-effects. MAOIs are still being prescribed and are often effective when other anti-depressants have not worked, but cannot be prescribed at the same time as traditional anti-depressants, amphetamines, chlorpheniramine, cocaine, cyclobenzaprine, dextromethorphan,

phencyclidine (PCP), pheniramine, and some over-the-counter food supplements such as St. John's Wort, or a potentially fatal reaction might occur.

Before making a switch between an MAOI and another anti-depressant, there should be a two week washout period before starting the other medication.

The SSRIs (selective serotonin reuptake inhibitors) have become more widely prescribed since the early 1990s and include fluoxetine (Prozac) as the first one introduced. The most recent is vilazodone (Viibryd). Others include escitalopram (Lexapro), sertraline (Zoloft), paroxetine (Paxil), Fluvoxamine (Luvox) and citalopram (Celexa).Selective serotonin reuptake inhibitors act only on the neurotransmitter serotonin. Other antidepressants which work somewhat differently than the SSRIs, MAOIs and tricylics include nefazedone (Serzone), bupropion (Wellbutrin), mirtazapine (Remeron) and trazodone (Deseryl). Venlafaxine (Effexor) and duloxetine (Cymbalta) are Serotonin and Norepinephrine Reuptake inhibitors (SNRIs) which are more effective compared to the SSRI antidepressants in some patients and also appear to help control pain — particularly caused by damaged nerves. This availability of effective anti-depressant medications is a promising development because social and characterologic disturbances, so pervasive in dysthymic, often recede with continued pharmacotherapy.

Extended Bereavement Exclusion:
The DSM-5™ considers the possibility that when symptoms of depression occur after a significant loss that these symptoms could be more than bereavement. The guideline for differentiating might be that; a) grief may subside over weeks, b) grief tends to come in waves, and c) cultural factors should be considered (APA, 2013, p. 126). A significant loss may be bereavement, financial ruin, losses from a natural disaster, serious medical illness or disability.

Normal grieving is not considered a disorder and passes through different phases such as anger, numbness, insomnia, crying, appetite loss, sighing, and sense of unreality, guilt, denial, disbelief, and thoughts of the dead (Brown & Stoudemire, 1983). If a grieving person becomes "fixed" in any of these phases after a significant loss and symptoms become exaggerated, the bereaved individual may appear to have a mental disorder and may, in fact, develop symptoms consistent with major depressive disorder. According to Hensley and Clayton (2008) about 24% of bereaved individuals meet criteria for major depression at two months, 15% at one year, and about 7% at two years. Although grieving is considered normal, it does depend upon the characteristics of the griever and the nature of the loss (Schwartzberg & Halgin, 1991). Persistent complex bereavement disorder was included in the chapter for further study.

Treatment:
The treatment for individuals who are suffering from bereavement is supportive counseling. Treatment is usually brief, and the procedure is to work through the developmental process of the loss. Many individuals also have benefited from supportive group therapy when the focus of the group is seeking resolution from impacted grief. Specifically, client-centered therapy provides nurturing and empathetic understanding; Gestalt therapy focuses on feelings; cognitive therapies emphasize client awareness of destructive thought patterns, and behavior therapies focus on specific behaviors.

Allumbaugh and Hoyt (1999) in conducting a meta-analysis of effectiveness of grief therapies found inconclusive evidence of grief reduction effectiveness.

Bereavement versus Major Depressive Disorder

Bereavement (normal) and clinical depression (not normal) are commonly linked to each other but also sometimes confused. The suddenness of the death and the length of the period of shock and disbelief shape the length and intensity of grief. When death has been long anticipated, much of the mourning period may have already occurred. Traditionally, grief normally lasts about 6-12 months. Feelings of sadness, preoccupation with thoughts about the deceased, tearfulness, irritability, insomnia, and difficulties in concentrating and carrying out daily activities are some typical signs and symptoms. Sometimes, symptoms of grief may persist much longer than a year. Survivors also may experience various grief-related feelings, symptoms, and behaviors throughout life. In general however, acute grief symptoms gradually lessen within one or two months as survivors are able to return to normal eating, sleeping, and general functioning patterns.

Pathological bereavement may result when the loss is sudden, caused by horrific circumstances, is associated with guilt, and if there was an intensely ambivalent or dependent relationship to the person who died. Because pathological bereavement is often associated with traumatic death there may also be symptoms consistent with post-traumatic stress disorder. In addition there are often additional symptoms, including: (a) guilt about actions taken or not taken by the survivor at the time of the death; (b) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; (c) morbid preoccupation with worthlessness; (d) marked psychomotor retardation; (e) prolonged and marked functional impairment; and (f) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person. The diagnosis of major depression may be given to someone severely bereaved whose symptoms meet the criteria for that diagnosis and have persisted for two months or more after the loss. The treatment of major depression, as previously described, generally warrants the use of antidepressant medications.

Anxiety Disorders

A number of disorders are contained within the classification of anxiety disorders. According to the American Psychological Association (APA, 2013) these are: separation anxiety, selective mutism, specific phobia, social anxiety disorder, panic disorder, agoraphobia, generalized anxiety disorder, substance/medication-induced anxiety disorder, anxiety disorder due to another medical condition, other specified anxiety disorder and unspecified anxiety disorder. Anxiety disorders no longer include OCD, PTSD, and acute stress disorders. Panic attack with and without agoraphobia are unlinked and are separate disorders, panic attack and agoraphobia.

Fear and anxiety are predominate emotions and autonomic responses. Assessment for anxiety disorders tends to be differentiating according to age of onset, the different types of objects or fears, autonomic reactions, thoughts, danger expressed, and escape from the situations.

This section of the preparation supplement for the clinical mental health examination will focus upon generalized anxiety disorder, agoraphobia, panic disorder and anxiety disorder due to another medical condition. Each of the anxiety disorders has a given specific set of symptoms and specifiers that define that particular disorder.

Beidel and Turner (1991) have differentiated anxiety disorders from normal anxiety by considering the severity of the symptoms, disabling effect on work, interpersonal relationships, and daily functioning. Reiss (1980) indicates that fear of injury, anxiety, and social fears are fundamental and cut across all anxiety disorders. Anxiety may or may not include the typical physiological symptoms referred to as panic attacks. If present, the counselor may consider whether the panic attacks were unexpected, situationally bound, situationally predisposed and whether they include at least four or more of the 13 characteristics of a panic attack.

Definition and Interview:
Individuals experiencing anxiety have one or more of the following presenting symptoms: emotional (fear and dread), cognitive (worry), physical/physiological (palpitations, tightness in the chest, shortness of breath, physical tension) or behavioral (fight/flight). Knowing the relationship of the main presenting symptom to the disorder provides a clue to the type of anxiety disorder from which the client suffers. However, Fong and Silien (1999) and Brown, O'Leary, and Barlow (1993) suggest that individuals with different anxiety disorders may share similar symptoms. One such symptom is anxious apprehension.

Anxious apprehension is defined as "a future-oriented mental state in which the individual becomes anxiously concerned and/or cognitively prepared for upcoming negative events" (Brown et al., p. 13). A panic attack has both physiological and behavioral components (i.e., an unknown precipitating event triggers a predictable physiological response along with automatic withdrawal and avoidance). All of the different anxiety disorders share avoidance as a common symptom. For example, as a defense against experiencing panic, the anxious client avoids certain situations: leaving home (Agoraphobia), group situations (social phobia), traumatic reminders (post-traumatic stress disorder/PTSD), and dirt or disorderliness (obsessive-compulsive disorder).

Fong and Silien (1999) indicated that many of the anxiety disorders have behavioral symptoms, which tend to be diagnosed in relationship to the presence (PTSD) or absence (panic disorder, OCD, generalized anxiety disorder) of antecedents or consequences. But antecedents are not always clearly remembered because anxious patients may recall, repress, or avoid the memory of a stressful past experience.

Incidence:
Many of the anxieties are rooted in childhood and females are approximately a 2:1 ratio compared to males (APA, 2013). Frances and Ross (1996) indicated that anxiety disorders are the second most common type of all mental disorders and are frequently misdiagnosed or unobserved. The National

Comorbidity Survey data reveals that 24.9% of the population experiences symptoms typical of an anxiety disorder at some time during their lifetime (Kessler et al., 1994).

When conducting a diagnostic interview, the interviewer should assess the duration, frequency, onset, antecedents, and consequences of the specific symptom (Fong & Silien, 1999) and use a step-by-step interviewing format like the following:

Assessing Anxiety Disorders

Step 1: Ask about the problem. In response to the client's complaint "I have anxiety attacks" the interviewer should ask an open-ended question: "Can you describe your anxiety attacks for me? "If the client describes four (or more) of the following symptoms, a diagnosis of panic attack can be made:(1) palpitations (rapid pounding heart) (2) sweating (3) trembling or shaking (4) shortness of breath (5) feeling of choking (6) chest pain or discomfort (7) nausea or abdominal distress(8) lightheadedness (9) derealization or depersonalization (10) fear of losing control or going crazy (11) fear of dying (12) numbness or tingling (13) chills or hot flushes (APA, 1994).

Step 2: Ask if there were any precipitating events or antecedents to the panic attack (panic attacks may or may not be a symptom of panic disorder). Frances, First and Pincus (1995) and APA (1994) differentiate according to whether the panic attack was uncued (unexpected) such as occurs with panic disorder, cued (situationally bound) as occurs within social phobia, or non-specific situationally predisposed anxiety.

Step 3: Assess for the cognitive content of the anxiety by asking the client what thoughts or memories went through his or her mind when feeling anxious (i.e., obsessive worrying about a child becoming injured).

Step 4: Explore the client's life history for prior traumatic or disturbing happenings. Fong and Silien (1999) stress that the client will often present an acute picture of current emotional symptoms but fail to relate this to events in the past. When asking specifically about possible traumatic events (assault, rape, abuse, witnessing violence), the interviewer should allow the client the freedom to discuss any or all such events, as well as the option to avoid talking about them.

Step 5: Be aware of specific cultural, age, or gender variations, which may be associated with anxiety. Age is a factor to consider when the individual is over 40 years of age (Smith, Sherrill, & Colenda, 1995). Cultural differences will influence the causation and types of anxiety symptoms found among specific cultural groups such as Cambodian refugees, Native Americans on reservations, homosexuals, and first-year college students.

Step 6: Inquire about medical conditions and use of medications or other substances. Some medical conditions are known to cause or be associated with anxiety such as hyperthyroidism, mitral value prolapse, withdrawal symptoms from discontinuing alcohol, anxiolytic and certain antidepressants (APA, 1994, p. 400), and temporal lobe epilepsy (Coplan, Tiffon, & Gorman, 1993).

Step 7: Once medical conditions and substances are ruled out, the task is to identify whether attacks are random, predictable, or episodic. Panic disorder is characterized by unpredictable episodic panic

attacks. Persistent "worry" and non-specific anxiety is consistent with generalized anxiety disorder. Repetitive compulsive rituals are associated with obsessive compulsive disorder (OCD). Mixed anxiety symptoms, intrusions, and nightmares follow post-traumatic stress and acute stress disorders. The presence of more than one anxiety disorder together or combined with a personality disorder such as obsessive compulsive personality disorder or borderline personality disorder complicates the diagnostic process. (As noted in the introduction, multiple or dual diagnoses will be given limited attention in this manual.)

In summary, the interviewer should assess for the major symptom or symptoms, original cause, precipitating events, and the extent of impaired functioning. The interviewer should not forget to review any medical conditions or use or abuse of substances, which might have set off this syndrome. A final step is to determine the specific anxiety disorder, any other co-existing disorder and a personality disorder, if present.

Instrumentation:
A number of interview scales and instruments will be listed for the anxiety disorders described in this supplement. The authors are not endorsing the instruments as the best for each disorder. The instrument selection still has to be based upon the reason for referral and the strengths and weaknesses of the specific instrument.

1. The Multicenter Collaborative Panic Disorder Severity Scale (Shear et al., 1997). This is a seven-item scale which uses single items to measure the multiple components of the panic syndrome.
2. Pharmacotherapy of Panic Disorder. An anxiety self-report rating scale used effectively for patients to monitor their own symptoms. (Roy-Byrne, Stein, Bystrisky, & Katon, 1998).
3. Cognitive-Somatic Anxiety Questionnaire (Schwartz, Davidson, & Goleman, 1978). This instrument is a self-report to measure cognitive and somatic components of anxiety.
4. Clinical Anxiety Scale (CAS; Westhuis & Thyer, 1986). The CAS is a scale to measure the amount, degree or severity of clinical anxiety.
5. Beck Anxiety Inventory

Separation Anxiety Disorder (SAD)

Definition and Assessment:
John Bowlby's early work on attachment focused on relationships and environment that he believed shaped early development. This belief was centered on his observations in how animals seek protection when frightened (survival pattern). He translated this idea to humans. He further conjectured that this concept was not just because of feeding rather, in addition, the disposition of closeness with a protective person. From these observations he developed two principles; early interactions with caretakers shape the quality of attachment relationships and relationships attachment becomes the foundation for later personality development (Sroufe & Siegel, 2011).

Mary Ainsworth conducted field experiments and focused on attunement (sensitive responsiveness to an infant's cues (cries) critical to determine the type and quality of interactions between the caregiver and infant. When caregivers willingly and effectively respond to an infant's cry, less crying. When there is less crying the infant begins to trust that the caregiver is reliable and displays confidence in the caregiver (securely attached). The 'strange situation' procedure was developed by Jane Ainsworth which created separation anxiety between the infant and caregiver. The observer evaluates how the infant reacts to the reunion and determined that there were different attachments. The patterns she found were secure, anxious, avoidant, ambivalent/resistant, and disorganized.

The reunion is what determined the classification. These classification are securely attached, anxious attached, avoidant attached, anxious resistant, and disorganized. The significance may not be a dysfunction but is likely to be a liability and if not corrected could lead to psychological dysfunctions. The secure attached child seeks or is active in initiating renewed engagement. The anxious attached infant actively avoided the caregiver upon reunion or failed to be comforted by the caregiver. The avoidant attached experienced routine rebuffs when the infant needed tender care. They were held as much but not when they needed it. The anxious/resistant attached fail to be comforted (passive or angry) upon reunion.

Bowlby and Ainsworth believed that the relationship between the caregiver and infant was basis for emotional regulation. If the infant felt or experienced rejection the result might be that the child would interpret or sense others rejection. Bowlby saw attachment and attunement as the pathway for development yet some infants were constrained by either paths taken. The basis of these ideas promoted an interpretation that if a child had an anxious/resistant type of development it more likely increased the probability for anxiety disorders, avoidant attachment more likely increased the probability of conduct disorders, and disorganized attachment (frightened or a parental abusive behaviors) created in the child an irresolvable conflict (an avoidance-avoidance conflict) and dissociation (Soure & Siegel, 2011). This was based upon the pattern of behavior established during infant development and that corrective pathways or patterns were forthcoming.

APA (2013) defines separation anxiety disorder as a "developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached" (p. 190). For this diagnosis to be made the client must have at least three symptoms from Criterion A and the fear is to be evident for at least four weeks for children and at least six months for adults (Criterion B). Home and major attachment figure are the prominent themes within the eight symptoms for Criterion A. Paraphrased the symptom list includes recurrent fear or excessive distress anticipating or experienced separation, persistent and excessive worry about losing major attachment figures, persistent and excessive to the point it could lead to separation from a major attachment figure, persistent reluctance or refusal to go out, away from home, school work, for fear of separation, excessive fear or reluctance about being alone or without major attachment figure, reluctance or refusal to sleep away from home or go to sleep without major attachment figure, repeated nightmares involving the theme of separation, and repeated complaints of physical symptoms when anticipating or experiencing separation from major attachment figure (p. 190-191).

The assessor is likely to recognize comorbidity with generalized anxiety disorder when working with children and PTSD, panic disorder, GAD, social anxiety disorder, agoraphobia, OCD and personality disorder with adults (APA, 2013).

Incidence:
A 12-month prevalence according to the DSM-5™ (APA) in children 6-12 is approximately 4% and adults 0.9%-1.9%.

Treatment:
Most treatment programs that are family oriented recommend parent training. There is literature to support the fact that the mother may have had exposure, as a child, to certain aspects of separation issues thus models it to the child.

A behavioral approach offered by Dia (2001) has a four phase approach that includes psychoeducation for parents and client, development of cognitive-behavioral coping strategies, graded exposure and family work, and a booster session.

There are a number of family treatment procedures that have been utilized with SAD. Two different family programs, a Family-Based Cognitive-Behavioral Treatment (FBCB) and Cognitive Behavioral and Attachment Based Family therapy (ABFT) report success for the family and for the child (Siqueland, Rynn, & Diamond, 2005).

The FBCB program consists of sixteen 50 minute sessions broken into segments. Treatment consists of four weekly sessions with the child and four weekly sessions with the parents. The main focus for these sessions is psychoeducation about anxiety, reframing irrational beliefs, coping strategies, and the rational for exposure. The second segment is an eight week portion divided into parent-child and parent-only. The family sessions focus on exposure in vivo planned and practiced with the last session a planning session for any relapse. The parent-only sessions are devoted to discussing and practicing parent behavior during the exposure sessions. This program was compared to a child-focused group for the same time period of sixteen 50 minute sessions (Schneider, Blatter-Meunier, Herren, In-Albon, Adornetto, Meyer & Lavalee, 2013).

The Coping Cat Model as reported by Podell, Martin, and Kendall (2008) and Podell et al. (2010) is an evidenced based manualized approach program that involves cognitive, affective, sociological, parent and family as well as psychoeducation. The two part program consists of education and exposure.

There are a number of techniques that are incorporated within these family programs such as reframing, restructuring, relaxation, and deep breathing for anxiety reduction.

Social Anxiety Disorder (Social Phobia)

Definition, Interview, and Assessment:
A phobic disorder is noted by a persistent fear of objects or situations to which exposure to the phobic stimulus elicits an immediate anxiety response of panic. A social anxiety disorder or phobia is a fear of public scrutiny in one or more places and evaluation resulting in humiliation or embarrassment and

impairment in functioning. Otto and Gould (1996) illustrate three maladaptive conditions associated with cognitive functioning. These are: a) under-estimating his or her ability to cope in social situations; b) exaggerating the perceived consequences of performing adequately in social situations; and c) rehearsing self-defeating and global failure attributions about themselves and their future social behavior. These thought patterns and fear of negative evaluations by others cause avoidance behaviors.

The DSM-5™ has removed from the criteria that the individual is to recognize their fear is excessive or unreasonable. A minimum time frame of six months is required and the types of specific situations are specifiers. Criterion A provides specific situations in which the individual is feeling a fear or anxiety such as social interactions, being observed, performing or in a conversation. Criterion B stipulates that the individual acts or shows the symptom in a negative way. Future involvements in that situation will be avoided (Criterion C), out of proportion (E), last for six months (F), impairment (G), not attributable to physiological effects of substance (H), not another mental disorder (I), if medical, fear is unrelated to or is excessive (APA, 2013, p. 202-203).

Incidence:
The two month prevalence is approximately 7% (APA, 2013). Social phobia is considered one of the most prevalent anxiety disorders in the United States with a conservative incidence of 2% to 3% in the general population reported by Otto and Gould (1996) and a higher incidence – up to 13% – also reported (APA, (2000, p. 453); Kessler et al. (1994). Fear of public speaking appears to be one of the most prevalent of the Social Phobias. Age of onset is at 16 (Öst, 1987) although peaks at 5 and 13 years have been found to exist (Juster, Heimberg, & Engelbert, 1995). Clients with social phobia tend to live alone, be unemployed, and abuse alcohol more than those clients with panic disorder (Norton et al., 1996). Adult social phobia and fear of negative evaluation may not develop until somewhat later in life (Bennett & Gillingham, 1991; Crozier & Burham, 1990).

Instrumentation:
Instrumentation can be helpful in sorting out associated features of a disorder and in determining a differential diagnosis between all of the anxiety disorders. The instruments selected to assist in the assessment (subjective-cognitive) data-gathering should be chosen for their diagnostic specificity. The presenting order of the instruments does not indicate preference.

1. Diagnostic Interview Schedule for Children (Costello et al., 1984)
2. Schedule for Affective Disorders and Schizophrenia for Children (Puig-Antich & Chambers, 1978)
3. The Anxiety Disorders Interview Schedule for Children (Albano & Silverman, 1996)
4. Social Anxiety Scale for Children-Revised (LaGreca & Stone, 1993)
5. Social Phobia and Anxiety Inventory for Children (SPAI; Beidel, Turner, & Cooley, 1993; Beidel, Turner, & Morris, 1995)
6. Social Phobic Scale and Social Interaction Scale (SIAS; Mattick & Clark, 1989)

7. The Social Avoidance and Distress (SAD) and Fear of Negative Evaluation (FNE; Watson & Friend, 1969)
8. The Interaction Anxiousness Scale (IAS; Leary, 1983)
9. Brief Social Phobic Scale (BSPS; Davidson, Potts, Richichi, Krishnan, Ford, Smith, & Wilson, 1991)
10. Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987)

Assessment:
When making a diagnosis of social phobia the evaluator should ask about specific situations that trigger symptoms. The differential diagnosis should also be assessed to include avoidant personality since the boundary between social phobia and avoidant personality is not always clearly distinct. Individuals with avoidant personalities have life styles pervaded by the avoidance of interpersonal relationships and social encounters while individuals with social phobias tend to have symptoms in more specific conditions. Although they may have phobic symptoms in generalized conditions (fears in all domains) it is more likely that symptoms are associated with specific conditions. These may include entering rooms or locations under public scrutiny, answering questions where everyone can hear, speaking in a class or group settings, formal speech making to a large group, and being in a setting where one is afraid of being noticed. The diagnosis of social phobia may also have specific subtypes, one of which is social phobia, performance anxiety. These subtypes are credited to Heimberg (Heimberg, Holt, Schneier et al., 1993).

Treatment:
The treatment of choice for social phobias is cognitive-behavioral therapy. Hope, Herbert and White (1995) conducted a study using group therapy to treat social phobia and results indicated client improvement. Psychopharmacology has also been effective and SSRI antidepressants, particularly Paroxetine, which has received approval from the FDA to treat social phobia, have been found to be useful.

Panic Disorder

Definition and Interview:
The APA (2013) defines panic disorder as the occurrence of recurrent, unexpected panic attacks. The panic attack is an abrupt surge of intense fear/discomfort that reaches a peak within minutes and the client experiences at least four of the 13 symptoms in Criterion A (APA, 2013, p. 208). The panic attack is followed by at least one month of persistent concern about having another panic attack, worry about possible consequences, or significant related behavior change (Criterion B) Fear and avoidance of situations or events associated with previous panic attacks also occur. A panic attack is defined as an episode of intense fear of sudden onset, usually peaking within one minute. The fear, often bordering on terror, is generally accompanied by unpleasant bodily sensations, difficulty in reasoning, and a feeling of imminent catastrophe which can be expressed as "something terrible is happening to me " (Rachman & de Silva, 1996, p. 1).

The fear or discomfort in surge from calm to an anxious state in a panic attack is assessed from the list of specifiers that include, palpitations, sweating, shaking, shortness of breath, choking feeling, chest pain, nausea, feeling dizzy, chills, numbness/tingling, derealization, losing control feeling and a fear of dying (APA, 2013, p. 208).

Panic attacks can be unpredictable (uncued) and seem to surface with no known cause while some are caused by exposure to stressors (cued), situationally predisposed (Rachman & deSilva) and finally nocturnal (waking from sleep in a state of panic (Craske, 1999). A cued attack is one in which the person is exposed to the triggering situation, such as a spider or a roach or a social situation, characteristic of phobic disorders. A predisposed situation is defined as part of the evolution of panic attacks wherein the person develops a conditioned response to the panic attack and begins to avoid situations in which an attack may be likely.

Symptoms specifically related to panic disorder include heart palpitations, shortness of breath, dizziness, chest tightness, and fear of dying. The DSM-IV-TR lists 13 symptoms at least four of which must be present (APA, 2000). Specific panic attacks usually last 10-15 minutes, leave the sufferers feeling spent and drained of energy, and are usually not triggered by specific external events. However, Otto and Gould (1996) indicated that individuals with panic disorder often recall their initial panic attacks as having first occurred after a significant stressful event or events.

Incidence:
The DSM-5™ reports a prevalence rate of 0.2% - 0.3 % for adults and adolescents (APA, 2013). Bradley, Wachsmuth, Swinson, and Hnatko (1990) and Sargent (1990) approximate that 2.9 to more than 4.0 million in the general population experience panic attacks. Panic disorders are reported to affect 1.5% of the general population at some time during their lives (Clum, Clum, & Surls, 1993; Rachman & deSilva 1996; Weissman, 1994). Nutt, Ballenger, and Lepine (1999) found that lifetime rates of panic attacks worldwide are in the range of 7% to 9%. These authors suggest that panic disorders occur twice as frequently between the ages of 25 to 44 than any other age group. Lifetime prevalence for community samples is 3.5%, mental health settings 10%, and 10% to 30% in medical settings (APA, 2000, p. 436).

Counselors should be aware that persons with panic disorder rarely come for mental health treatment until they have exhausted all medical options because their symptoms, which typically involve chest pains and shortness of breath are severe enough to prompt hospital emergency room visits and/or referrals to cardiologists. Research has indicated that panic disorder clients receive four times the number of medical tests and procedures as the average primary care patient.

Diagnostic Consideration:
Panic disorder is a psychiatric condition manifested by panic attacks not precipitated by any known triggering events and often, but not always, associated with agoraphobia. Lifetime prevalence rate is 3.5% (APA, 2000, p. 436). The typical age of onset is between late adolescence and the mid-30s. This disorder is chronic and progressive, although sometimes waxing and waning. Agoraphobia may develop at any point but the onset is usually within the first year (30% to 50% of the time). In some cases, Agoraphobia may become chronic, regardless of the presence or absence of panic attacks.

Concurrent Diagnosis:
Panic disorder may occur in conjunction with other disorders, and in adolescents, includes behavior disorders and ADHD. In adults, major depression, post-traumatic stress disorder, and generalized anxiety disorder are not uncommon. The co-morbidity rates between anxiety disorders and depressive disorders are significant. Additionally, a psychiatrist may at times have to choose whether it is the anxiety disorder or the depressive disorder that is primary vs. secondary when choosing medication options. In fact, the incidence of major depression among individuals with untreated panic disorder is significant and frequently undiagnosed causing a fairly high rate of suicide. Depressive symptoms may include preoccupation with guilt feelings, physical symptoms, ill health and poverty. Consider the following depressive disorders as sometimes accompanying panic or other anxiety disorders.

Treatment:
Beamish et al. (1996) conducted outcome studies for the treatment of panic disorders and found psychopharmacological and cognitive-behavioral interventions as more effective than other forms of treatment. McCarter (1996) has reported on the effectiveness of pharmacotherapy and cognitive-behavioral treatment and found success rates of 80% for cognitive behavior therapy and 70% for pharmacotherapy. Sturpe and Weissman (2002) report that medication (SSRIs, tricyclic antidepressants, benzodiazepines) and cognitive behavioral therapy are effective treatments for panic disorders with or without agoraphobia. Addis, Hatgis, Cardemil, Jacob, et al. (2006) conducted an effectiveness study between two groups. The first group was a treatment as usual (TAU) and the second was panic control therapy (PCT) over duration of 12-15 weeks. The PCT treatment consisted of a manual guided approach while the TAU treatment was the counselor's deemed approach for panic disorder. Effectiveness information was supportive of PCT treatment.

Historically, benzodiazepine anxiolytics, tricyclic antidepressants, and monoamine oxidase inhibitors (MAOIs) were the most commonly used psychopharmacological interventions to treat individuals with panic disorder. The benzodiazepine anxiolytics are still widely used because they control panic attacks quickly and effectively. However, current long-term treatment relies primarily on several of the newer serotonin reuptake inhibitor antidepressants to control and prevent recurrence of panic attacks while Benzodiazepine anxiolytics, although quickly effective, are likely to cause dependency problems when taken regularly over a period of time.

Cognitive behavioral therapies include a combination of techniques such as cognitive restructuring, focused cognitive therapy, imaginal coping, and education. The basis for using cognitive therapy is that panic-disordered individuals misinterpret and exaggerate their bodily sensations and psychological experiences (Clark, 1986). The treatment involves educating and training patients to understand realistically their physiological sensations and then patiently learn how to take cognitive (mental reframing) and physical (relaxation and proper breathing) corrective action.

Beamish et al. (1996) and Sanderson and Wetzler (1995) cite the following cognitive techniques as having demonstratively reduced the severity and frequency of panic attacks:

1. Cognitive therapy, including cognitive restructuring and focused cognitive therapy;

2. Combined cognitive-behavioral treatment including panic inoculation, panic information, cognitive restructuring, breathing retraining, biofeedback, and relaxation training.

Agoraphobia

Panic disorder with and without agoraphobia have been separated or unlinked to be distinct disorders, panic disorder and agoraphobia.

Symptoms for each remain the same.

Interview, Definition, and Assessment:
Agoraphobia is defined as anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event the individual has an unexpected or situationally predisposed panic attack or panic-like symptoms (Frances & Ross, 1996, p. 163). Individuals with this disorder usually are fearful of being outside of the home alone, in a crowd, confined, or encountering the public. The DSM-5™ defines agoraphobia as an intense fear by a real or anticipated exposure to situations in which two of five situations are noted. Criterion A specifies the five situations to be using public transportation, being in open spaces, in enclosed situations, standing in a line/crowd, and being outside of the home alone (APA, 2013, p. 217).

The individual avoids these situations because of a fear that it will be difficult to escape and experience the panic like symptoms and resultant harm.

Frequently the client will request another person to accompany them in a social context. The fear is out proportion to any actual danger (E) and the agoraphobia specifiers last six months.

Comorbidity with other mental disorders includes panic disorder, social anxiety disorder, depressive disorders, PTSD, and alcohol disorders (APA, 2013).

Incidence:
The prevalence for adolescents and adults is approximately 1.7% (APA, 2013). Lifetime incidence of panic disorder with agoraphobia is .5% to 1.5% annually (APA, 2000) and without agoraphobia is estimated to be the same while about one third also suffer from agoraphobia (Kessler et al., 1994). Thayer, Friedman, and Borkovec (1996) suggest that the strongest predictor of agoraphobia is gender. Women tend to experience panic disorder with agoraphobia more so than men. The mean age of onset appears to be 23 to 29 (Craske, 1999).

Differential diagnosis is necessary to clarify panic disorder from social phobia. One determining factor in panic disorder with agoraphobia is a time element. If the individual suffers recurrent unexpected panic attacks, at least one of the attacks must be followed by one month of one or more of the following three: persistent concern about having additional attacks, worry about the implications of the attack or consequences and a significant change in behavior as a result of the attacks. If the individual has a panic attack immediately after the cued exposure (e.g., being the center of attention in a group of people), more than likely a social phobia classification is warranted. It is recommended

that the interviewer be aware of comorbidity and there is at least a 5% chance that an alcohol involvement exists with a diagnosis of panic disorder with agoraphobia (Kushner, Sher, & Beitman, 1990).

Treatment:
A structured and focused treatment plan is recommended. Frances and Ross (1996) suggest an integrative approach, which includes psychoeducation for panic disorder with and without agoraphobia, medication to alleviate the panic attacks and cognitive-behavioral therapy (CBT) strategies for coping skills. Craske (1999) also suggests three components to CBT, which are: education, cognitive restructuring, and breathing retraining (designed to treat or manage anxiety and panic), and exposure to internal and external cues that trigger panic and agoraphobia. Agoraphobia treatment often includes exposure techniques designed to address the avoiding behaviors and of situations. When alcohol is involved in the diagnosis, Lehman, Brown, and Barlow (1998) found cognitive-behavioral treatment to be effective along with panic control treatment (PCT; Craske & Barlow, 1993).

Generalized Anxiety Disorder (GAD)

Interview, Definition and Assessment:
The symptoms for generalized anxiety disorder criteria are mostly unchanged. The DSM-5™ describes the symptoms of generalized anxiety disorder (GAD) as an excessive amount of anxiety and worry about a number of events occurring more days than not for a period of at least six months. "The distinguishing feature of this disorder is a chronic and uncontrollable form of worry concerning any kind of circumstance or activity" (APA, 2013, p. 222). In addition, there must be at least three additional symptoms besides worrying (Criterion C). These symptoms include restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance (p. 222). It is important for the interviewer to assess for the frequency and duration of the symptoms and to differentiate from other anxiety disorders including adjustment disorder with anxious mood. A major difference between GAD and panic disorder is that GAD pervades the client's life most of the time, whereas a client with a panic disorder typically has panic attacks which are episodic and have relatively brief duration. It is also important for the interviewer to ask whether the client's anxiety occurs in social, occupational, or school related functioning (Maier, Gansicke, Freyberger, Linz, Huen, & Lecrubier, 2000).

Clients experiencing GAD tend to have higher levels of arousal and sensitivity than normal and tend to attribute their worries to illnesses for which they frequently seek medical treatment. An assessment for GAD should include an appraisal of both physiological and cognitive functioning. According to Brown, O'Leary, and Barlow (1993) this would include assessing the level of fear, type of worries, sense of responsibility, the need to maintain control, and perfectionism.

In differentiating anxiety from mood disorders, the symptoms of hypervigilance, autonomic nervous system hyperactivity, and muscle tension are found in anxiety disorders but not mood disorders except for mixed bipolar states and mixed bipolar depression.

Incidence:
The 12-month prevalence for GAD is 0.9% among adolescents and 0.2.9% among adults (APA, 2013).

Data from the National Comorbidity Survey reveals that 5.1% of the population will experience a generalized anxiety disorder during their lifetimes (Kessler et al., 1994). Kesler, Berglund, Demler, Jin, and Walters in 2005 raised the increase to 5.7%.Otto and Gould (1996) estimate a 3% prevalence rate, while APA (2000) reports lifetime prevalence rate to be 5%. The disorder is twice as common in women as in men. Keable (1989) indicates that studies have revealed that clients who have been diagnosed with a generalized anxiety disorder have tended to be older than 24, separated, widowed, divorced, unemployed, homemakers, and associated with other mental disorders.

Instrumentation:
Generally, cognitive, behavioral, and psychological are domains for assessment. The interviewer may use clinical interviews, self-report scales, behavioral observations, and physiological recordings to assist in the assessment. Some examples of instruments, which are used by the assessment expert, may be:

1. State-Trait Anxiety Inventory-Child Scale (Spielberger, 1973)
2. Child Depression Inventory (CDI; Saylor, Finch, Spirito, & Bennett, 1984)
3. Child Assessment Schedule (Hodges, Kline, Fitch, McKnew, & Cytryn, 1981)
4. Anxiety Disorders Interview Schedule for Children (Albano & Silverman, 1986)
5. Beck Anxiety Inventory (BAI; Beck & Steer, 1990)
6. Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990)

Treatment:
According to Frances and Ross (1996), very little research has been conducted on generalized anxiety disorder and there does not appear to be an agreed-upon definition of the disorder. As a result little is known about effective treatments. Of the anxiety disorders, GAD is the least effectively treated (Brown, Barlow, & Liebowitz, 1994). Frances and Ross indicate that medications in the past have not produced effective outcomes, although benzodiazepines seem to have the widest clinical use in spite of the potential risk for dependency. Fortunately there are some non-benzodiazepine medications which have anxiolytic effects and are sometimes effective, including SSRI's, buspirone, and the SNRI-venlafaxine (Ellison, 1996).

Psychotherapies, which have been most helpful, include cognitive-behavioral therapy (Evans, Ferrando, Findler, Stowell, et al., 2008), which focuses upon the target symptoms of worry and avoidance (internal and external anxiety cues and somatic symptoms). Psychodynamic psychotherapy has also been found to have a role for individuals whose GAD symptoms are caused by unconscious conflicts. Mavissakalian and Prien (1996), in researching outcome studies, found success rates varying from 37% to 42% when medication treatment and anxiety management programs have been combined. Overholser and Nasser (2000) indicate that GAD can be treated effectively by cognitive-behavioral therapies and that treatment plans should include "relaxation training, calming self-statements, and exposure to the feared situations (p. 150)." Evidenced based psychological treatment for older adults has been reported for the use of relaxation training, cognitive-behavioral therapy

(CBT) and supportive therapy (Ayers, Sorrell, Thorp, & Wetherell, 2007). Recently Evans, Ferrando, Findler, Stowell, et al. (2008) reported that GAD clients improved with a mindfulness-based approach to CBT utilizing meditation. Other authors have expressed skepticism about meditation being effective for this disorder (Krisanaprakornkit, Piyavhatkul, & Laopaiboon, 2006).

Even though medications and therapies can often enhance coping mechanisms for individuals with GAD, the DSM-IV-TR notes that there is a probable self-defeating personality component which tends to negate treatment effectiveness. Often the families of these clients will report that their family member does not seem "happy unless he/she is worrying about something."

Obsessive-Compulsive And Related Disorders

Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive and related disorders include obsessive-compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder, hair pulling disorder (trichotillomania), and excoriation disorder (skin picking).

Interview, Definition and Assessment:
Obsessive-compulsive disorder (OCD) is comprised of both obsessions and compulsions. Obsessions are recurrent and intrusive thoughts, feelings, ideas, or sensations. Compulsions are conscious, standardized recurring patterns of behavior, such as counting, checking, or avoiding (APA, 2013). Obsessions take time and interfere with people's normal routine, occupation, and social activities. Researchers concluded that OCD is associated with impaired social functioning, poorer quality of life (Tenneys, Denys, van Megen, Glas, & Wesenberg, 2003), increased use of health services and heightened attempts at suicide (Hollander et al., 1996).

Results from clinical studies show that OCD clients are four times more likely to be unemployed than other persons (Koran, Thienemann, & Davenport, 1995).Rasmussen and Tsuang (1986) indicate that OCD clients may have associated risks for social phobia, panic disorder, and other phobias.

OCD is recognized as an excessive and disruptive disorder characterized by recurrent obsessions and persistent intrusive and inappropriate thoughts, impulses, or images associated with repetitive, compulsive behaviors. The diagnostic criteria and definition include the presence of obsessions, compulsions or both. Clients with obsessions attempt to suppress and neutralize their anxiety through compulsive behaviors. Compulsions are repetitive, driven behaviors, or mental acts (APA, 2013, p. 235). According to Frances and Ross (1996), approximately 90% of the individuals with this disorder have both obsessions and compulsions, while a smaller percentage may have only one of the two.

Assessing for OCD is for obsessions and compulsions and the presence of recurrent or persistent thoughts and that the individual tends to ignore or suppress intrusive thoughts. Compulsions are repetitive behaviors and are mental acts to prevent or reduce the anxiety. Criterion A requires one of

two symptoms for each compulsion and obsession. Criterion B indicates that the compulsions or obsessions occupy more than one hour per day and cause distress or impairment (APA, 2013).

Comorbidity is important to assess because the diagnosis of OCD is not appropriate if the recurrent intrusive thoughts or impulses are in the context of another mental disorder (i.e., PTSD). Clients who lack awareness of the severity of their obsessions and compulsions are assigned a diagnosis of OCD with poor insight. During 1996 the World Health Organization (1996) classified OCD as the fourth most common psychiatric disorder and the 10th leading cause of disability.

Incidence:
The APA (2013) has reported a 12-month prevalence rage of 1.2%. The DSM-IV-TR (2000) has reported a lifetime prevalence rate for OCD of 2.5% with a 1-year rate of 0.5%-2.1%. A 2.0 to 2.5% lifetime prevalence rate of OCD has been reported in two epidemiological studies by Karno, Golding, Sorenson, & Burnam (1989) and Weissman (1994). Meltzer, Gill, and Petticrew (1995) reported the six-month prevalence rates to be 1.5% to 2.1% in Great Britain. Comorbid psychiatric disorders (OCD plus a second disorder) run as high as 50% for clinical disorders and 40% for personality disorders (Mavissakalian & Prien, 1996). The onset of obsessive-compulsive disorder appears to occur before 18 years of age (Insel, Donnelly, Lalakea, Alterman, & Murphy, 1983) although the onset of OCD in children has been found to be within an age range of 9 to 12.8 (Riddle et al., 1990).

Instrumentation:
Instrumentation can be helpful in the assessment of OCD because of the high rate of comorbidity with anxiety, mood disorders, learning disorders, somatoform disorders, psychosis, eating disorders, and substance abuse (Albano, March, & Piacentini, 1999). When co-existing diagnoses have been defined, it becomes possible to plan or triage for appropriate treatments. Several semi-structured interview schedules are available to assist in differential diagnosis.

1. Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Version (Silverman & Albano, 1996)
2. Child OCD Impact Scale (Piacentini & Jaffer, 1996)
3. Children's Yale-Brown Obsessive-Compulsive Scales (Goodman, Price, Rasmussen, Mazure, Delgado, Heninger, & Charney, 1989) - a semi-structured interview schedule
4. Comprehensive Psychopathologic Rating Scale OCD (Thoren, Asberg, Cronholm, Jornestedt, & Traskman, 1980)
5. Leyton Obsessional Child Version (Berg, Rapoport, & Flament, 1986)
6. Leyton Obsessional Inventory (Cooper, 1970)
7. Maudsley Obsessional-Compulsive Inventory (Hodgson & Rachman, 1977)
8. Padua Inventory (PI; Sanavio, 1988)
9. Thought Fusion Instrument (TFI; Wells, Gwilliam, & Cartwright-Hatton, 2001)

10. Obsessive-Compulsive Beliefs Questionnaire (OCBQ; Wells, & Carter, 1999)
11. Yale-Brown Obsessive-Compulsive Scale (Goodman, Price, Rasmussen, Mazure, Delgado, Heninger, & Charney, 1989a b; Steketee, Frost, & Bogart, 1996)
12. Obsessive Compulsive Scale of the Symptom Checklist 90, Revised (Woody, Steketee, & Chambless, 1995)

Computer-assisted software packages for assessment and treatment are currently available. Lack and Storch (2008) provide a comprehensive table of such programs that include Kraeplin's early work with language questions to the more recent BT- STEPS - a package of nine steps that include assessment, treatment plan development, and progress maintenance (Baer & Griest, 1997). The program requests clients to list their rituals, ritual performance costs, and the amount and degree of distress experienced as they proceed through the treatment program. The use of computer-assisted software packages for assessment and treatment of OCD appear to be useful but there have been a limited number (8) of outcome studies contained in the literature thus far.

Treatment:
Karno and Golding (1991) found that clients reported having OCD symptoms at least seven years before seeking treatment. After seeking help they are likely to receive medication, non-medical approaches such as psychotherapy or CBT, or combined treatments. Greist and Jefferson (1989) point out that psychodynamic therapy had been the treatment of choice until other therapies such as Exposure Response Prevention (ERP) became available and was supported by research effectiveness studies. Hill and Beamish (2007), in their literature search of effectiveness studies, indicate that behavioral treatment is the most effective. The interventions were systematic desensitization, modeling, muscle relaxation, exposure, and response prevention (McLeod, 1997). A combined treatment of exposure and response prevention (Basco, Glickman, Weatherford, & Ryser, 2000) and/or ritual prevention (Allen, 2007; Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Riggs & Foa, 1993) have been found to be most effective.

Cognitive behavioral therapy (CBT) is preferred for clients experiencing mild to moderate levels of severity and impairment (Allen, 2006). CBT is considered a general approach to therapy and attempts to focus on current symptoms. It uses techniques based on learning theory and combines exposure and response prevention with cognitive restructuring.

The three approaches to CBT are cognitive, behavioral, and physiological. The cognitive strategies are to identify and change maladaptive thoughts while the behavioral strategies are to change maladaptive behaviors, and the physiological strategies are to focus on physiological reactions and to employ techniques of relaxation (deep breathing, muscle relaxation). Cognitive therapy has less support from the literature.

Fisher and Wells (2008), in a case study of four clients, provide support for Metacognitive therapy as an effective treatment. This treatment differs from the traditional cognitive behavioral approach in that metacognitive focus is to acquire the knowledge or beliefs about thinking and strategies that are used to regulate and control the thinking processes. The specific aim is to determine the maintenance of

the disorder. The approach is to recognize themes of thought action fusion (TAF) regarding obsessions and compulsions. This approach does not attempt to modify uncertainties, perfectionism, and client responsibilities.

Harris and Weber (1992) recommend a less intense form of exposure therapy for children as well as relaxation and breathing training. Marks (1981) indicates that for adults combining exposure therapy with response prevention is a treatment of choice. Karasu (1989) has found support for supportive psychotherapy.

Medication, used in conjunction with psychotherapy, is recommended for moderate to severe symptoms and impairment (Leonard, Swedo, March, & Rapoport, 1995). Research results with pharmacological therapy demonstrated that the older anti-depressants - except for the tricyclic Clomipramine (Anafranil) - are ineffective for significantly reducing OCD (Mavissakalian & Prien, 1996). However, in addition to Clomipramine (Thoren, et al. 1980; Turner, Jacob, Beidel, & Himmelhoch, 1985) selected SSRI antidepressants, particularly Fluoxetine and Luvoxamine, have proven to be effective. Buhlmann, Tolin, Meunier, Pearlson, Reese, Cannistraro, Jenike, and Rauch (2008) in a recent study found that D-cycloserine enhanced the effectiveness of behavior therapy with OCD clients.

Hollander, Alterman, and Dell'Osso (2006) suggest that approximately 40% of OCD clients are resistant to pharmacologic and behavioral treatment. For patients with treatment resistant OCD, a number of direct physical interventions in the brain have been studied. These include: transcranial magnetic stimulation (TMS; alternating magnetic fields-coil applied to the head), deep brain stimulation (DBS; a surgical implantation of a 'brain pacemaker' which sends electrical impulses to specific parts of the brain) and electroconvulsive therapy (ECT). None of these techniques are recommended at this time (Hollander, Alterman, & Dell'Osso, 2006). ECT is the most effective of these treatments but remains controversial and unproven.

A recent treatment recommendation has been computer-assisted assessment and treatment. Computer assisted treatment are of three types based on the type of technology (virtual reality, hand-held computers, software programs). Greist, Marks, Baer, et al. (2002) conducted a study of 218 OCD clients using the BT STEPS and results revealed a significant improvement in symptoms for OCD clients. They concluded that BT STEPS treatment is superior to no treatment and was found to be as effective as a client-counselor face-to-face treatment.

Relapse Prevention:
The stability of improvement falls off rather rapidly when medication is discontinued. Thus, relapse prevention training is often recommended to continue and sustain improvements. The intent is to prepare the client for any future setbacks, including relapses, if medication is stopped.

Body Dysmorphic Disorder

Body dysmorphic disorder is a preoccupation with one or more perceived defects or flaws (imagined defect in appearance) and often displays repetitive behaviors to avoid the appearance (APA, 2013). The

flaws or concerned defects are not noticed by others but are often the client compares oneself to others. The concern can be that one's body is too small or too large.

Possible treatment outline many involve:

1. CBT (education, progressive muscle relaxation and imagery)
2. Cognitive therapy (identifying and changing negative automatic thoughts
3. CBT (self-reinforcement exercises)
4. Reflective therapy (exploring body image over developmental periods
5. Group CBT

Trauma and Stressor-Related Disorders

Trauma and stressor related disorders include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders (APA, 2013).

Adjustment Disorder

An adjustment disorder, which comprises 5% of the client population in outpatient clinics and up to 50% in hospitals or psychiatric consultations (APA, 2013). Data supports that 10% of psychiatric diagnoses is defined as a constellation of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors, causing moderate symptoms or moderate impairment in social or occupational functioning occurring within three months of the stressful event and lasting no longer than six months (APA, 1994). Symptoms include depressed mood, anxious mood, disturbed conduct, or a mixture of several of these features.

Adjustment disorders are the most common psychiatric diagnoses for depressed or anxious clients hospitalized for medical and surgical problems. Among adults, common precipitating stresses are marital problems, divorce, bankruptcy, loss of friend, loss of job, moving, financial problems, and disabling illnesses. Adjustment disorders are also frequently seen in individuals experiencing transitions during specific developmental stages such as leaving home, getting married, becoming a parent, and retiring.

The symptoms of adjustment disorder, which must be different from bereavement, should appear within three months of a stressor's onset and are disproportionate to the nature of the stressor and/or cause more significant impairment in social or occupational functioning than would be normally expected. There is usually resolution within six months, although symptoms last longer if produced by a chronic stressor or one with long-lasting consequences (Kaplan & Sadock, 1998). The severity of the stressor is not always predictive of the severity of the disorder and is influenced by factors such as

culture, degree, quantity, duration, reversibility, environment, and personal context. Criterion B emphasizes that the severity is out of proportion to the stressor according to external and cultural factors (APA, 2013). Furthermore, not everyone who is exposed to a stressful event develops symptoms because of the following factors: the nature of the stressors, coping skills, unique conscious and unconscious meanings, individual vulnerabilities, individual ego strength, social supports, unresolved emotional stressors, losses, and disappointments from the past (Kaplan & Sadock, 1998).

Specifiers are associated with adjustment disorder. The following represent the six listed in the DSM-5™:

1. Adjustment disorder with depressed mood: Symptoms are that of a minor depression. This depression is a temporary response to an identifiable stressor occurring within three months after the onset of the stressful event, such as a financial reversal, divorce or separation, or loss of job. There is marked distress and significant impairment in social, occupational, or other functioning areas.
2. Adjustment disorder with anxiety: Symptoms of anxiety are dominant.
3. In combination with mixed anxiety and depressed mood: Symptoms are a combination of depression and anxiety.
4. Adjustment disorder with disturbance of conduct: Symptoms are demonstrated in behavior that violates the rights of others or "major age-appropriate societal norms and rules" (APA, 1999, p. 680); for example, truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities.
5. Adjustment disorder with mixed disturbance of emotions and conduct: Symptoms include combined affective and behavioral characteristics with mixed emotional features and with disturbance of conduct.
6. Adjustment disorder unspecified: This residual diagnosis is used when a maladaptive reaction not classified under other adjustment disorders occurs in response to stress.

Specifiers include acute and chronic distinctions of adjustment disorder. Acute indicates the persistence of symptoms for less than six months. Chronic indicates the persistence of symptoms longer than six months. Because adjustment disorder, by definition, cannot last longer than six months, chronicity describes the condition of a chronic stressor with "enduring consequences" (APA, 2000, p. 680). The DSM-5™ does not list the severity ratings of acute and chronic.

Factors that place youths at risk for the onset of adjustment disorder have been outlined by Kazdin (1998) and are as follows:

Child Factors

1. Child temperament
2. Psychological deficits and difficulties

3. Subclinical levels of conduct disorder
4. Academic and intellectual performance

Parent and Family Factors

1. Prenatal and perinatal complications
2. Psychopathology and criminal behavior in the family
3. Parent-child punishment
4. Monitoring of the child
5. Quality of the family relationships
6. Marital discord
7. Family size (the larger, the higher risk)
8. Sibling with antisocial behavior
9. Socioeconomic disadvantage

School-Related Factors

1. Characteristics of the setting (e.g., little emphasis on academic work, infrequent praise)

Incidence:
The APA (2000) reports that adjustment disorders are fairly common. In fact, it is estimated that in the mental health outpatient setting prevalence rates are between 10% and 30%. Individuals coming from disadvantaged lifestyles are thought to be at an increased risk of developing adjustment disorders, primarily because of increased likelihood of having and developing stressors. The prevalence rate is 12% in a hospital setting (APA, 2000). According to Kazdin (1998), one of the most frequent findings is that men and boys show three to four times higher prevalence rates than women and girls.

Diagnostic Considerations:
The diagnosis of adjustment disorder is less serious than post-traumatic stress disorder (PTSD). The latter is characterized by exposure to a life-threatening trauma (experience, witness, actual or threatened death or serious injury, or threat to physical integrity with a response of intense fear, helplessness, or horror) and specific post-traumatic symptoms occurring beyond three months after the traumatic event. These symptoms include re-experiencing the trauma in the form of nightmares, flashbacks, or intrusive thoughts and images, physiological distress, and persistent avoidance of stimuli with numbing of responsiveness and memory disturbance.

Adjustment disorder with depressed mood should also be differentiated from other depressive disorders. A patient with major depressive disorder would have more significant symptoms, including thoughts about death or suicide, loss of pleasure, guilt feelings, hopelessness and helplessness, weight loss and psychomotor disturbances, sleep and appetite disturbance, loss of energy, loss of concentration and cognitive functioning, and significant interpersonal withdrawal. Individuals with

uncomplicated bereavement, which is not considered a disorder, typically improve over several months.

Treatment (Adults):
The treatment of adults with adjustment disorder includes the following modalities: cognitive-behavioral therapy, interpersonal psychotherapy, behavior therapy, psychodynamic therapy, group therapy, self-help and pharmacotherapy to help them with dysfunctional thoughts, behaviors, and relationships.

Lazarus (1992) has recommended a seven-pronged treatment approach using assertiveness training, sensate focus on enjoyable events, new coping skills, imagery techniques, time projection, cognitive disputation, role-playing, desensitization of disturbing emotions, family therapy, and physiological restoration.

A traditional approach to treating adjustment disorder focuses on resolving the client's overwhelming psychological reaction to a stressor. The first goal in this treatment approach is to identify the stressor. Second, the client needs help to express, verbalize, and gain mastery over unmanageable emotions. Third, the therapist should attempt to help the client reframe the meaning of the stress and find ways to diminish the psychological deficit. Fourth, there should be an attempt to clarify and interpret the client's residual capacity to engage in meaningful work and positive relationships. Finally, the therapist should help the client establish supportive relationships with family, friends, and members of support groups, when appropriate (Strain, 1995).

Treatment (Children):
Among the most established treatments (supported by empiricism) for adjustment disorder in adolescents are the following: 1) cognitive problem-solving skills training, 2) parent management training, 3) functional family therapy and 4) multi-systemic therapy. While many forms of behavior therapy have extensive literature demonstrating that various techniques can alter aggressive and antisocial behaviors, their focus has tended to be on specific behaviors. These four treatments appear to treat the constellation of symptoms present in these adolescents (Kazdin, 1998). Kazdin provides a brief overview of some effective treatment modalities:

Cognitive problem-solving skills training (PSST) consists of developing interpersonal cognitive problem-solving skills. The emphasis in PSST is on how the child cognitively approaches a situation. The child is encouraged in developing pro-social behaviors through the use of games, academic activities and stories (Kazdin, 1998).

Parent management training (PMT) refers to the procedures used to train parents to alter the child's in-home behaviors. The general goal of PMT is to alter patterns of interaction between the parent and the child so that prosocial, rather than coercive, behavior is reinforced (Kazdin, 1998).

Functional family therapy (FFT). The main goals of FFT are to increase reciprocity and positive reinforcement among family members. The therapist in this approach points out family system obstacles during the continual addressing of the problem that has brought the family in for treatment (Kazdin, 1998).

Multisystemic therapy (MT) encompasses many other treatment techniques and is essentially the traditional family systems approach to treating the family. In MT, the clinical problems of the child emerge within the context of the family (Kazdin, 1998).

Acute Stress Disorder

Acute stress disorder is not a shorter version of PTSD rather is differentiated from PTSD by two characteristics: timing (symptoms appear quickly) and severity (the presence of dissociative symptoms). For example, a diagnosis of acute stress disorder is appropriate when the survivor's symptoms occur at the time of or quickly following the traumatic event, last at least two days, extend up to four weeks, and include at least one of the exposures (Criterion A) and nine or more of 14 symptoms in Criterion B.

The four types of exposures are:

1. Directly experiencing
2. Witnessing, in person, the events as it occurs to others
3. Learning about the event to a close family member or close friend
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event (p. 280).

The 14 Criterion B symptoms include within intrusion symptoms, negative mood, dissociative symptoms, avoidance symptoms, and arousal symptoms.

Acute stress disorder (ASD), like PTSD, can occur after an individual experiences, witnesses, learns about or experiences extreme aversive details that involve a threat or actual death, serious injury, or another kind of physical violation to the individual or others, and responds to this event with strong feelings of fear, helplessness or horror. The diagnosis of ASD was recently established when it became clear that trauma survivors often quickly exhibited signs of PTSD-like symptoms after major traumatic events. It was also found that more than 50% of those who had the symptoms of ASD would eventually develop post-traumatic stress disorder. While ASD is a relatively new diagnosis, this condition was once referred to as "shell shock" in World War I and, even before that, symptoms now characterized as acute stress disorder were observed in soldiers as far back as the U. S. Civil War in 1865.It is now known that severely traumatized individuals, both combatants and civilians, may also suffer from ASD.

Because of the instability of a stress disorder, there are inherent problems with diagnosing PTSD (Bryant, Harvey, Dang, & Sackville, 1998). Furthermore, there has been increasing numbers of workmen's compensation cases filed by individuals traumatized at work. As a result, the interviewer must be aware when the client's PTSD symptoms were caused by an injury for which compensation may be forthcoming so that malingering may be ruled out. According to Resnick (1997), malingering may be present if any combination of poor work record, prior incapacitating injuries, markedly discrepant capacity for work and recreation, unvarying and repetitive fabricated dreams, anti-social personality traits, overly idealized functioning before the trauma, evasiveness, and/or inconsistency in

symptom presentation can be identified.

Incidence:
According to the DSM-IV-TR prevalence rates in the general population run from 14%-33% (APA, 2000). The DSM-5™ indicates that prevalence rates vary according to the type or nature of the event although tends to be less than 20% following a traumatic event (APA, 2013).

Post-Traumatic Stress Disorder (PTSD)

Definition and Interview:
The definition of PTSD has expanded to include hearing of a trauma, direct experience, learning that it happened to someone else, repeated exposure to details of trauma and also includes new symptom clusters, and a separate criteria for children age six or younger (APA, 2013). Post-traumatic stress disorder (PTSD) is defined by events that involve actual or threatened death, or serious injury, or threat to the physical integrity of oneself and others, plus a response at the time that involved intense fear, helplessness or horror (APA, 2000, p. 463). The traumatic event is re-experienced in one of several ways such as recurring recollections of the event, distressing dreams, sense of reliving the event, psychological distress at experiencing symbolized aspects of the trauma, and physiological reactivity to the symbolized aspects of the event (Frances & Ross, 1996). Another major symptom of PTSD is a persistent hyperarousal as manifested by sleep disturbances, anger, impaired concentration, hypervigilance, and the startle response.

This condition is different from other anxiety disorders, with the exception of acute stress disorder, because symptoms are caused by a prolonged physiological and psychological response to an extreme stressor.

Assessment:
Assessment consists of the type of exposure such as direct, watching it occur to others, learning that it happened to someone else, repeated exposures to details of a trauma, and does not apply to media exposure unless it is work related (first responders).

Symptom clusters for Criterion B are intrusions, avoidance, alterations in cognition and mood, and increased arousal and reactivity.

Intrusions are memories, dreams, flashbacks, physiological or psychological reactions from trauma reminders. Avoidance is to avoid situations that elicit the memories or external reminders (need one). Alterations in cognition and mood is to forget details of the trauma, have negative beliefs or distorted thoughts about the cause of the trauma, and negative emotional state. Increased arousal and reactivity are characteristics such as irritability, recklessness, hypervigilance, sleep problems, increased startle response and decreased concentration (APA, 2013, Carter, 2013).

Assessment of post-traumatic stress disorder (PTSD) or acute-stress disorder (ASD) first depends on exposure to any psychological event outside the range of normal experiences (i.e., disaster, assaults, war, etc.; Emmelkamp, 1994) and the patient's subjective description of symptoms (Resnick, 1997). If

he or she does not spontaneously report having survived a traumatic event during the initial interview, the interviewer should ask generally about past traumatic events and associated features, such as anxiety, depression, and substance abuse, which may be prominent in the history of the individual. To avoid triggering undesirable traumatic emotions the examiner can ask the client to discuss only as much as he or she is comfortable. Finally, it is important to inquire about interpersonal detachment and other symptomatic response areas from the DSM-5™ (2013). The practitioner should also attempt to clarify whether the client's symptoms are consistent with criteria for acute stress disorder as described in the DSM-5™, i.e. symptoms of dissociation (e.g., numbing, depersonalization, reduced awareness, de-realization, and amnesia). Other symptoms which may be present in either ASD or PTSD include re-experiencing (e. g., intrusive thoughts or actions, dreams, sense of reliving the trauma, and distress on exposure to reminders of the trauma), avoidance (e.g., not talking or thinking about the trauma, avoiding places or people that are reminders of the trauma, active avoidance of distress) and arousal (e.g., sleep disturbance, irritability, concentration deficits, hypervigilance, startle response, and autonomic arousal (Bryant et al., 1998).

Incidence:
APA (2013) cites a 12-month prevalence rate of 3.5%. APA (2000) cites a lifetime prevalence of post-traumatic stress disorder (PTSD) in approximately 8% of the adult population while the DSM-5™ cites 8.7% at age 75. The lifetime prevalence for men is 5% to 6% and 10% to 11% for women (Kessler, Davis, Andreski, & Peterson, 1995). In medical facilities the percentages are even higher (12% general medical population, 20% VA ambulatory care clients; Hankin, Spiro, Miller, & Kazis, 1999).

There has been considerable research on the prevalence of PTSD in veterans of the Vietnam era. Kulka et al. (1990) found an overall prevalence of 15% in Vietnam veterans approximately 19 years after their military experiences, indicating that the incidence of PTSD in Vietnam veterans decreased as time went on. However, this survey was based on a total of 3.14 million veterans, the majority of who did not see direct combat.

Symptoms of PTSD are more severe and prolonged in individuals who have suffered catastrophic traumas. Among World War II POWs, 40 years after combat duty and prison confinement, the prevalence of PTSD was found to be around 50% (Goldstein, vanKammen, Shelly, Miller, & van Kammen, 1987; Kluznik, Spleed, VanValkenburg, & MaGraw, 1986).Selected groups of combatants from military action have also demonstrated higher rates of PTSD. Solomon (1987) found that 56% of 3,553 Israeli soldiers who had had acute combat stress reaction during the 1982 Lebanon War showed symptoms of PTSD two years later, while only 18% of the non-combat soldiers had PTSD. Of interest is the incidence of co-morbid disorders associated with PTSD. At least 50% of Vietnam combatants were found to have PTSD, plus one of the following panic disorders: generalized anxiety disorder, OCD, major depression, substance use disorder, and personality disorder (Kulka et al., 1990). Otto and Gould (1996) cite the following prevalence statistics for PTSD: 1% for the general population, 15% for individuals with mental disorders, 13% for Vietnam veterans, 27% for crime victims, and 57% for rape victims.

Instrumentation:

1. The Revised Civilian Mississippi Scale for PTSD (Keane, Caddell, & Taylor, 1988; Norris & Perilla, 1996). Self-reported symptoms of post-traumatic stress in veteran populations.
2. Civilian Version of the Mississippi PTSD Scale (Norris & Perilla, 1996)
3. MMPI-PTSD (Terrence Keane, National Center for PTSD) (Keane, 1998; Keane, Malloy, & Fairbank, 1984)
4. Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979)
5. Diagnostic Interview Schedule for DSM-IV (Robins, Cottler, Bucholz, & Compton, 1995).
6. Composite International Diagnostic Interview (CIDI; World Health Organization, 1997)
7. Short Screening Scale for DSM-IV Post-Traumatic Stress Disorder (Breslau, Peterson, Kessler, & Schultz, 1999)
8. Short Screen Scale for DSM-IV PTSD (Breslau, Peterson, Kessler, & Schultz, 1999).
9. Harvard Trauma Questionnaire (Mollica, Caspi-Yavin, Lavelle, Tor, Yang, Chan, Pham, Ryan, & deMarneffe, 1995)
10. PTSD Interview (Watson, Juba, Manifold, Kucala, & Anderson, 1991)

Treatment:
Several therapeutic approaches that have been found useful to help resolve the symptoms of traumatic stress: Critical Incident Stress Debriefing (CISD; Mitchell, 1988), psychotherapy, group therapy, pharmacotherapy, cognitive-behavioral therapy, art therapy, hypnotherapy, abreactive therapy, flooding, neuro-linguistic programming, eye movement desensitization, and restructuring (EMDR), and trauma incident reduction therapy (TIR). Many of today's post-traumatic treatment modalities are based on variations of hypnosis (Brende, 1985) and 'reliving' techniques first used a century ago (i.e., hypnotic abreactive treatment) (Breuer & Freud, 1893) and abreaction (Jung, 1954). Drug induced abreaction was also used (Perry & Jacobs, 1982) as well as other non-chemical 'adaptive regressions' (Fromm, 1977), integrative regressions (Brende & McCann, 1984), meditation (Carrington & Ephron, 1978), and biofeedback and meditation (Glueck & Stroebel, 1975). During the past decade, desensitization techniques alone or in combination with reliving techniques also have been used with success. These include eye movement desensitization and restructuring (EMDR; Shapiro, 1995, 1996) and trauma incident reduction (French & Harris, 1999).

Behavioral treatment for PTSD also has been cited as an effective mode of psychotherapy. Behaviorists believe that PTSD is created by an aversion resulting from operant or classical conditioning (Emmelkamp, 1994). Behavior therapy generally consists of some form of exposure exercise (flooding, in vivo, or imaginative) to habituate to the experience and stress management (Felmingham, Kemp, et al., 2007). Behaviorists would argue that clients with PTSD caused by war trauma have benefited from flooding as a specific technique (Boudewyns, Hyer, Woods, Harrison, & McCranie, 1990; Cooper & Clum, 1989; Fairbank & Keane, 1982).

Rape trauma victims with PTSD have benefited from stress management (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Veronen & Kilpatrick, 1983). Specifically, Foa et al. (1991) and Resick et al. (1988) found stress inoculation training (SRT) to be superior in the short-term versus supportive counseling and exposure. However, to sustain symptom reduction beyond 3.5 months, exposure therapy was found to be the most effective treatment for rape victims experiencing PTSD. Additionally, compelling evidence shows that brief psychotherapy can be effective (Foa, Heart-Ikeda, & Perry, 1995; Smith, Glass, & Miller, 1980).

Mueser, Rosenberg, Xie, et al. (2008) researched the effectiveness of cognitive-behavioral therapy (CBT) for PTSD with severe mental illnesses including suicidal depression, self-injurious behavior, psychosis, mood swings, and acting out behaviors. This controlled study revealed CBT to be more effective in helping trauma victims process and modify trauma-related beliefs than did traditional treatments.

Group treatment has also been a useful modality for PTSD clients. A study at the National Center for PTSD found modest improvements from group therapy in the distress level of the veterans (Bolton, Lambert et al., 2004).

Dissociative Disorder

Dissociative disorders include dissociative identity disorder (DID), dissociative amnesia, depersonalization/derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder. Derealization is included in what was formerly depersonalization disorder. Dissociative fugue is a specifier of dissociative amnesia.

Most people see themselves as human beings with one basic personality and a unitary sense of self; however, people with dissociative disorders have lost that unifying sense of self. Although there are several types of dissociative identity disorders, the extreme form-dissociative identity disorder-is manifested by a lack of integration of thoughts, feelings, and actions and the unique capacity to cope with internal conflicts and external stress via multiple personalities. Dissociation initially arises as a defense against physical and emotional trauma and has the function of removing oneself from the pain of the traumatic experience.

Dissociative Identity Disorder (DID)

Dissociative identity disorder (DID) is a disruption of identity characterized by two or more distinct personality states. In dissociative identity disorder (DID), previously called multiple personality disorder, different representations of the self-take on the existence of separate personalities. The APA (1994, 2013) characterizes a dissociative disorder as a disruption in the usually integrated functions of consciousness, memory, identity, or perception of one's environment.

The assessment is made when two or more distinct personality states or an experience of possession and recurrent episodes of amnesia are present. The disruption is discontinuity in sense of self with alteration in affect, behavior, consciousness, memory, perception, cognition and sensory-motor functioning (APA 2013, Criterion A, p. 292). The age of onset of a person developing dissociative disorder may vary but it is most commonly observed during adolescence or early adult life for individuals, if they have been abused as children.

Assessment:
The symptom of amnesia is the most common dissociative defense and occurs in dissociative amnesia, dissociative fugue (specifier), and dissociative identity disorder. Dissociative amnesia is characterized by the inability to recall information, most generally about stressful or traumatic events, and is the most common symptom of the dissociative disorders. DID Criterion A has been modified and now may be observed or reported and everyday gaps in memory may be a symptom (APA, 2013). Although epidemiological data for these disorders are limited they seem to occur more often in women.

Dissociative identity disorder (DID) is defined as the presence of two or more distinct personalities or identity states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and the self (APA, 2013, p. 529). There are additional essential features combined with the aforementioned definition to consider the DID diagnosis.

1. Criterion A states that there is a disruption in identity in terms of a sense of self and a sense of agency. At least two of the personalities recurrently take control of the person's behavior. The disruption is evidenced by alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning (APA, 2013, p. 292). Criterion A has been modified and now may be observed or reported and everyday gaps in memory may be a symptom.
2. Criterion B states there are recurrent episodes of amnesia (gaps in memory of everyday activities, personal information and traumatic events) and are inconsistent with everyday memory.
3. Criterion D states that the disturbance is not attributable to cultural or religious practice (APA, 2013).
4. Criterion E states that the symptoms of DID are not attributable to the direct effects of a substance or general medical condition (APA, 2013, Chu, 1998).

Ross (1997) explains four potential pathways leading to DID: childhood abuse, childhood neglect, factition, and iatrogenesis. The latter two of these are viewed as 'phony' and the first two 'genuine'. Dissociative Identity Disorder has been associated with sexual abuse in children in over 90% of cases (Putnam, 1991).

Incidence:
APA (2013) reports a prevalence rate from a small U.S. community was 1.5% and 2% as a lifetime prevalence rate. The overall prevalence for these disorders is probably unknown; however, at some time approximately all adults have experienced depersonalization, as well as one-third of those exposed to life-threatening dangers and 40% of hospitalized patients for mental disorders (APA, 2000,

p. 531). It is not easy to find good prevalence statistics regarding dissociative identity disorder; however, it is interesting to note that the reported numbers of DID patients has risen dramatically over the past 5 decades. Braun (1984) found a ten-fold increase in DID cases reported in the literature compared to 1944 at which time there were only 76 documented cases. There seem to be a number of reasons for the increase in reported DID cases including the increased incidence of child abuse occurring in U.S. society and improved diagnostic sensitivity to the disorder. Nonetheless, such clients are not easy to recognize. Putnam, Guroff, Silberman, Barbara, and Post (1986) have found that it takes an average of 6.8 years after first entry into the mental health system before the typical DID client is accurately diagnosed.

Instrumentation:
The Dissociative Experience Scale (Bernstein & Putnam, 1986; Carlson et al., 1993). This is a 28-item self-report scale that takes 7-20 minutes to take and be scored. It is primarily a screening instrument wherein an approximate score of 30 or more is considered positive.

1. The Dissociative Disorders Interview Schedule (DDIS; Ross, 1989; Ross, Heber, Norton, & Anderson, 1989). This is a 236 question structured interview that is 90% sensitive, taking 75-90 minutes.

2. Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1993a, b).

Treatment:
Chu (1998) suggests that prior to embarking on treating a patient with DID or similar dissociative disorders, the mental health professional must determine the accuracy of the diagnosis and not confuse it with disorders which may have some similar characteristics, such as bi-polar disorder, intermittent explosive disorder, borderline personality disorder, schizophrenia, and post-traumatic stress disorder. Individuals with DID typically have received one or more other diagnoses before an accurate diagnosis of DID can be considered. The counselor, when learning that the patient has experienced hallucinations and been diagnosed with psychosis should become suspicious when there is a history of childhood sexual abuse and symptoms include auditory hallucinations associated with different specific names, memory lapses, and 'lost time'.

The treatment of DID is individual psychotherapy. The therapeutic process should include helping the client reduce reliance on dissociation by acquiring new, flexible, and adaptive coping resources (Ross, 1997). This procedure will involve some training in cognitive behavioral techniques although cognitive behavioral treatment alone is inadequate.

The initial goal in treating a patient with DID is to identify and gain control over or rapport with one or more of the 'persecutor' personalities to prevent 'them' from sabotaging the therapy. It is equally important to identify and gain cooperation with the 'protector' personality (ies) in order to protect the 'victim' personality and counteract the persecutor(s). It is helpful to know that one or more of the personalities are typically of a different sex than the client as well as different ages (Ross, 1989).The treatment most utilized has been psychodynamic psychotherapy. In some cases the judicious use of hypnosis can also be helpful. The goal of therapy, ideally, is 'integration' of all personality fragments, which is generally not achieved. A lesser but more obtainable goal allows the therapist to bring about

a greater level of cooperation within the inner "family" of conflicting personalities which Kluft (1995) has referred to as 'resolution'- functioning 'well' despite remaining multiple." He refers to integration as the "ongoing process of undoing all aspects of dissociative dividedness that begins long before there is any reduction in the number of distinctness of the personalities. This process persists via fusion of some personalities and even disappearance of others no longer essential. This process continues at a deeper level even after the personalities have blended into one" (pp. 1616-1617). Follow-up data indicate that clients who achieve and sustain 'integration' do far better and relapse into dysfunctional dividedness far less frequently than those who opt for 'resolution' (Kluft, 1995).

Bowers et al. (1971) offers the following general guidelines for the therapist embarking on therapy (although not included is the important step of controlling persecutory or destructive personalities).

1. The goal of treatment is integration.
2. Help each alternate personality understand that he/she is one part of the whole.
3. Use alternates' names as labels not as licenses for irresponsible autonomy.
4. Treat all alternates fairly and empathetically.
5. Encourage empathy and cooperation between alternates.
6. Be gentle and supportive, remembering the severity of trauma.
7. Stay within the limits of your competence.
8. If hypnosis is considered to be necessary, it should be used judiciously while avoiding the use of leading questions about being abused.
9. Treat the person in his/her social context and intervene systematically when necessary.
10. Group therapy may help.
11. Do not dramatize symptoms such as amnesia.

Braun (1986) recommends 13 guidelines in treatment, (although not included is the important step of controlling persecutory or destructive personalities) as follows:

1. Developing trust.
2. Making and sharing the diagnosis.
3. Communicating with each personality state.
4. Contracting (this would include setting boundaries and 'rules' for the therapeutic relationship.)
5. Gathering history (for instance, the history of abuse, welfare, drug abuse, etc.).
6. Working with each personality state's problems.
7. Undertaking special procedures.

8. Developing inter-personality communication.
9. Achieving resolution/integration.
10. Developing new behaviors and coping skills.
11. Networking and using social support systems.
12. Solidifying gains.
13. Following up.

Sakheim, Hess, and Chivas (1988) suggest the following seven-steps for a short-term treatment:

1. Establish the diagnosis
2. Develop awareness of multiplicity
3. Develop awareness of past history and purpose of alters
4. Work through dissociative defenses
5. Integrate and fuse
6. Postintegration
7. Termination

Chu (1998) posited other considerations for the treatment process. First, establishing a consistent and generally slow pace of treatment is important with the DID client and often mental health professionals make the mistake of moving too quickly in therapy in order to comply with the limited time demands of insurance companies. Second, therapists should be aware clients are often eager to purge themselves of toxic past traumatic memories and as a result can overwhelm themselves with the flood of such re-experiences. Third, professionals may over-involve themselves emotionally with DID patients. While there is a necessary level of involvement, Chu warns professionals about losing their therapeutic perspectives. Fourth, mental health professionals should encourage their clients to build coping resources before moving forward too quickly, respect their needs to proceed carefully, focus on the ultimate goal of becoming whole persons (although various personalities should be acknowledged), create realistic goals that move toward "increased communication, cooperation, and integration" (p. 161). Fifth, the therapist should always remember to be interested in the client as a person rather than fascinated by the disorder and the intriguing personalities (Chu, 1998).

Dissociative Amnesia (DA)

Dissociative amnesia (DA) is a disturbance characterized by one or more episodes during which times individuals are unable to recall important personal information that isn't explained by ordinary forgetfulness. An individual with DA can be expected to report gaps, retrospectively, in his or her own personal history, frequently associated with one or more traumatic or stressful events (APA, 2013, 2000, p. 520). The prevalence rate is reported to be 1.8% over a twelve month period (APA, 2013).

Dissociative Fugue (DF)

Dissociative fugue is now a specifier of dissociative amnesia and is a disturbance characterized by sudden, unexpected travel away from home with the inability to recall one's past (APA, 2013). This primary feature is accompanied by confusion about one's identity or adopting a new identity.

Depersonalization/Derealization Disorder (DD)

According to the APA (2013), the essential features of depersonalization disorder are persistent or recurrent episodes depersonalization, derealization or both (Criterion A). The client's symptoms are characterized by a feeling of detachment from one's self (depersonalization) or surroundings (derealization). The individual may have the experience of feeling like an "automaton", "living in a dream or movie" (p. 530), or feeling like an observer of one's body or parts of one's body. During these experiences, reality testing remains intact.

Somatic Symptom and Related Disorders

Somatic symptom and related disorders include somatic symptom disorder, illness anxiety disorder, conversion disorder, psychological factitious disorder, other specified somatic symptom and related disorders, and unspecified somatic symptom and related disorder (APA, 2013). Somatization disorder, hypochondriasis, pain disorder and undifferentiated somatoform disorder were removed from this category to avoid overlap. Somatic symptom disorder replaces somatoform disorder, undifferentiated somatoform disorder, and pain disorder, but only if the person also has maladpative thoughts, feelings, and behaviors that define the condition (Carter, 2013).

Somatic Symptom Disorder

Definition and Assessment:
Somatic symptom disorder is a chronic relapsing condition which is difficult to treat. The disorder commonly begins during late adolescence, although it may start up during the 30s. These clients tend to repress childhood memories and do not volunteer the fact they may have suffered from child abuse. They find emotional expression difficult, if not impossible, and tend to somatize painful memories and emotions. Individuals with this disorder often have complicated medical histories rather than emotional complaints and report vague and inconsistent medical symptoms that are often associated with psychological problems such as anxiety, substance abuse, and personality disorders. Symptoms of somatic symptom disorder include gastrointestinal complaints such as vomiting, nausea, bloating, and diarrhea, pain in at least four different places on the body, one sexual symptom, and one pseudoneurological symptom such as fainting or blindness. Such symptoms cannot be related to a diagnosable medical disorder, do not have to occur at the same time, cannot be feigned out of an effort to gain attention, and they cannot be deliberately induced. Typically somatic symptom disorder

complaints are often triggered by, or become worse with stress or fear of having a serious disease (Smith, 1995). These clients' physical symptoms, which are somatization of emotional states such as anxiety and depression, will last from 6-to-12 months with periods of distress coinciding with the development of new symptoms or worsening of pre-existing symptoms. To be diagnosed with somatic symptom disorder the client is to be symptomatic for at least six months (King, 2013).

An accurate mental health assessment relies a great deal on the physician's findings and medical report. Thus, it is imperative for the mental health professional to request the client's medical record and have a collaborative relationship with his or her doctor. Because clients with somatization disorder have physical symptoms which represent emotional states, the mental health assessment must take this into account, and interviewer's questions should be directed in ways that can determine the connection. Clients with physical symptoms and/or somatization disorder also may have been victims of childhood trauma and sexual abuse (Brende, Dill, Dill, & Sibcy, 1998; van der Kolk, 1994; Walker & Stenchever, 1993) and the interviewer's questions can pursue this information.

Criterion A specifies one or more somatic symptom that is distressing. Criterion B specifies at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of the symptoms
2. Persistently high level of anxiety about health
3. Excessive time and energy devoted to symptoms or health (p. 311)

When the mental health professional sees the client during subsequent interviews or therapy sessions, symptoms may vary and change with time, depending on the client's level of emotional distress. When the client presents a new physical symptom, he or she is communicating an emotional need, saying, "I hurt" or "I am in distress." Rarely do new symptoms represent the onset of a new illness. However, if true disease is present, the client's manner is qualitatively different, and that may be evident to the examiner (Smith, 1995).

Clinicians interviewing for an accurate diagnosis should be cognizant of possible comorbidity with other disorders such as body dysmorphic, undifferentiated somatization, hypochondriasis, monohypochondriasis, and physical defects. APA (2013) emphasizes thoughts, feelings, and behaviors that accompany the symptoms and are persistent for six months. McKay and Bouman (2008) caution the clinician to be aware that individuals with somatization disorder often don't establish clear boundaries and may lack conviction about the nature of their illnesses. Taylor and Asmundson (2004) provide guidelines for the clinician to clarify and identify the presence of strong disease conviction. Other factors that differentiate from somatization disorder include: Clients with body dysmorphic disorder often report embarrassment and may also be obsessed or even delusional about physical abnormalities. Patients with conversion disorder can be emotionally detached and lack appropriate concern about the seriousness of their physical disorder. Hypochondriacal patients often are excessively convinced about the seriousness or even potentially lethal nature of their physical symptoms and psychotic patients' symptoms include delusional beliefs and body sensations.

Incidence:
APA (2013) reports no known prevalence rate at this time; however, it may be around 5%-7%. Prevalence is predicted to be between undifferentiated somatoform disorder (19%) and somatization disorder (<1%) (Carter, 2013). Somatic symptom disorder is relatively rare in the general population according to the ECA Study (Swartz, Landerman, George, Blazer, & Escobar, 1991). It is estimated that . 13% of the general population or one in every 1,000 people suffers from this disorder although some sections of the country seem to be higher (Swartz, Blazer, George, & Landerman, 1986). More current data reports as many as 2% of women suffer from this disorder (APA, 2000, p. 487). Clients with this disorder tend to congregate in primary care and hospital settings because they perceive themselves to be very ill. Thus, estimates of the prevalence of somatization disorder among clients seen in primary care settings ranges from .2% to 4% (Kessler, Cleary, & Burke, 1985).

Instrumentation:
The Prime-MD is a validated instrument (Spitzer et al., 1994, 1995) that has been used by primary care physicians to quickly diagnose major psychiatric disorders that are often overlooked by physicians. This instrument, which also can be used by mental health professionals, measures several categories of physical and emotional symptoms in clients – mood, anxiety, alcohol use, eating behavior, and somatoform disorders.

A History and Severity of Traumatic Events and Twelve Theme Assessment of Post-Traumatic Symptoms (HSTE-12) are a validated instrument (Brende, Gfroerer, & Arthur, 1997) that assesses the prevalence of traumatic histories and the severity of post-traumatic symptoms. This self-report questionnaire includes 43 possible stressful or traumatic events, including 12 violent stressors and 24 questions pertaining to 12 symptom categories: (a) powerlessness, (b) loss of meaning and concentration, (c) shame and distrust, (d) memory problems, (e) anger, (f) fear, (g) guilt, (h) unresolved grief, (i) suicidal thinking, (j) bitterness and revenge, (k) purposelessness, and (l) difficulties with interpersonal relationships.

Treatment:
The treatment of individuals with somatic symptom and related disorders is a challenge to health care providers. Physicians are most commonly involved with these clients but often make referrals to mental health professionals when the physical complaints are recognized as having strong emotional overtones. Somatizing clients tend to be "doctor shoppers," high users of medical care, and tend to avoid seeking psychiatric treatment on their own (Ford, 1995). At least 10% of all medical services are, in fact, provided to individuals with no clear evidence of a physical illness or disease stated (Ford, 1984). The diagnosis of somatization disorder had not been clear until the 1960s when diagnostic consistency was obtained after a series of research studies (Guze & Perley, 1963; Perley & Guze, 1962). A previous name, Briquet's syndrome, had been used for this disorder before the DSM-III was published in 1980 (Smith, 1995).

Most clients with this disorder have many medical complaints and treatment tends to be basically medical with primary care physicians being primarily responsible. Because of their multitude of medical complaints, physicians may soon become frustrated with these patients because of failed medical treatments. Ideally, clients with this disorder should remain with one physician rather than

change frequently, as they often do. There are frequent comorbid conditions, such as anxiety, which accompanies many medical illnesses (Smith, 1995); depression, which often accompanies cardiovascular disease (Musselman, Evans, & Nemeroff, 1998); body dysmorphic, undifferentiated somatization, hypochondriasis, monohypochondriasis (Looper, & Kirmayer, 2002; McKay & Bouman, 2008) and emotional distress often associated with respiratory illness, migraines, hypoglycemia, hyperthyroidism and cardiac arrhythmias (Sadock & Sadock, 2000).

Mental health professionals have a significant role in the treatment of individuals with somatic symptom disorder and should continue collaborative relationships with the referring physicians.

Counselors can utilize a variety of therapeutic modalities to help clients with issues like distorted body image, somatization of anxiety, somatization of traumatic memories and loss, and repressed emotion and techniques for emotional expression. Cognitive-behavior therapy (CBT) has been recommended for the treatment of hypochondriasis, body dysmorphic disorder, and undifferentiated somatoform disorder. Looper and Kirmayer (2002) and McKay and Bouman (2008) include CBT as a treatment for the medically unexplained chronic fatigue syndrome, and group treatment for somatization disorder. Each of these disorders has a theme of worry or conviction of a serious medical illness (hypochondriasis), physical defect (body dysmorphic), unexplained bodily complaints (somatization), and unexplained symptoms.

Group treatment may be most beneficial for somatization disorder clients with an emphasis on improving clients' socialization and coping skills (Corbin, Hanson, Hopp, & Whitley, 1988; Ford, 1984). Smith describes his approach of leading such a group as follows:

Session 1: Set goals and procedural rules for the group

Session 2: Address techniques that patients use for coping with their physical problems

Session 3: Discuss how to be assertive with physicians

Session 4: Discuss how patients can take more control and increase the positive aspects of their own lives

Session 5: Address structured problem solving

Session 6: Focus on personal risk taking

Session 7: Help patients identify any positive changes they had made while part of the group and encourage them to continue making positive changes after the group ends.

Looper and Kirmayer (2002) conducted a review of treatments and interventions for hypochondriasis, body dysmorphia disorder, conversion disorder and somatization disorder. Review their article for an elaboration of specific treatments. A list for those psychological interventions found to be helpful is suggested. These interventions are composed of theories, attention training, distraction, hypnosis, social and environmental manipulation, and awareness to physiological disturbance.

Conversion Disorder (functional neurological symptom disorder)

This disorder may have one or more symptoms, motor, sensory, episodes, unresponsiveness, absence of speech volume, articulation, and diplopia (APA, 2013).

This diagnosis is to assess for unexplained motor or sensory functions and is to be devoid of a neurological disease and clear evidence is required. See APA (2013), page 318 for diagnostic criteria. The functional neurological symptom disorder symptom specifiers include weakness, abnormal movement, swallowing, speech, seizures, sensory loss, special sensory, and mixed symptoms. The assessor is to specify if acute episode or persistent and with psychological stressor or without psychological stressor (APA, 2013). A neurological examination is emphasized and the recognition of the importance of relevant psychological factors present at the time of diagnosis.

Treatment:

1. Limited findings. Hypnosis and stress management counseling has been used in hospitalized clients (Oakley, 2001).

Factitious Disorders

Factitious disorder provides criteria specific for imposed on self and imposed on another (proxy). Factitious disorder is characterized by an intentional production of physical or psychological signs or symptoms. Somatic symptoms are prominent in this condition. Some confusion exists in the literature as to an agreed upon name for this disorder. Several alternate terms have been used, such as Munchausen syndrome, hospital addiction, polysurgical addiction, factitious illness, hospital hoboes, peregrinating patients, and factitious disorder by proxy (Parnell & Day, 1998).

Definition and Interview:
A factitious disorder is a falsification of medical or psychological signs and symptoms in oneself or others that are associated with the identified person (APA, 2013, p. 325). Physical symptoms may be fabrication, self-infliction, or an exaggeration of a pre-existing physical condition. An interviewer conducting an assessment must consider malingering as a differential diagnosis and be alert to unique motivational factors. The malinger presents symptoms deceitfully to obtain secondary gain such as avoiding work, obtaining drugs, getting lighter criminal sentences, trying to get out of going to school, or simply to attract attention or sympathy. The factitious disorder patient feigns symptoms in order to receive care and habitually enters one hospital after another. When pressed for details, he or she will become very vague although possessing considerable knowledge of medical practices, terms, routines and diagnostic tests in order to manipulate admission to a hospital (Comer, 1996). When confronted with or hoping to avoid the truth about exaggerated or faked symptoms, the patient will self-discharge and often enter another hospital the same day. He or she will angrily discontinue care from a physician or therapist who begins to question in a confrontational manner about distortions or exaggerations and seek a different therapist or physician. A careful review of this individual's previous medical record and history of physical or psychological care likely would reveal a variety of diagnoses.

Munchausen syndrome is a chronic form of this disorder and is also called factitious disorder with physical symptoms (Comer, 1996; Taylor & Hyler, 1993). Munchausen syndrome by proxy is the applied term when parents fabricate or induce physical illnesses in their children.

Factitious disorder is not easy to diagnose but should be considered when the client repetitively seeks the care of doctors for suspicious reasons. If the diagnosis cannot be substantiated (there is often a history of deception), and there appears to be a hidden agenda or secondary gain, it is recommended that a team of professionals be involved. For further information, see Parnell and Day's (1998) guidelines, which include 18 guidelines of features in three categories: child-victim, mother-perpetrator, and family.

Incidence:
APA (2013) reports the prevalence rate is unknown other than hospital settings (1%). Frances and Ross (1996), consider this disorder one of the most under-diagnosed. Parnell and Day (1998) reported a number of studies regarding specific populations sampled in research or practice, such as 1% asthmatic patients (Gooding & Kruth, 1991), .27% apnea (Light & Sheridan, 1990), 1% of hospitalized patients seen by psychiatric consultants (APA, 2000), and 5% allergy clients (Warner & Hathaway, 1984).

Assessment:
An accurate assessment of factitious disorder relies a great deal on the physician's findings and medical report. Thus, it is imperative that the mental health professional request the client's medical record and have a collaborative relationship with his or her doctor in order to ascertain the truth about the client's medical condition. Because patients with factitious disorder have physical symptoms that represent self-destructive or injurious behaviors that represent emotional pain, the mental health assessment must take this into account, and the interviewer's questions should be directed gently, yet confrontively, in ways that can determine the truth. Because reports have indicated a high rate of suicide in clients with factitious disorder, it is important to assess for the presence of depression (Popli, Masand, & Dewan, 1992).

Specific criteria for factitious disorder imposed on self or another are:

Criterion A: imposed on self are falsifications of physical or psychological signs or sympotoms or induction of injury or disease in another, associated with the identified client.

Criterion B: the client presents another person to others as ill, impaired or injured

Criterion C: the deceptive behavior is evident in the absence of obvious external rewards

Criterion D: behavior is not better explained by another mental disorder (p. 324-325).

The mental health professional must differentiate between this disorder and malingering, as previously described. The malingerer intentionally makes false or grossly exaggerated physical or psychological symptoms to obtain secondary gain while the client with factitious disorder may be deliberately self-injurious but with a different intent – to obtain attention through self-injurious behavior or express a negative emotional response such as anger in a physically self-injurious way.

The most common psychodynamic explanation for factitious disorder is the presence of unresolved conflicts from childhood. Physical symptoms become an indirect means to obtain medical attention as a substitute for love and affection because desired parent-child relationships were either unavailable or repeatedly broken. However, these clients repeatedly fail to resolve their conflicts because they tend to provoke caregivers and experience rejection, repeating a pattern experienced as children. One study reported a 9% rate of factitious disorders among those admitted to a hospital. It is important for the physician or counselor to secure information from available friends, relatives, or other sources to verify the facts of the physical or psychological illness. Psychiatric consultation is requested in about 50% of cases when these patients are treated in a hospital setting. It is important that the professional or consultant carry out evaluations in ways that avoid accusatory questioning, which would only provoke more serious symptoms (Kaplan & Sadock, 1998).

Instrumentation:
The Prime-MD is a validated instrument developed by Spitzer et al. (1995) that has been used by primary care physicians to quickly diagnose major psychiatric disorders often overlooked by physicians. This instrument, which also can be used by mental health professionals, measures several categories of physical and emotional symptoms in patients – mood, anxiety, alcohol use, eating behavior, and somatoform disorders. Although it is more useful in clients with somatization disorders, it could also be of some use in diagnosing factitious disorder.

A History and Severity of Traumatic Events and Twelve Theme Assessment of Post-Traumatic Symptoms (HSTE-12) is a validated instrument (Brende, Gfroerer, & Arthur, 1997) which has been used to assess the prevalence of traumatic histories and the severity of post-traumatic symptoms. This is a self-report questionnaire, which includes 43 possible stressful or traumatic events, including 12 violent stressors and 24 questions pertaining to 12 symptom categories. Although it is more useful in clients with post-traumatic syndromes or somatization disorder, it also may be of some use in the client with factitious disorder.

Treatment:
The level of denial, manipulation, and deception is to be taken into consideration when developing a treatment program for these clients, who often have personality disorders in conjunction with Munchausen by proxy. A treatment framework is recommended that includes avoiding unnecessary hospitalization. While no specific treatment is known to be consistently beneficial, it is recommended that the therapist be empathic and gently confrontative while reducing or avoiding dependency. Individual therapy is recommended if the client is old enough and has a capacity for insight. Using a co-therapist may help to deal with denial and other resistance more effectively while family therapy can be used to help individuals with supportive families regain some degree of autonomy (Eisendrath, 1995). However, even with the best of therapists or physicians, Munchausen by proxy patients often avoids or flees treatment.

Feeding and Eating Disorders

The DSM-5™ lists within the classification of feeding and eating disorders: pica, rumination disorder, avoidant/restructive food intake disorder, anorexia nervosa, bulimia nervosa, and binge eating disorder (APA, 2013). Changes were made to create more specificity in diagnosis and to reduce the dependence on the catch all diagnosis of "NOS" which was eliminated (Carter, 2013).

Abraham and Llewellyn-Jones (1997) postulate that individuals with eating disorders attempt to control their "love" for food either "rigorously or intermittently" (p. 64). Increased attention has been given to eating disorders in the professional literature, particularly over the last three decades. The most common eating disorders are anorexia nervosa and bulimia nervosa. According to the APA (1994), eating disorders are, in general, characterized by "severe disturbances in eating behavior" (p. 539). The specific disorders of anorexia nervosa and bulimia nervosa are associated with significant morbidity and mortality. There is "an enormous personal and systemic cost" (Skekter-Wolfson, Woodside, & Lackstrom, 1997, p. 2) due to prolonged hospitalizations and comparable mortality to diabetes mellitus or schizophrenia over a similar duration of time. Psychological disturbances associated with eating disorders include irritability, confusion, depressed mood, insomnia, and obsessive-compulsive behavior. Physical disturbances, particularly in anorexia nervosa, include emaciation, brachycardia (slow heartbeat), low blood pressure, bloating, constipation, swelling of hands and feet, dry scaly skin, appearance of fine facial and body hair, loss of head hair, feeling cold, amenorrhea (absent menstruation), and mild anemia (Abraham & Llewellyn-Jones).

Definition and Interview:
It is recommended that the interviewer learn when and why the client developed eating disturbances and whether it has been associated with health problems, vomiting, diarrhea, menstrual irregularities, and other metabolic disorders (Shekter-Wolfson et al., 1997). An essential part of the interview is obtaining the client's weight history, which is vital for the diagnosis and also gives the clinician an indication of the extent of the client's preoccupation with size and shape. The clinician should be supportive of the client but also firm and forthright when asking for a history and details of disturbances. Additionally, the interview should include the following: past history of emotional disturbances, past medical history, and family history – both past and present (Shekter-Wolfson et al.). Shallcross (2013) indicates that gender is important because males and females use different languages to describe an eating disorder and body image with words such as "toned or ripped" for males in terms of desire. Women tend to describe the same with weight or dress size.

Anorexia Nervosa

Definition:
The core concepts for anorexia nervosa are unchanged. The requirement for amenonhea has been eliminated and is not to be applied to males, pre or post-menstrual women or some using oral contraceptives. Anorexia nervosa is characterized by the self-imposition of dietary restriction caused by a distorted self-image and an intense drive for thinness (e.g., Shekter-Wolfson et al., 1997). The

essential features of Anorexia nervosa as reported by the APA (2000, 2013) are unchanged and are the following: refusal to maintain a minimally normal body weight, intense fear of gaining weight, and significant disturbance in the perception of the shape or size of his or her body. The criteria has been expanded to include persistent behavior that interferes with weight gain in addittion to an overly expressed fear of gaining weight. Severity is based on BMI.

Palmer, Oppenheimer, Dignon, Chaloner, and Howells (1990) recommend that history of sexual abuse should be taken in the early phase of the interview and assessment.

Criterion A refers to a restriction of energy intake regarding the requirements. Thus the individual is prone to a significantly low body weight based on age, sex, developmental trajectory, and physical health. Significant low body weight is defined as weight that is less than minimally normal for children and adolescents, less than that minimally expected. Criterion B is an intense fear of gaining weight or of becoming fat and Criterion C refers to a disturbance in how one's body weight or shape is self-evaluated and experienced (APA, 2013, p. 338-339).

The diagnosis is to specify one of two commonly identified subtypes of anorexia nervosa are restricting and binge-eating/purging. The restricting subtype presents with weight loss that is accomplished generally through dieting, fasting, or excessive exercise. The individual who has regularly engaged in binge-eating or purging (or both) during the current episode typifies the binge-eating/purging subtype. Purging is usually induced by purposeful vomiting or by misusing laxative agents (p. 585). Several noteworthy conditions may mimic anorexia nervosa. For instance, weight loss associated with depression (generally there is no drive for thinness in this instance) and psychotic illnesses in which the person may develop bizarre delusions about food (Shekter-Wolfson et al.).

Incidence:
The prevalence for a 12-month period for anoxreia for young females is 0.4% (APA, 2013). The prevalence of eating disorders is most appropriately separated by gender. Most research has shown prevalence rates of anorexia nervosa to be between .5% for women between 15 and 40 years old. While there are cases of anorexia nervosa in men, the prevalence appears to be 1/20 of that for women (Garfinkel et al., 1995; King, 1989; Lucas, Beard, O'Fallon, & Kurland, 1991; Shekter-Wolfson et al., 1997). Bulimia prevalence rates are reported by the APA (2000) to be slightly higher (1% to 3%) in young females with male occurrences of 1/10th that for women.

Instrumentation:

1. Bulimia Test-Revised (BUILT-R; Thelen, Farmer, Wonderlich, & Smith, 1991)
2. Body Esteem Scale (BES; Franzoi & Shields, 1984)
3. Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987; Mazzeo, 1999)
4. Eating Disorder Belief Questionnaire (EDBQ; Cooper et al., 1997)
5. Eating Disorder Thoughts Questionnaire (EDTQ; Cooper et al., 2006)
6. Body Image Avoidance Questionnaire (BIAQ; Rosen, Srebnik, Saltzberg, et al., 1991)

7. Body Checking Questionnaire (BCQ; Res, Whisenhunt, Netemeyer, et al., 2002)
8. Satisfaction with Body Parts Scale (SBPS; Berscheid, Walster, & Bohrnstedt, 1997)
9. Eating Disorder Examination Interview (EDE-Q; Fairburn & Belgin, 1994)
10. Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Regier, Touyz, ….et al., 2002)

Treatment:
Anorexia nervosa can be a potentially life threatening disease requiring immediate medical attention. An extensive list of mainly female celebrities including actresses, athletes, musicians, fashion models, ballerinas, and authors have died from anorexia. Because of that fact there are numerous eating disorders treatment centers across this country that include inpatient, residential, partial hospitalization, recreation, psychotherapy, and behavior interventions to treat this and other eating disorders.

Wilson, Grilo, and Vitousek (2008) researched reports on family therapy by Fairburn (2005) and Vitousek and Gray (2005) and concluded that family therapy has been researched most thoroughly and results are encouraging, particularly for young persons (The NICE Guidelines, 2004). The Maudsley model has been studied more than any other family model. Besides the immediate use of psychotherapy for symptom reduction and elimination it also has a role in reducing the risk for relapse (Lowe, Zipfel, Buchholz, Dupont, Reas, & Herzog, 2001; Steinhausen, 2002). Psychoeducation is also recommended because of lack of knowledge and misconceptions about eating disorders (Bowers & Andersen, 1995).

Typically, anorexia nervosa clients maintain body weight 15% below expected weight and for adolescents this can have an adverse effect on normal development. They tend to have a distorted self-image and attempt to maintain weight loss by restricted calorie intake, exercise, vomiting and /or purging (Gowers, 2005). Emaciation is the prominent concern for family and health providers although there are also other physical features that need attending to considering a variety of treatment strategies that have been employed for eating disorders, the treatment of choice is cognitive-behavioral therapy (Harrington, et al., 1998; NICE, 2004) which includes exposure and prevention (ER), monitoring food intake, meal planning, problem solving and cognitive restructuring (Cooper, Todd, Turner, & Wells, 2007).

Therapy should also include helping to improve mood disturbances, poor self-esteem and feelings of ineffectiveness (control), which comprise a large component of psychological concerns for the eating disorder clients. Discrepancy exists regarding effectiveness regarding CBT for body image. CBT results do reflect improvement for the symptoms of binge eating/purging (Walsh, Wilson, Loeb, et al., 1997).

CBT is moderately effective at the symptomatic level for adults. A recent treatment strategy is mirror exposure or mirror confrontation. Clients will systematically observe themselves in a full-length mirror and react to the distress as a phobic stimulus (Tuschen-Caffier, Voegele, & Bracht, et al., 2003). This strategy is based on Linehan's Mindful treatment. This approach emphasizes emotional processing of distressing thoughts and feelings about body shape and weight. Improvement has been detected in body checking and avoidance, weight, dieting, depression, and self-esteem (Delinsky & Wilson, 2006).

Although most outpatient treatments for anorexia have not been successful, Bowers and Anderson (1995) indicate that outpatient treatment may be appropriate for a few individuals, mainly those who have been ill for less than a year and have lost less than 25% of their ideal body weight, do not binge or purge, and have a well and supportive family. Cooper, Todd, Turner, and Wells, (2007) believe that treatment approaches can be modified or elaborated in order to take into account the extreme weight and shape concerns that play a key role in dieting, binge eating, purging, fasting, and excessive exercising. For serious or protracted cases hospitalization is the treatment of choice because of the potential lethality of the disorder, not necessarily for pharmacotherapy but to manage the weight loss and establish dietary counseling, individual, and group counseling. Hospitalization is also recommended for suicidal risk and after failure to improve from psychotherapy. Although selected antidepressant therapy has sometimes been useful, there is no empirical evidence that antidepressants are consistently effective for this disorder (Wilson, Grilo, & Vitousek, 2008).

Psychotherapy in the form of systematic desensitization and operant conditioning procedures, which include reinforcers as well as individual psychoanalytically-based psychotherapy (Eckert & Mitchell, 1989), has been found effective in treating anorexia nervosa. However, many clinicians prefer cognitive-behavioral approaches to address eating behaviors and interpersonal strategies in order to explore other issues related to the disorder. Family therapy has been used to examine interactions among family members as contributing to the disorder (Kaplan & Sadock, 1998).

Bulimia Nervosa

Definition and Assessment:
According to the APA (2000), the essential features of bulimia nervosa are "binge eating and inappropriate compensatory methods to prevent weight gain" (p.589). The DSM-5™ (APA, 2013) Criterion C changed the minimum frequency of binge eating average from twice a week to once weekly for three months. The severity is based on the number of purge behaviors per week (mild, 1-3, moderate, 4-7, severe, 8-13, and extreme, 14 or more). Binge eating has been removed from the appendix in the DSM-IV-TR and is considered a disorder in the DSM-5™. Body shape, weight, and the capacity, or lack of it, influences the bulimic's self-evaluation regarding their ability to maintain self-control. Ironically, the loss of self-control is a significant part of both bingeing and purging. Criterion A is a recognition of recurrent episodes of binge eating and characterized by both eating at one time an amount of food that is definitely larger than what most individuals would consume and there is a sense of a lack of control over the eating (APA, 2013, p. 345). Criterion B refers to the compensatory behaviors such as self-induced vomiting, misuse of laxatives, diuretics, or other medications and resulting fasting.

Defining a binge is an important element in the diagnosis of this disorder. The APA (2013) defines a binge as "eating in a discrete period of time, an amount of food that is definitely larger than most individuals would eat under similar circumstances" (p. 350). The clinician should also consider the context of the binge for purging and/or restricting. The purging type refers to self-induced vomiting or misuse of laxatives, diuretics, or enemas. The restricting type involves the use of other compensating behaviors, such as fasting or excessive exercise.

Incidence:
The prevalence rate for young females for a twelve month period of time is 1%-1.5%.

Treatment:
Treatments for bulimia nervosa include CBT (NICE, 2004), nutritional counseling (diet therapy), psychotherapy, parental counseling, and pharmacotherapy (Halmi & Garfinkel, 1995). Treatment of choice for adults is manual-based cognitive-behavioral therapy (NICE, 2004).

The aim of therapy and psychoeducation for individuals with eating disorders may include the following (Abraham & Llewellyn-Jones, 1997; Tuschen-Caffier, Pook, & Frank 2001):

1. Persuade her (sic) to achieve a weight which lies in the normal range.
2. Help her gain insight into her eating behavior and why the behavior is persisting.
3. Educate her about nutrition and normal eating and dispel myths about food and eating.
4. Help her overcome any problems in her life which may be aggravating the eating behavior or preventing her recovery.
5. Help her alter or modify her lifestyle, if appropriate (p. 67).

Three primary psychological treatments have been demonstrated to be the most effective: cognitive behavioral therapy, supportive therapy, and behavioral techniques. Of these, cognitive-behavioral therapy has demonstrated superior results to the others (Abraham & Llewellyn-Jones, 1997). The specific aim of cognitive behavioral therapy is to:

1. Explore the client's thoughts and beliefs, which maintain binge-eating and dangerous methods of weight control.
2. Establish healthy eating habits.
3. Establish regular eating behavior in which she (sic) eats three meals a day with one or two snacks if she desires.
4. Help the client learn about food, eating, shape, and weight and to eliminate myths about food and eating.
5. Help the client increase her self-esteem and decrease the importance of her physical appearance in her evaluation of herself (sic) (Abraham & Llewellyn-Jones, 1997, p. 74).

According to Abraham and Llewellyn-Jones (1997), most authorities support a multi-disciplinary, multi-dimensional treatment approach due to the belief that these illnesses start with any variety of psychological problems that include family, biological, or intrapsychic issues. In this approach, the first step of treatment should be to help normalize eating and then move to address other issues associated with the eating disorder. Normalization generally begins with consultation with a dietitian to formulate a plan for normal eating. The second step is psychoeducation which is providing the client with accurate information about the illness. Finally, psychotherapy and the use of medication should be determined. One of the SSRI antidepressant medications, Fluoxetine, has been

demonstrated to be helpful in bulimic patients in high doses, i.e. 60 mg daily (Fluoxetine BNC Study Group, 1992), but the combination of medication and psychotherapy in the treatment of eating disorders appears to be better than medication alone. When comparing psychotherapies, cognitive-behavioral therapy (CBT) and interpersonal therapies (IPT) show the greatest effectiveness with no clinical efficacy differences between the two with one exception, CBT proves to be more cost-effective. Trials have shown results for CBT occurring within 20 weeks, while IPT needs up to one year (e.g., Fairburn, Jones, & Peveler, 1991; Stolorow, Brandchaft, & Atwood, 1987).

Family therapy is also recommended by NICE (2004) although a recent study by Schmidt, Lee, Beecham, et al. (2007) conducted a comparison study with 85 Bulimia Nervosa clients. Two groups composed of family therapy (41) and CBT guided self-care (44) revealed CBT was more effective at 6 months while at 12 months this difference disappeared. The conclusion was CBT had a slight advantage when it came to time (cost) but not necessarily symptoms.

Sleep-Wake Disorders

The sleep-wake disorders include 10 disorders or groups of sleep disorders. The disorders are:

1. Insomnia disorder, hypersomnolence disorder, narcolepsy (presence of cataplexy-loss of muscle tone), hypocretism deficiency as measured by rapid eye movement or cerebrospinal fluid assessment and for sleep latency deficiency as measured by polysomnography.
2. Breathing-related sleep disorders include obstructive sleep apnea hypopnea, central sleep apnea, sleep-related hypoventilation, circadian rhythm sleep-wake disorder (six types): delayed sleep phase type, advanced sleep phase type, irregular sleep-wake type, non-24-hour sleep-wake type, shift work type and unspecified type.
3. Parasomnias: non-rapid eye movement (NREM), sleep arousal disorder and rapid eye movement (REM), nightmare disorder, rapid eye movement (REM) sleep behavior disorder, restless legs syndrome, and substance/medication-induced sleep disorder. REM sleep behavior disorder and restless legs syndrome have been added to the sleep-wake classification (APA 2013; King 2014b).

The new disorders for the DSM-5™ are obstructive sleep apnea hypopnea, central sleep apnea and sleep-related hypoventilation.

Definition:
Troubled sleeping is one of the most common complaints in the general population (Spielman & Glovinsky, 1997). Stepanski, Rybarczk, Lopez, and Stevens (2003) categorize sleep complaints as an inability to initiate or maintain sleep at night (insomnia) and an inability to maintain wakefulness during the day (excessive-daytime sleeping).

Dyssomnia is a term in the DSM-IV-TR representing the primary sleep disorders. The classification in the DSM-5™ is sleep-wake disorders and include primary insomnia, primary hypersomnia, narcolepsy, breathing -related sleep disorders, and circadian rhythm disorders. Wake was added to the sleep category for sleep disorders because arousal and sleep cycles are dysregulated causing daytime and impairment concerns.

According to Swanson (1999), approximately 40 million Americans suffer from sleep disorders. Hauri (2000) reported that 30% to 33% of the population in the United States experience sleeping difficulties. The data also indicated that 10% to 12% had chronic sleep problems. The current section will address the sub classifications of primary sleep disorders, dyssomnias and parasomnias. Dyssomnias are those sleep disorders that affect the quality of sleep (amount and timing of sleep). Parasomnias are those sleep disorders that are associated with abnormal behavioral or physiological events that occur with sleep. Phillips and Ancoli-Israel (2001) classify primary sleep disorders as sleep-disordered breathing, obstructive sleep apnea (OSA) central sleep apnea, sleep-related hypoventilation, and restless legs syndrome (RLS).

Incidence:
Sleep disruption is probably experienced by all individuals at one time or another (Rothenberg, 1997). Prevalence rates of all the sleep disorders across the U.S. population have been reported from 13% to as high as 49% (Bixler, Kales, Soldatos, Kales, & Healey, 1979; Ford & Kamerow, 1989; Rothenberg, 1997; Shapiro & Dement, 1989). Older adult (65 and older) incidence was reported by Foley, et al. (1995) to be 53% experiencing inadequate sleep or daytime alertness.

Interview:
The interview with the client suffering from sleep disruption should begin with a history of sleep complaints. The history should account for two main areas: the part of the night that sleep is most problematic and the type of complaint (e.g., trouble falling asleep, trouble staying asleep). The clinician should determine the age of onset and extenuating factors surrounding this complaint (Spielman & Glovinsky, 1997). Sleep disorders and sleep deprivation may relate to pain, medical conditions directly related to decreased respiratory stability, neurodegenerative disorders, medications effects, depression, and cardiopulmonary disorders, congestive heart failure and should be considered during the interview (Stepanski, Rybarczk, Lopez, and Stevens, 2003). Other issues to consider in the interview are the daytime consequences of sleeplessness, past treatments, conditions that either promote healthy sleep or exacerbate the problems, medical disorders, medications used, psychiatric disorders, quality and time of work conditions, and family factors. The interviewer should determine if the client experiences early morning headaches, stops breathing during sleep, experiences fatigue during the day, naps during the day, falls asleep during waking hours, and has a history of high blood pressure.

Most clients are encouraged by family members to see their family physicians. For example, if the spouse becomes aware and concerned that the client stops breathing (sleep apnea) for several prolonged periods of time during the night and feels compelled to awaken him or her, he or she should consult a physician. Assuming obstructive sleep apnea is suspected; the physician will most

likely make a referral to a sleep laboratory for analysis of a sleep disorder and/or may refer to an ENT (ear-nose-throat) specialist to diagnose for an airway obstruction.

Assessment:
It is important to understand the stages of sleep and for daytime and eveningness. Eveningness is the preference of an individual for later to bed and later to rise or wake times. Involved in these patterns are the behavioral activities and alertness with later times during the day. The Epworth Sleepiness Scale is an often used checklist to identify and isolate those times in which the client falls asleep or other behaviorally related sleep issues such as those while sitting and reading, in public places, as a passenger in a vehicle, taking naps (falling asleep), talking to someone (drowsing off), after lunch, at a traffic light or after a workout (Johns, 1997).

The DSM-5™ details more focus to comorbidity and to co-existing conditions. In addition times and situation frequency is important such as insomnia disorder occurring three times a week for at least three months or hypersomnolence where the severity is based on the number of days of difficulty maintaining alertness. Rapid eye movement sleep behavior disorder symptom is often talking and moving during the REM phase of sleep and has a prevalence rate of 0.38-0.5% (APA, 2013). The specifiers include episodic, persistent, and recurrent. It is important to keep in mind comorbidity as sleep disorders are often accompanied by depression, anxiety and cognitive changes and comorbidity examples include breathing-related sleep disorders, disorders of the heart and lungs, neurodegenerative disorders, and disorders of the neurodegenerative, and musculoskeletal system (p. 361). A sleep laboratory analysis is recommended (polysomnography). For children or adults the DSM-5™ recommends the use of the Level 2 Sleep Disturbance Patient-Reported Outcome Measurement Information System (PROMIS) Short Form. This form can be located on-line.

The assessing for a specific sleep-wake disorder the interviewer is to be aware of neurobiological validators and genetic evidence before and during the phase of assessment.

This is important because of the relationship that exists between sleep-wake disorders and mental and medical conditions.

King (2014b) reviewed many of those relationships and found embedded sleep as an issue with bipolar I, major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoria disorder, separation anxiety disorder, GAD, PTSD, ASD, alcohol, cannabis, opioid, sedative, hypnotic, anxiolytic, stimulant or tobacco withdrawal, and caffeine intoxication. In addition mental health disorders also co-exist with sleep-wake disorders such as autism spectrum, ADHD, panic, adjustment, dissociative, somatic symptom, feeding and eating, elimination, amphetamine, neurocognitive, and persistent complex bereavement disorders (DSM-5™, pages 789-792).

The assessment as pointed out earlier can include inventories and questionnaires such as a sleep diary, Sleep Disturbance Questionnaire (Espie, Brooks, & Lindsey, 1989), Sleep History Questionnaire (Edinger, 1987), Sleep Impairment Index (Morin, 1993), The Beliefs and Attitudes about Sleep Scale (Morin, 1993),

Pittsburgh Sleep Quality Index (Buysse, Reynolds, Monk, Berman, & Kupfer, 1989), and the Epworth Sleepiness Scale (Johns, 1991). Morin (1993) developed an interview for identifying sleep issues for insomnia. This interview is also helpful for the treatment phase as the client identifies what he/she thinks may be the cause (s) as well as the sleep disturbance. A client experiencing insomnia may complain about intrusive thoughts, worry, and rumination which often carries over into daytime disruptions in alertness. Along with these issues may be found hyperarousal experiences contributing to daytime and night time disturbances for restful sleep.

The check-list may highlight issues such as snoring, leg movements, and daytime fatigue may alert the assessor to sleep-wake disorders such as sleep apnea, restless legs syndrome, narcolepsy, co-existing mental disorders. A biological related issue may be circadian rhythm shifts, the timing of sleep and wakefulness with a 24-hour cycle. These different cycles may reflect sleep-onset insomnia or delayed sleep phase. In other words the two do not match, rhythm and sleep time.

If the client is older natural aging is factored into the sleep analysis. Sleep for this client is often fragmented, broken up, poorer sleep (stage 1) with a longer latency to sleep (stages 3 and 4), earlier morning awakenings, and reduced sleep efficiency.

Treatment:
Treatment for sleep-wake disorders may vary depending upon the specific disorder.

Pharmarcotherapy are typically hynotic and antidepressant medications.

There is a strong correlation between sleep issues and mood or depressive disorders. Bright light therapy has some benefits for insomnia (Cambell, Dawson, & Anderson, 1993). Cognitive-behavioral therapy (CBT) has demonstrated helpfulness for insomnia and improvement noted in two to six essions.

Bibliotherapy has some positive effects in booklet form or specific CBT strategies and exercies.

Sleep education is imperative for most all in learning the importance of restful sleep, the sleep stages, sleep routine, sleep logs, and benefits specific to the client's sleep-wake disorder. Sleep restriction is a therapy that is targeted at those who have excessive amount of time in bed (more wake time, less deep sleep and more light sleep-stage 1; Hauri, 2000).

Stimulus control is a program designed to combine stimulus control with sleep restriction.

Some specific psychological techniques have also shown positive gains such as cognitive restructuring, paradoxical intention and relaxation therapy.

Two new approaches although lack literature experimentation with sleep-wake disorders are mindfulness and a treatment identified as CBT-I for insomnia (Milner & Bilecki, 2010).

Carey (2013) reported the American Psychological Association sleep as a speciality area and that depression is the most common mood disorder and that a standard procedure for sleep disordes may be CBT-I.

Brief data reports from four studes indicated that 40% to 50% clients reported improvements above expectations.

The patient records bedtimes and when they wak each day and record perceptions of the sleep qulaity and number of awakenings. Common sense advice is offered like reducing caeffine and alcohol intake and to make sure the bedroom is dark and quiet. The therapy is composed of three segments, stimulus control, restriction, and common sense.

There are several surgical procedures a client can discuss with a neurologist and a surgeon regarding certain sleep disorders such as sleep apnea but will not be discussed in this supplement.

Insomnia Disorder

Poor quality and quantity, insufficient, or non-restorative sleep for a period of three months (Criterion C) characterizes the insomnia subtype of sleep disorders (APA, 2013; Buysse & Reynolds, 1990). The diagnosis of insomnia disorder is further defined by a sleep disturbance that causes clinically significant distress in a number of areas of daily functioning and not caused by a substance. The loss of a pleasant quality of life is a basic concern if insomnia is untreated. Voinescu, Szentagotai, and David (2012) reported that the symptoms of inattention with ADHD and insomnia symptoms were determined , together with sleep circadian cycles.

Incidence:
The prevalence rate is an estimate of a third of the general population and broken down into 10%-15% experiencing daytime impairment and 6%-10% symptoms of all sleep disorders (APA, 2013). Insomnia is defined as difficulty initiating or maintaining sleep three or more nights per week for six months or longer with impairments of daytime functioning, fatigue and disturbed mood (NIH, 2007). Among individuals afflicted with sleep disorders, Insomnia appears to occur more frequently in women and in both sexes with advancing age. Younger individuals tend to have higher rates of complaints falling asleep, while middle-aged adults and the elderly have a more difficult time maintaining sleep (APA, 2000). The prevalence of primary insomnia is 1% to 10% in adults and 25% in the elderly (APA, 2000) The APA also reports that 30% to 40% of adults complain of insomnia.

Assessment:
The DSM-5™ criteria (A) is one or more of the following: difficulty initiating sleep, difficulty maintaining sleep, and early-morning awaking with inability to return to sleep. The disturbance in sleep is to occur at least three nights per week (C) and present for at least three months (D), impairment in functioning (B), and not better explained by physiological effects or substance (G) or another sleep disorder (F). See assessment for Sleep-Wake Disorders.

Hypersomnolence Disorder

This disorder is generally associated with excessive sleeping despite the ability to get seven hours of sleep per rest period. This disorder is generally associated with sleep-related sleep disorders and can

be divided into apnea, hypopnea and hypoventilation (three disorders in the DSM-5™). Sleep disordered breathing in the hypersomniac is caused by obstructed air passages occurring during sleep – usually resorting in snoring (Rothenberg, 1997). When the obstruction is significant enough to block adequate breathing during the night, sleep apnea results. Clients with OSA are at risk for hypertension, pulmonary hypertension, and stroke. Interviewers should note symptoms of loud snoring, reports by others of apnea, awakenings with choking, coughing, or gasping for breath (Stepanski, Rybarczk, Lopez, and Stevens, 2003). The disorder takes place with the between times of sleep and waking and may take minutes or up to an hour. The individual may be observed to have difficulty with manual dexterity, memory issues, disorientation in time and space (APA, 2013).

The criteria for this assessment is the presence of one or more of recurrent periods of sleep or lapses into sleep within the same day, (1) prolonged main sleep episode of more than nine hours per day that is nonrestorative; (2) difficulty being fully awake after abrupt awakening; and (3) occurs at least three times per week, for at least three months (APA, 2013, p. 368). In addition there is to be impairment in cognitive, social, occupational or other areas of functioning (C) and not explained by another sleep disorder (D) or physiological effects of a substance (E).

The DSM-5™ indicates that individuals with this disorder fall asleep quickly and have sleep efficiency but may have difficulty awakening in the morning and may be confused or even irritably combatative. The combination of these activities is referred to sleep inertia.

Incidence:
The prevalence rate is approximately 5%-10% for individuals with complaints of daytime sleepiness (APA, 2012).

Assessment:
Sleep breathing disorders are diagnosed with the use of a systematic interview with a checklist of symptoms. A polysomnograph and an electroencephalogram (EEG) sleep study are recommended to determine the amount of restful sleep the client is experiencing. This study will determine the degree of sleep fragmentations (awakenings) and oxygen desaturation. Obesity is known to be a predictor of OSA.

Hypersomnolence disorder consists of excessive sleepiness (prolonged sleep episodes almost daily) for a period lasting at least seven hours with at least one of the following symptoms (recurrent periods of sleep or lapses, prolonged main sleep episode of more than eight hours per day, and difficulty being fully awake after abrupt awakening). The hypersomnolence causes significant distress in a number of areas of functioning. Associated symptoms are one is unable to stay awake and has non restorative sleep. Criterion B indicates hypersomnolence occurs at least three times per week for at least three months.

Parasomnias

The term parasomnia refers to a wide range of behaviors associated with sleep.

Disorders associated with this term all experience an activation of the physiological system (autonomic nervous, motor, or cognitive systems) at inappropriate times during the sleep-wake cycle (APA, 2013, 2000). The associated behaviors can include sleep walking, sudden or partial awakenings from deep non-REM sleep, night terrors (nightmare disorders), and confused awakenings (insomnia disorder). Parasomnia disorder is characterized by rapid eye movement behavior disorder (RBD). The interviewer is to consider reports of acting out dreams where the client has physically hurt a sleep partner (Stepanski, Rybarczyk, Lopez, & Stevens, 2003). Acting out behaviors consists of flailing arms, kicking, falling out of bed, and vocalizations. The most common parasomnias are non-rapid eye movement sleep arousal disorders (NREM), rapid eye movement (REM), and sleep behavior disorders. Parasomnia is separated into four categories of disorders: REM, NREM, restless legs syndrome, and substance/medication-induced sleep disorder.

Nightmare Disorder

Nightmare disorder consists of repeated frightening dreams that lead to awakenings in which the individual is fully alert. Nightmare disorder causes significant distress. In children three to five years old, prevalence rates are reported to be 10% to 50%. In adults as many as 50% of the general population report experiencing at least an occasional nightmare (APA, 2000, p. 632). Nightmares typically include threats to survival, safety, and self-esteem. Effectiveness studies are few but some recommendations for treatment are systematic desensitization, imagery rehearsal, relaxation techniques, extinction, and eye movement desensitization (Krakow, Sandoval, Schrader, Keuhne, McBride, & Yau, et al., 2001).

Interview and assessment:
The interviewer when considering diagnostic features is to listen for repeated dysphoric and well-remembered dreams. Similar to other sleep disorders the disorder is not attributed to physiological effects of a substance and other mental disorders. In relating the dreams the client frequently has an elaborate, lengthy and story-like order in relating that seems real. Emotions may be a part of the relating as the client is often making attempts to avoid some sort of harm or danger and a part of the relating may be negative emotions. When the client awakens the nightmares are well remembered and can be described in detail. The sleep stage of REM is when these dreams take place (APA, 2013).

Instrumentation:
Inventories, interview rating scales, and paper-pencil tests are not commonly found to be of assistance in making a parasomnia diagnosis. A detailed clinical history is the most important diagnostic tool and should emphasize eliciting the specific type of sleep complaint, its duration and course, factors that either help or worsen the problem, and responses to previous treatments. Assessment should include maintaining daily sleep diaries and a referral for medical examination. Finally, it is possible for a sleep-disturbed individual to have a thorough evaluation in a sleep laboratory for detailed neurophysiological monitoring as he "sleeps" during the night.

Restless Leg Syndrome (RLS)

Clients experience an urge to move the legs and often experience a tingling sensation (creeping, crawling, burning or itching) that is usually relieved by movement and/or getting out of bed and walking to relieve the tingling. Criterion A characterizes this urge to begin or worsen during periods of rest or inactivity, and to move the legs is partially or totally relieved by movement and/or to move the legs is worse in the evening or night than during the day. The symptoms occur at least three times a week and persist for at least three months (APA, 2013). Possible causes for this syndrome in older adults are uremia, iron deficiency anemia, and peripheral neuropathy (Stepanski, Rybarczk, Lopez, & Stevens, 2003).

Periodic limb movement in sleep (PLMS) is present on 90% of those clients who are diagnosed with RLS (previously known as Willis-Ekbom disease) and is supporting evidence for RLS (APA 2013, p. 411). Periodic limb movement is a disturbing foot movement that takes place during circadian sleep disorders, altered or interrupted sleep schedules. Advanced sleep phase syndrome (ASPS) is a disorder of the biological clock that initiates sleep at an earlier time (8 p.m.) than that would ordinarily be recognized (11 p.m.). As a result the rise time also becomes earlier - say 4 a.m. rather than 7 a.m. The cause(s) are unknown (Weitzman, Moline, Czeisler, & Zimmerman, 1982).

Narcolepsy

Narcolepsy is a syndrome disorder of the neural control mechanisms (sensorimotor, neurological) that regulate sleep and waking. The disorder may also include the arms. The DSM-5™ distinguishes narcolepsy from other hypesomnolescence. Hypocretin deficiency is often cited as the cause for some clients. This disorder is represented by a recurrence of irrepressible need to sleep, lapsing into sleep, or napping occurring within the same day.

Specifically Criterion A sleepiness is to occur at a minimum three times a week for at least three months. One of the following is present, episodes of cataplexy, hypocretin deficiency, or nocturnal sleep polysomnography (confirmation of reduced REM sleep latency). Subtypes for narcolepsy (specifiers) are important in ruling in/out for hypocretin deficiency, deafness, obesity, diabetes, medical conditions). The most remarkable feature of narcolepsy is that extreme sleepiness can overwhelm a person at any moment, regardless of recent sleep quality.

Breathing-Related Sleep Disorders

Central Sleep Apnea (CSA)

Central sleep apnea (CSA) is one of three sleep-wake disorders of breathing-related disorders (obstructive sleep apnea, hypopnea syndrome, and sleep-related hypoventilation). CSA is characterized by repeated episodes of apneas (without breath). Symptoms usually involve snoring, fatigue or tiredness during the day, waking up with choking or gasping, not feeling rested in the

morning, strong desire to take a nap during the day and unexplained accidents during the day. The causes can be poor muscle tone in the throat and tongue, alcohol and sleeping pills relax muscles, long soft palate and uvula narrows the passage, deformities, and obesity.

Assessment and treatment:
An interview is to take place identifying symptoms regarding the reported concern such as snoring or waking up during sleep times gasping for breath. A physician will refer the client to a neurologist who will conduct a sleep laboratory for a polysomnography. If the client has five or more apneas per hour of sleep and is not explained by another sleep disorder the specific sleep apnea disorder is diagnosed.

Treatment:
Treatment is prescribed according to the diagnosis; however, most likely the use of a continuous airway pressure (CRAP) machine. Keeping the airway open avoids obstructive sleep apnea hypopnea disorder (15 or more obstructive apneas/hypopneas per hour of sleep). Other treatments are nasal airway surgery, palate implants, and the Pillar procedure (three small implants injected into the soft palate), uvulopalatopharyngoplasty (UPPP), tongue base reduction, genioglossus advancement (muscle under tongue), hyoid suspension (bone-larynx/tongue in neck), and tracheostomy (bypass the narrow airway-connecting lungs and voice box).

Medical conditions associated with sleep disorders

The assessor should be mindful that if any of the following neurological diseases are in the medical file, sleep disorders are to be considered.

1. Alzheimer's Disease (AD). Treatment issues include the control of the disease severity, medication effects, and "sundowning" (see terms section for definition). Treatment of choice is to slow the cognitive decline with newer medications.
2. Parkinson's Disease (PD).The client experiences an inability to change sleep positions, leg cramps, night sweats, and excessive nocturia (Lees, 1988).
3. Multiple Systems Atrophy (MSA). MSA is similar to Parkinson's disease but includes Shy-Drager Syndrome which is a progressive disorder of the central and autonomic nervous systems. This disorder often includes striatonigral degeneration - a form of multiple system atrophy involving the loss of connections between two areas of the brain, the striatum and the substantial nigra, which work together to ensure smooth movement and maintain balance. Vocal cord and respiratory dysfunction may occur, which will require a tracheotomy (insertion of a breathing tube into the trachea) to prevent sudden death (Plazzi, Corsini, & Provini, 1997).
4. Cerebral vascular accidents ('Strokes')
5. Lewy body disease (LBD). This disease is known to be associated with Parkinsonism and dementia. The prominent symptoms include visual hallucinations, abnormal movements, and daytime sleepiness (Grace, Walker, & McKeith, 2000).
6. Spinal cord injury

7. Cardiopulmonary disease. Clients with lung disease are at risk for sleep deprivation and sleep-breathing disorders

8. Arthritis

Treatment:
Bootzin and Rider (1997) offer several potential psychotherapy treatments for Insomnia, including sleep restriction therapy (Spielman, Saskin, & Thorpy, 1987) and the prescription of individual sleep-wake schedules (Spielman et al.). Sleep restriction consists of restricting clients to spending time in bed only for the purpose of night-time sleep or sexual relations. This treatment approach should also eliminate watching television, reading, or other activities while in bed.

CBT is recommended with multi-components that include sleep hygiene education, stimulus control, sleep restriction, and relaxation training (McCurry, Logsdon, Teri, & Vitiello, 2007).The use of daily sleep diaries also can have a therapeutic effect (Bootzin & Rider, 1997). Frequently used interventions related to relaxation training are meditation, progressive relaxation, yoga, hypnosis, and biofeedback training all of which have reportedly improved sleep (Espie, Lindsay, Brooks, Hood, & Turvey, 1989). Consistent with relaxation are one of the three types of biofeedback: sensorimotor rhythm (SMR), Electromyography (EMG), and theta electroencephalography (EEG) all of which have been successful (Sanavio, 1988). A number of cognitive therapies have been used to address the cognitive symptoms associated with sleep disorders (Bootzin & Rider). For instance, Shoham, Bootzin, Rohrbaugh, and Urry (1995) found paradoxical intention to be most effective with clients who are resistant and reactant to therapeutic suggestion. Cognitive restructuring tends to be an effective means of combating a client's faulty beliefs about sleep requirements. Finally, providing education in the form of the following sleep hygiene education tips can be helpful: (a) discontinue caffeine and nicotine late in the day; (b) do not drink alcohol because it produces fitful sleep later during the night; (c) exercise during the daytime but not close to the hour of sleep; and (d) minimize noise, light, and excessive temperatures by using ear plugs, window blinds, air conditioner, or adequate blankets (Buysse, Morin, & Reynolds, 1995). In summary sleep hygiene includes scheduled sleep times, dietary counseling, environmental alterations, and physical activities (controlled time for exercise).

The overall approach to treating primary sleep disorders includes CPAP for OSA, dopaminergic medications (similar to those used to treat Parkinson's disease) for RLS and PLMD, selected (sedative, antidepressant, antipsychotic, or anticonvulsant) medications for parasomnias, CBT (stimulus control) for primary or secondary insomnia, sleep restriction therapy, and CBT components that include sleep hygiene education and relaxation training (Stepanski, Rybarczyk, Lopez, & Stevens, 2003).

A 2006 evidenced based study by the American Psychological Association reported that sleep restriction-sleep compression therapy and multicomponent cognitive-behavioral therapy met effective criteria (APA, 2006). Support was also noted for stimulus control theory (Morin, 2004). Stimulus control and sleep control were the least time consuming of the therapies (Whitworth, Crownove, & Nichols, 2007).

Obstructive sleep apnea hypopnea is a medical condition requiring medical or surgical intervention in most cases. After a sleep study has been completed, the patient will likely be seen by an ENT specialist

to confirm the diagnosis and make treatment recommendations. There are different treatment options for obstructive sleep apnea depending upon the severity of the sleep apnea as determined from a sleep study, the physical structure of the upper airway, and other medical considerations. All treatment options are intended to prevent obstructions from occurring, usually by widening the airway.

Non-surgical remedies include avoiding sleeping on the back to keep the tongue from blocking the airway. For some people, sleeping with the back elevated from the waist up with foam wedges may reduce the collapsibility of the airway and therefore reduce the apneas. Sleep apnea can be weight-related and losing weight can usually be an effective treatment. Avoiding alcohol and central nervous system depressants close to bedtime may be helpful as well. Oral appliances may be effective by keeping the airway open in one of three ways: by pushing the lower jaw forward (a mandibular advancement device or MAD), by preventing the tongue from falling back over the airway (a tongue-retaining device), or by combining both mechanisms. The most common type is adjustable so that the dentist can move the jaw further or reduce the advancement as necessary.

For many patients with obstructive sleep apnea hypopnea, surgery can be useful to create a more open airway (see central sleep apnea for other surgical procedures). In addition, there are non-surgical procedures to remove excess or obstructive tissue or harden the soft palate by inserting small polyester rods. However, for most patients with this disorder Continuous Positive Airway Pressure (CPAP) is quite effective. CPAP works by gently blowing pressurized room air through the airway at a pressure high enough to keep the throat open. This pressurized air acts as a "splint." The pressure is set according to the patient's needs at a level that eliminates the apneas and hypopneas that cause awakenings and sleep fragmentation and must be high enough to eliminate the apneas and hypopneas.

Sexual Dysfunctions

Sexual dysfunction disorders include delayed ejaculation, erectile disorder, female orgasmic disorder, genito-pelvic pain/penetration disorder, male hypoactive sexual desire disorder, premature (early) ejaculation, substance/medication-induced sexual dysfunction, other specified sexual dysfunction, and unspecified sexual dysfunction (APA, 2013). The DSM-5™ has reduced the list of 17 in the DSM-IV-TR to 10. In addition the subtypes are now referred to specifiers for all sexual dysfunction. All sexual dysfunctions have a minimum time frame of at least six months except for substance and medication induced sexual dysfunction (King, 2014). Sexual desire and arousal disorders have been combined into one disorder, sexual interest/arousal disorder. Vaginismus and dyspareunia have been combined to a new disorder, genito-pelvic pain/penetration. Sexual aversion disorder has been removed (APA, 2013). In addition, subtypes have been added such as lifelong acquired and generalized versus situational.

Sexual dysfunction entails disorders that prevent individuals from having or enjoying coitus (APA, 1994). According to the APA (2013) sexual dysfunction is characterized by a person's ability to respond sexually or to experience sexual pleasure. The dysfunction is defined as an impairment in sexual

response or with pain associated with sexual intercourse. A sexual dysfunction must be experienced on most or all occasions between 75 and 100 percent of partnered sexual activity (APA, 2013, pps 424, 426, 429). The DSM factors that need to be considered during assessment are the partner, relationship, individual vulnerability, psychiatric comorbidity, stressors, cultural/religious factors, and medical factors (King, 2014). Specifiers include lifelong (present from first sexual experience), acquired (developed after a period of relatively normal sexual function), generalized (limited to certain types of stimulation, situations or partners) and situational (only with certain types of stimulation, situations, or partners (APA, 2013, p. 423). It is possible to consider a V or Z code if the relationship is in severe distress, partner violence, or significant stressors better explain sexual difficulties (King, 2014).

The response cycle is comprised of four primary phases: desire, excitement, orgasm, and resolution. Sexual function is further divided into subtypes that are indicative of onset, context, and etiological factors and which are either lifelong or acquired. Contextual specifiers (subtypes) are generalized and situational, and etiological specifiers (subtypes) consist of psychological causes and combined causes (psychological and general medical conditions).

Definition and Interview:
Psychological factors may be important in all forms of sexual dysfunction, but these factors appear to be the sole cause in fewer cases than were originally posited (Greiner & Weigel, 1996). The most common complaint in women is a decreased desire, followed by orgasmic dysfunctions (Frank, Mistretta, & Will, 2008). While success rates have not been adequately quantified, an attempt should be made to identify concomitant psychosocial stressors and how they could be reduced (Feldman, Goldstein, & Hatzichristou, 1994). Emphasizing treatment of the partners as a couple is still the primary focus, as originally recommended by Masters and Johnson's (1970). This is sometimes combined with individual therapy for a partner suffering from existing depression and/or performance anxiety (Emmelkamp, 1994). McCarthy (1990) points out that when sexual dysfunction results from trauma-based dyspareunia (painful intercourse), several potential foci should be considered in a behavioral therapy approach. Maybe, for example, past traumatic events of an emotional nature ought to be approached therapeutically in the context of the present dysfunction, realizing that such events affect both the individual and the relationship. Therefore, when past traumatic experiences affect the sexual relationship the best therapeutic approach is to help both the traumatized individual individually as well as the couple.

Health professionals are generally reluctant to take a detailed sexual history when clients complain of sexual issues. But if they were to do it properly, it would be best to obtain a sexual history composed of two components. Hatzichristou, Rosen, Broderick, et al. (2004) suggest a strategy for the management and evaluation of sexual issues and sexual history. The first component is the initial PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy) and the second component is ALLOW (Ask, Legitimize, Limitations, Open up, Work together). The interaction between the counselor and client proceeds best when open-ended questions are used.

The Brief Sexual Symptom Checklist can be used in conjunction to history taking. This checklist asks four questions to determine client satisfaction with her sexual function, details about specific

behaviors of sexual problems, and the willingness of the client to discuss the issues with the interviewer (Potter, 2007).

Assessment:
There are a variety of causative factors for sexual disorders. It is important to rule out interpersonal, intrapersonal, and cultural context. Frank, Mistretta, and Will (2008) charted Berman's (2005) causes, examples, and sexual symptoms. Berman (2005) listed causes as hormonal/endocrine, musculogenic, neurogenic, psychogenic, and vaculogenic.

Clients with arousal /interest problems often use inhibition of desire in a defensive way to protect against unconscious fears about sex. Lack, or absence or reduced desire, can be the result of sexual conflicts dating back to childhood, chronic stress, sexual trauma, anxiety, or depression. Sexual arousal/interest components include sexual thoughts, dreams, fantasies, and possible cognitive motivation. Abstinence from sex for a prolonged period sometimes results in suppression of sexual impulses. Loss of desire or aversion may be an expression of hostility toward a partner or the sign of a deteriorating relationship. In fact, marital discord is the most common reason for cessation or inhibition of sexual activity. Sexual dysfunction is mixture of physiologic, psychological, emotional, and relational factors.

Female sexual arousal/arousal disorders are characterized by a persistent or recurrent partial or complete failure to attain or maintain the lubrication and swelling response of sexual excitement until the completion of the sexual act. Criterion A identifies manifestations to be in three of six absent/ reduced categories. These absent/reduced activities are: in sexual activity, sexual/erotic thoughts or fantasies, initiation of sexual activity, sexual excitement/pleasure, sexual interest/arousal in response to any internal or external sexual/erotic cues, and genital or nongenital sensations during sexual activity (APA, 2013, p. 433). Female sexual arousal/interest disorder, often underestimated, has dysfunction during the early excitement phase and continuing throughout.

A recurrent and persistent partial or complete failure to attain or maintain an erection to perform the sex act characterizes male erectile disorder. Criterion A must meet three of the marked difficulty areas and persist for six months (B).

Genito-pelvic pain/penetration disorder (painful intercourse) is also frequently associated with a lack of desire. Criterion A defines this persistent or recurrent difficulty with one or more areas for pain, vaginal, vulvovagional or pelvic pain, fear or anxiety about pelvic pain in anticipation, and marked tensing or tightening of the pelvic floor muscles (APA, 2013, p. 437).

Hormonal dysfunction may contribute to women's lack of sexual responsiveness (Kaplan & Sadock, 1998).

Incidence:
In general, there has been a dearth of reliable prevalence rate studies for sexual dysfunction. However, several reviews have yielded the following rates for particular dysfunctions: female orgasmic disorder (5% to 10%), male erectile disorder (4% to 9%), male orgasmic disorder (4% to 10%), premature ejaculation (36% to 38%) and insufficient data exists for female arousal disorder, vaginismus,

dyspareunia and hypoactive sexual desire disorder (Spector & Carey, 1990). Recent incidence reported by the APA (2000) is 20% (female orgasmic disorder), 10% (male erectile disorder), 10% (male orgasmic disorder), 27% (premature ejaculation), 15% (female dyspareunia), and 33% (female hypoactive sexual desire disorder) (p. 538).

The DSM-5™ cites prevalence rates for delayed ejaculation, the least common male complaint (lack of definition) less than 1% (p. 425), erectile disorder is unknown, female orgasmic disorder to be 10%-42% (p. 431), female sexual interest/arousal disorder is unknown (p. 435, combined disorders), genito-pelvic pain/penetration disorder is 15% in U.S. (p. 438), male hypoactive sexual desire disorder varies according to age, 6% for 18-34, 41% for 66-74 (p. 442), premature ejaculation depending on definition, 20%-30% men 18-70 (p. 444), and substance/medication-induced sexual dysfunction varies by medication (APA, 2013).

The sexual disorder receiving most attention appears to be erectile dysfunction (NIH Consensus Conference, 1993). While prevalence rates of sexual dysfunction are difficult to discern due to the wide variability of disorders, assessment methods, definitions used, and sampled population characteristics, erectile dysfunction seems to receive the most attention in the professional literature. According to several sources (Greiner & Weigel, 1996; NIH Consensus Conference, 1993), erectile dysfunction is experienced by 20-30 million men in this country, with a 5% prevalence rate for 40-year-olds and up to 15% for 70-year-olds. A number of other medical literature sources have reported prevalence rates of 2% at age 40, 25% to 30% at age 65, and over 50% for men over the age of 75 (Feldman et al., 1994; Jackson & Lue, 1998; Kirby, 1994; Morley & Kaiser, 1993).

Treatment:
The foundation of treatment is education and therapy. Client education is often focused on what is 'normal', the importance of emotional intimacy, and normal anatomy. Therapy focuses on positive approaches such as positive emotions, to include hope, which is an important aspect of treatment. Hope theory, which has been applied to the treatment of sexual offenders is comprised of cognitive, affective, and behavioral elements of hope and has contributed to effective outcomes for those individuals who have not been considered worthy or responsive to treatment. Synder (2000) defines hope as a positive motivational state involving goal-directed energy (agency) and goal-planning (pathways). Hope theory is similar to control theory, self-efficacy and self-esteem; however, it is yet different in goal-directed energy, situation-specific (Bandura), and the role of emotions.

The Eros Clitoral Therapy Device may be recommended for female sexual arousal disorder to improve arousal by increasing blood flow to the clitoris with gentle suction (Berman, 2005) Treatment for orgasmic disorder is behavior therapy and sensate focus (Meston, Hull, Levin, & Sipski, 2004).

Pain disorders are treated by first assessing the underlying causes such as infection, vaginal atrophy, and endometriosis (Weijmar, Schultz, Basson, Bink, et al., 2005). Physiological treatment is usually the first order of business followed by counseling for the client's individual issues that will likely include the partner. These issues may include facing fears of vaginal penetration and encouraging increasing comfort with her genitals (Crowley, Richardson, & Goldmeier, (2006).

If a lifelong/acquired subtype is assessed for genito-pelvic pain/penetration disorder then five factors are to be considered. These factors are: 1) partner factors; 2) relationship factors; 3) individual vulnerability; 4) cultural/religious; and 5) medical factors (APA, 2013, p. 438).

Research suggests that marital dysfunction is significantly involved in one-third or more of clients experiencing sexual dysfunction (Metz & Weiss, 1992). These authors posit that optimally effective therapy must combine marital therapy as well as sex therapy. According to Metz and Weiss, combination therapy may involve the following:

1. Getting clients to think, act, and feel more confidently and skillfully.
2. Consider how the couple thinks and relates and the extent of their intimacy.
3. Integrate individual and sexual dimensions.
4. Consider the main goal of therapy as developing cooperation.

According to Pollets, Ducharme, and Pauporte (1999), disorders such as erectile dysfunction must include both organic and psychological factors to ensure positive outcomes for clients. However, O'Donohue, Swingen, Dopke, and Regev (1999) argued that there appears to be little evidence that effective psychological interventions exist for males. Segraves and Althof (1998) argued that the lack of evidence for successful psychological interventions has stemmed from methodological problems in sex therapy outcome studies.

Hawton (1995) compiled five criteria for sex therapy clients that were associated with positive outcomes. The five criteria were: (1) the quality of the couple's relationship, particularly the female partner's positive pretreatment assessment of the relationship; (2) the motivation of the partners for treatment, especially the male partner; (3) the absence of severe psychiatric disorder in either partner; (4) physical attraction between partners; and (5) compliance with the treatment program early on in therapy.

In support of Hawton's findings, Zeiss and Zeiss (1999) reported that couples who place a high value on sexual intimacy, regardless of age, are able to make the necessary adjustments that allow them to continue to be sexually active. However, risks of sexual dysfunction in older adults can be increased by the presence of poor health, negative stereotypes about aging, or lack of flexibility for making needed adjustments to age-related changes in desire or capacity. Furthermore, in a study of nearly 1,000 females, Dunn, Croft, and Hackett (1999) found those emotional factors (anxiety and depression) and age-related physical factors (vaginal dryness and dyspareunia) were associated with sexual problems.

When working with age-related sexual dysfunction, interdisciplinary approaches to treatment are essential (Zeiss & Zeiss, 1999), although the most successful modality for these clients based on empirical research, has been cognitive behavioral models (Cyranowski, Aarestad, & Andersen, 1999). Other forms of psychotherapeutic treatment have shown promise as well, including bibliotherapy, about which Van Lankveld (1998) reported a meta-analysis of positive outcomes in the treatment of sexual dysfunction disorders.

In a study of nearly 1,000 females, Dunn, Croft, and Hackett (1999) found that all female sexual problems were associated with anxiety and depression. Vaginal dryness and dyspareunia were age-related.

Arentewicz and Schmidt (1983) contend that systematic desensitization might be particularly useful to treat sexual dysfunction associated with pain. In clients whose sexual problems are related to sexual trauma, McCarthy (1990) suggests integrating the treatment of post-traumatic symptoms and sexual dysfunction. Treatment should include individual and couple cognitive and communication exercises to address the traumatic event in treatment, encourage continued sexual pleasuring, identify problematic areas, and help them respect each other's boundaries and needs for affection.

Gender Dysphoria

Definition, Interview, and Assessment:
Gender dysphoria identity refers "to an intense feeling of depression and discontent that individuals experience when their physical body is incongruent with their manifest gender identification, as opposed to having psychological confusion regarding their gender identification" (King, 2014, p. 13). A basic sense of self as a male or female is the public manifestation of gender identity (Money & Lehne, 1999). The DSM-III used the term transsexualism to mean the desire to live permanently in the social role of the opposite gender via sex reassignment surgery (SRS; Caldwell, 1949). The term gender identity disorder (GID) replaced the term transsexualism and is defined as "individuals who show a strong and persistent cross-gender identification and a persistent discomfort with their anatomical sex or a sense of inappropriateness in the gender role of that sex, as manifested by a preoccupation with getting rid of one's sex characteristics or the belief of being born in the wrong sex" (Cohen-Kettenis & Gooren, 1999, p. 316). The DSM-5™ defines gender dysphoria as the "stress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender" (APA, 2013, p. 451). The diagnostic criteria is separate for children and for adolescents and adults. The criteria for children assessed for aversive attitudes, aversive behaviors, mental fixation, and strong desires (King, 2014). The emphasis in the diagnosis is for gender incongruence versus cross-gender identification. A specifier exists for posttransition. The assessment is to note that incongruence is to have existed for six months duration and manifested by six of eight criterion measures in Criterion A (APA, 2013, p. 452).

Gender dysphoria is the subjectively negative experience of the discordance (Money & Lehne, 1999). The discordance exists between the changes occurring in the person and the natal sex identified at birth.

Money and Lehne (1999) recommend an open-ended nonjudgmental interview when conducting the assessment. The interview is to include past history, sex history, and function. Each family member is to be interviewed separately, in dyads with the child, and as a group. A systematic schedule of inquiry is necessary in order to follow its own logical sequence and to ensure that no questions or topics are omitted. The interviewer must also safeguard against collusion between family members to provide

inaccurate or biased information. Some interviewers include waiting room observations and drawings from projective techniques such as The Draw-A-Person-Test.

Assessment:
The diagnostic criteria for gender identity disorder must have a strong desire to be of the other gender or an insistence that one is the other gender and meets six of eight symptoms in Criterion A. The client declares (1) persistent discomfort about one's assigned sex; (2) persistent preoccupation with getting rid of one's sex characteristics and acquiring the sex characteristics of the opposite sex; and (3) the individual must have reached puberty. The DSM-5™ indicates that two components must be met in order to apply the term GID. The first component of the DSM-IV classification is a strong and persistent cross-gender identification, which is the desire to be or the insistence that one is of the other gender (Criterion A1). Criterion B is to ascertain if there is a persistent discomfort with his or her gender or sense of inappropriateness in the gender role of that sex (APA, 2013, p. 452).

Cohen-Kettenis and Gooren (1999) believe it is impossible to conduct a diagnosis of GID (gender dysphoria) strictly on objective criteria. Subjective information is especially difficult to trust, because a number of dysphoric clients will distort or manipulate their life histories and feelings regarding gender in order to have sex reassignment surgery. These authors indicate from the onset that this interview is very time-consuming and should be extensive. In order to do this effectively, they recommend a two-phase procedure. The procedure is derived from the Standards of Care of the International Harry Benjamin Gender Dysphoria Association (Walker et al., 1985).

The quality of the mother-child relationship is significant in establishing early gender identity. A hostile and rejecting mother can lead to gender identity problems. Gender problems also become related to abnormal separation and individuation issues so that the failure to achieve separation/individuation leads to the use of sexuality to remain in symbiotic relationships. Some children are given the message that they would be more valued if they were to change their gender identities (Kaplan & Sadock, 1998). This is particularly true for abused children. The death of the mother may also cause a boy to incorporate his mother as a primary part of his own identity as a way of perpetuating her existence.

According to the diagnostic manual the essential feature of a gender identity disorder is a person's persistence and intense distress about his or her assigned sex (gender dysphoria) and a desire to be, or an insistence that he or she is of, the other sex (APA, 2013). The following diagnostic considerations should be given to an individual with gender dysphoria (Schaefer, Wheeler, & Futterweit, 1995, p. 2019):

1. Primary and secondary transsexualism
2. Transvestism with depression or regression
3. Schizophrenia with gender identity disturbance
4. Effeminate homosexuality with adjustment disorder
5. Homophobic homosexuality

6. Career female impersonators
7. Borderline personality disorder with severe gender identity issues
8. Body dysmorphic disorder
9. Gender identity disorder, nontranssexual type
10. Atypical gender identity disorder
11. Ambiguous gender identity adaptation
12. Malingering

Phase One of the Standard of Care assessment is to interview for the presence of the DSM-IV-TR criteria. Several factors must be considered for Criterion A and B. Risk factors associated with Sex Reassignment Surgery (SRS) have to be weighed heavily, as well as how capable the person is to live in the desired role.

During this phase, information gathering is essential.

The following areas need to be explored:

1. General and psychosexual development
2. Subjective meaning and type of their cross-dressing
3. Sexual behavior and sexual orientation
4. Body image
5. Social network
6. Informed about the possibilities and limitations of SDS
7. Risk factors for postoperative failure
8. Differential diagnoses

The same procedure is utilized for adolescents, although it is more extensive and time-consuming than for adults (Cohen-Kettenis et al., 1999).

Phase Two is to assess and inform family members of a life of permanence in the desired sex. Family members are informed of all known changes, including such items as name change, hormone treatment, psychotherapy, doubts and any known prognosis for the SRS.

Instrumentation:
Money and Lehne (1999) indicate that some questionnaires and checklists screen for masculinity, femininity, or androgyny. This should be followed by an assessment that includes past history, sex history, function, and observations of gender-related behaviors. A specific assessment schedule may be necessary (checklist/instrument). They do indicate that The Draw-A-Person Test can be helpful. This

projective should request the drawing of a person, opposite sex, yourself, a friend and your family (Money & Lehne, 1999).

Incidence:
The DSM-5™ (APA, 2013) estimates a prevalence as a range for natal adult males, 0.005% to 0.014% and in children a ratio of 2:1 to 4.5:1 of boys to girls. The DSM-IV (APA, 1994) does not list a prevalence ratio for gender identity disorder (GID). Ettner (1999) estimates that 3% to 5% of the U.S. population has some form of gender dysphoria. The APA (1994) estimates a rate of one per 30,000 adult males and one per 10,000 adult females based upon European data. Bakker, van-Kesterer, Gooren, and Bezemer (1991) suggest a male to female ratio of three to one. Adolescent clients 15 years and older seen in a clinical setting who have characteristics of GID have revealed a history of cross-gender interest before the age of six and more so between the ages of two and four. Money and Lehne (1999) indicate that this disorder in children is rare. The Harry Benjamin International Gender Dysphoria Association (1985) estimated an undocumented 3,000 to 6,000, as of 1979, had undergone hormonally and surgically sexual reassignment. The association estimated that between 30,000 and 60,000 individuals in the United States considered themselves valid candidates for sex reassignment.

Treatment:
Based on standards of care that have been developed (Walker et al., 1985), psychotherapy is required for individuals suffering from gender dysphoria and may take such forms as individual, group, behavioral, family, or a combination of all of these (Schaefer, Wheeler, & Futterweit, 1995). For the individual experiencing gender dysphoria, group therapy has been recommended (Keller, 1980). Individuals who are confused about having a complete gender identity change may benefit from psychodynamic psychotherapy. For those who desire sex change surgery, psychotherapy has only been successful for informing and educating clients in order to provide some relief pre- and post-operatively. Hormone therapy in conjunction with the social role changes has been helpful in real-life tests. Specific hormones will suppress sex characteristics such as facial hairs, penile erections, and appetite for a male-to-female change. Speech therapy may be necessary for prospective SRS candidates to learn to use their vocal cords like females or males. If the real live test is successful for a social role change, the next step is surgery.

Treatment of gender identity disorders is complex and not usually successful when the goal is to reverse the disorder. Green (1985) has developed a treatment program designed to inculcate culturally acceptable behavior patterns in boys and uses role-modeling to teach masculine behavior.

Children

Treatment for children has been helpful through behavior therapy by rewarding sex-appropriate behaviors and non-rewarding sex-inappropriate behaviors (Zucker & Bradley, 1995). Psychotherapy can help children deal with peer rejection, teasing, self-image problems, and unresolved trauma (Money & Lehne, 1999).

Ongoing sex education is important for children, adolescents, and adults. Pharmacotherapy is helpful for children when depressed but not for secondary sexual characteristics.

Disruptive, Impulse-Control and Conduct Disorder

Disruptive, impulse-control, and conduct disorders define and characterize problems in emotional and behavioral self-control. This category includes oppositional defiant disorder, intermittent explosive disorder, antisocial personality disorder, pyromania, kleptomania, other specified disruptive, impulse-control and conduct disorder, and unspecified disruptive, impulse-control and conduct disorder.

Conduct Disorder

Definition and Interview:
The DSM- 5 and DSM-IV-TR (APA, 2013, 2000) describes conduct disorder as a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (p. 469, 93). 15 specific criteria are divided into four categories: (a) aggression to people and animals, (b) destruction of property, (c) deceitfulness or theft, and (d) serious violation of rules (APA, 2013, p. 469-470). This criteria list includes behaviors such as bullying, initiating physical fights, using a weapon to cause serious physical harm to others, perpetrating physically cruel acts on people and/or animals, stealing, running away from home, and deliberately destroying property. As in several other disorders, the child or adolescent's disturbance in behavior must include impairment in social, academic, or occupational functioning. The clinician also specifies whether the disorder is childhood-onset or adolescent-onset (no behavioral observations before age 10) and whether the behaviors are considered mild, moderate, or severe. At least 3 of the 15 criteria must be met within a 12-month time period and at least one in the last 6 months. It also should be noted that oppositional defiant disorder is closely related but less severe than conduct disorder. Conduct disorder also overlaps and includes many symptoms of ADHD, suggesting a need for the clinician to assess the presence of attention and hyperactive symptoms. Finally, gender differences appear to be significant. The DSM-5™ criteria indicates that males are more aggressive and confrontational compared with females, who tend to act out delinquency behaviors by lying, truancy, running away, substance use, and prostitution (Frances & Ross, 1996). Specifiers or subsets include childhood onset, adolescent onset, and unspecified onset. The assessor is to specify if the subset is with limited prosocial emotions, lack of remorse or guilt, callous (lack of empathy), unconcerned about performance, and with shallow deficient affect.

Criterion C indicates that if the individual is over 18 and criteria are not met for antisocial behavior personality disorder, the assessor is to specify if childhood onset, adolescent onset, unspecified onset and specify if with limited prosocial emotions, callous-lack of empathy, unconcerned about performance, or shallow or deficient-affect (APA, p. 470).

In most cases, the assessment of children with conduct disorder can be difficult and confusing, because of parent and teacher misinformation, counselor countertransference, comorbidity, and confounding cultural and situational factors (Sommers-Flanagan & Sommers-Flanagan, 1998).

According to Frick et al. (1994), children and adolescents with conduct disorder tend to have deceitful and manipulative behaviors. They minimize their difficulties, deny personal responsibility, and blame others for their social and academic difficulties. They cannot be trusted to provide accurate information about themselves on self-reporting instruments or structured interviews. However, during the data-gathering process, the interviewer can use these reports to highlight or reveal the client's capacity for lying and deceiving by comparing and validating the self-assessment data with other, more objective, information.

The parent and teacher observations as reported on paper-pencil forms, at best, are highly suspect. Reliability coefficients characteristically have been very low (Kazdin, 1995) because supervision of children has tended to be minimal so that many delinquent behaviors are concealed from adult awareness.

Counselor countertransference reactions can provide a clue during the assessment interview. On one hand, the interviewer may feel angry, rejecting, or retaliative during the interview (Willock, 1987). On the other hand, the inexperienced interviewer may overlook or minimize the client's destructive behaviors (Sommers-Flanagan & Sommers-Flanagan, 1993). Sommers-Flanagan and Sommers-Flanagan (1998) stipulate that comorbidity is commonly found with the following conduct disorders, as follows:

1. Attention-deficit/hyperactivity (45%-70%) (Fergusson, Horwood, & Lloyd, 1991)
2. Oppositional defiant (84%-96%) (Hinshaw, Lahey, & Hart, 1993)
3. Substance abuse and dependence disorders (52%) (Frances & Ross, 1996; Meyers, Burket, & Otto, 1993)
4. Depressive disorders (15-35%); (Harrington, 1993)
5. Anxiety disorders (15%) (Cohen, Cohen, Kasn, Velez, Hartmark, Johnson, Rojas, Brook, & Streunig, 1993)

The therapist is cautioned not to make a diagnosis of conduct disorder too quickly, unless the behaviors are symptomatic of the underlying dysfunction and not a function or reaction to socio/cultural context or gender differences (APA, 1994). Sommers-Flanagan and Sommers-Flanagan (1998) suggest the following as a guide to the interview process for Conduct Disorder:

1. Be familiar with DSM-IV-TR behavioral criteria.
2. Use multi-method, multi-rater, multi-setting assessment procedures.
3. Be familiar with the literature on differential diagnoses and develop checklists.
4. Obtain historical information before completing assessment interviews.
5. Rule out adverse family environments, social forces, and cultural circumstances.
6. Consult with colleagues.

The actual interview may take a combination of one of four forms: 1) structured; 2) unstructured; 3) attachment-oriented; and 4) morality-values-oriented (Sommers-Flanagan & Sommers-Flanagan, 1998).

The structured interview is frequently used to obtain the presence or absence of the 15 criteria of the DSM-5™. Since the criteria have not changed for conduct disorder in the DSM-5™ it would appear this instrument remains valid. According to Costello, Edelbrock, Dulcan, Kales, and Klavic (1984), this type of interview for conduct disorders has many limitations as well as low correlation coefficients. The structured interview is considered an effective method to obtain the developmental history (Sommers-Flanagan & Sommers-Flanagan, 1993; Tolan & Cohler, 1992). The interview is to be structured because clients with a conduct disorder are known to attempt to control the interview through the manner of presentation. Often the interviewer can expect the client to use threatening type behaviors (Yates, 1995). Answers to the developmental history are important to determine reactive or proactive aggressive behaviors of the client (Vitiello & Stoff, 1997).

The unstructured interview is useful in obtaining historical information such as antisocial or illegal behaviors. With this type of interview, the interviewer cannot only observe how the client reports involvement with others but also use the information gained as a reliability measure.

The attachment-oriented interview, which can be useful for a variety of disorders, focuses on observing the opportunities and abilities the child or adolescent has with forming attachments. These attachments can be observed through the client-counselor interactions. According to Bradford and Lyddon (1994), one of four types usually is apparent. First, note whether the client is disrespectful of the interviewer. Second, assess the client's ability to form attachments by asking an open-ended question in which the child is to hypothesize, in a given situation, with whom he or she would choose to be. Third, listen for themes such as harm-protection-safety, lack of intimacy-closeness, dependence-independence, and bad attitude information. Fourth, assess for morality and values through the use and involvement in simulations.

Culture:
Studies in 1995 revealed that, in comparison to other cultures, adolescent conduct disorders were highest within the United States (Dishion, French, & Patterson, 1995).Over the last decade rising rates of legal and illegal immigration has probably contributed to increasing amounts of cultural clashes within American cities. Shaffer and Steiner (2006) point out that many feel trapped between two cultures and experience acculturative stress, accounting for a disproportionate number of conduct disorders for 'clients of culture'. For example, Hispanic, Asian, or Middle Eastern adolescents thrust into less constrained and a declining moral American culture may engage in amoral or even anti-social behavior. Adolescents and children from families with strict cultural values encounter more liberal ones in public schools and the media. Adolescents in large urban areas may become part of gangs that commit violent crimes against a foreign culture. Immigrant children and adolescents from impoverished families may rebel with anti-social behavior against the 'wealthy' society within which they feel alienated. The failure of these culturally alienated youth to integrate their ethic identities, for whatever reasons, is paralleled by an inability to integrate self-identities (Phinney & Rosenthal, 1992).

Training in assessing for ethnic, linguistic, and culturally diverse populations is a recognized need. When assessing for cultural factors, it is recommended the following be addressed: 1) cultural identity of the client; 2) cultural explanations of the client's illness; 3) cultural factors related to psychosocial environment and levels of functioning; 4) cultural elements regarding the relationship between the client and counselor; and 5) overall cultural assessment for diagnosis and care (APA, 1994). Szapocznik (1986) recommends Bicultural Effectiveness Training (BET).

Incidence:
The DSM-5™ prevalence rate is for one year and to range from 2% to more than 10% (APS, 2013, p. 464) while the DSM-IV-TR (APA, 2000) indicates that conduct disorders are prevalent in the general population from less than 1% to more than 10% higher in males than females (p. 97).

Treatment:
While developing a treatment plan, the clinician will want to keep in mind that individuals with a history of behaviors commensurate with conduct disorder generally have exhibited those behavioral patterns for a long time. Kazdin (1995) and APA (1994) pointed out that clients experiencing conduct disorder are typically resistant to treatment, especially outpatient therapy (Kazdin, 1996, 1998). Yates (1995) reported that during treatment adolescents with conduct disorder frequently exhibit transference issues because they feel threatened, manipulated, and will often emotionally 'seal off' to the therapist or examiner. Some of these clients demonstrate improved behaviors if a DSM-5™ disorder exists such as ADHD, anxiety disorder or mood disorder can be treated (Bernstein, 1996; Biederman, Baldessarini, Wright, Keenan, & Faraone; 1993; Frances & Ross, 1996). Conduct disorder treatment at home can be recommended for some if firm behavioral controls are maintained. Outpatient psychotherapy is most appropriate for some youth with a high level of ego integration (usually not the case), capacity to experience guilt, ability to feel empathy, and the capability of forming relationships (Yates, 1995).In addition, for the very young (pre-and early school) a previously successful response to cognitive-behavioral theory (social learning theory) (Kazdin, 1993) is a positive predictive factor.

Research has indicated that children with severe conduct disorder problems may respond to long-term, highly structured residential treatment facilities that emphasize respect for authority and peer-monitored behavioral interventions. However, as these children move from early to late adolescence, the effectiveness of these treatments is diminished. Lastly, functional family therapy using behavioral, structural, strategic, and communication techniques are recommended for the entire family. Generally speaking the earlier and more aggressive the interventions the better the prognosis.

Instrumentation:
Assessment for conduct disorder usually involves gathering data from the family, child, school, and community. One or two instruments will be listed for each source or area.

Individual

1. Minnesota Multiphasic Personality Inventory, Adolescent Form (MMPI-A; Butcher & Williams, 1992)

2. Adolescent Antisocial Behavior Checklist (Ostrov, Marohn, Offer, Curtiss, & Feczko, 1980)
3. Child Behavior Check List (CBCL; Achenbach, 1992; Achenbach & Edelbrock, 1991a)

Parent, Teacher, Family Members

1. Dyadic Parent-Child Interaction Coding System (Eyberg & Robinson, 1983)
2. Family Intake Form (Horne & Sayger, 1990)
3. Genogram (McGoldrick & Gerson, 1985)
4. Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978)
5. Teacher Report Form (Achenbach & Edelbrock, 1991)
6. Medical Records

Projective Instruments

1. Rorschach Inkblots (Exner, 1993)
2. Child Apperception Test (Murray, 1943)

Oppositional Defiant Disorder

Definition, Interview, and assessment:
"The essential feature of oppositional defiant disorder is a recurrent pattern of angry/irritable, argumentative/defiant behavior, or vindictiveness lasting at least six months and at least four symptoms from criteria A" (APA, 2013). This list is divided into three segments, angry/irritable, argumentative/defiant behavior and vindictiveness. The descriptors include negativistic, defiant, loses temper, annoy others, touchy, disobedient and hostile behavior toward authority figures that persists for at least six months (APA, 2013, p. 462). In addition, the frequency in terms of severity of violations are different for children younger than five years of age (most days for six months) and those children older than five years of age (once a week for six months). At least four of the following behaviors must be present: 1) losing temper; 2) arguing with adults; 3) actively defying or refusing to comply with the requests or rules of adults; 4) deliberately doing things that annoy other people; 5) blaming others for his or her own mistakes; 6) being easily annoyed by others; 7) being angry and resentful; and 8) being spiteful or vindictive. The frequency and intensity of the behaviors must be greater than for those typically found in children of comparable age and development. The individual must experience impairment in social, academic, or occupational functioning. "The diagnosis is not made if criteria are met for conduct disorder or if symptoms occur in conjunction with a psychosis, anti-social personality disorder, or mood disorder in an individual over 18 years of age" (APA, 2013, p. 462).

Severity ratings are based on pervasiveness with three ratings, mild (one setting), moderate (at least two settings), and severe (present in three or more settings). Those children who display oppositional defiant behaviors in multiple settings are more symptomatic than those children presenting in one setting.

This disorder is characterized by the client's deliberate intent to annoy, to be resistant, and to resist compromise. It is possible these defiant behaviors may not be apparent in the interview. Distinctive features are as follows: Oppositional defiant clients have less-serious physical aggression than conduct disorder clients, behaviors are more evident at home than at school, and opposition is usually directed at known individuals.

Incidence:
The incidence of oppositional defiant disorder is reported to be in the range of 1% to 11% of the population (APA, 2013). The onset may occur as early as five to six years of age but can be apparent even in preschool children. However, it is more likely to surface in late or early adolescence. This behavior is more common in males than females, but by the teenage years there seem to be as many females as males.

Instrumentation:
As with conduct disorder, attention deficit hyperactivity disorder and social phobias, behavioral checklists are available, including the following:

1. Child Behavior Checklist (CBCL; Achenbach, 1991a)
2. Parent Report Form (Achenbach, 1991b)

Substance-Related and Addictive Disorders

There are 10 separate classes of drugs for the substance-related and addictive disorders category. The drugs are alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, and anxiolytics, stimulants, tobacco, and other substances. Gambling is also covered within this category.

Two classifications exist for substance-related disorders: substance-use disorders (SUDs) and substance-induced disorders (SIDs). Substance induced disorders include intoxication, withdrawal, and other substance/medication-induced mental disorders. Substance abuse and substance dependence was combined into a single disorder with a continuum from mild, moderate, or severe use and a removal of legal consequences and craving was added as a symptom.

These disorders include abuse and dependency of alcohol, inhalant, chemical, or toxic substance. They also include disorders caused by using or abusing substances. The DSM-IV-TR used the terms abuse and dependence and these terms are now combined into one disorder and considered a continuum. It would seem likely that abuse in the DSM-5™ refers to those symptoms that are similar to taken in larger amounts over a long period of time, drug in continuous use, tolerance-increased amounts and dependence to persistent desire to cut down, spend time seeking out the drug, craving, recurrent use, alcohol use is continuous. For most conditions there are three levels, substance use, substance intoxication, and substance withdrawal.

Definition and Interview:
Substance-use disorders include dependence and abuse; however, are classified as a continuum. Substance-induced disorders include anxiety disorder, delirium, hallucinogen persisting perception, intoxication, mood disorder, persisting amnestic disorder, persisting dementia, psychotic disorder, sexual dysfunction, sleep disorder, and withdrawal.

A cluster of cognitive, behavioral and physiological symptoms is employed to define substance dependence (substance use disorder). Dependence is a repeated pattern of self-administration resulting in tolerance, withdrawal, and compulsive-drug taking behavior. Many substances potentially cause both dependency and abuse. Nicotine and caffeine are both associated with withdrawal symptoms and nicotine with extreme dependence but neither have been linked to abuse. According to the DSM-IV (1994) dependence is characterized by a cluster of three or more symptoms during a 12-month period. Some of these symptoms are tolerance, withdrawal, substance consumption in larger amounts over longer period of time, a persistent desire to cut down or control the substance, a great deal of time spent in acquiring the substance, and the abandonment of important social, occupational, or recreational activities. Craving, which may be associated with dependence, is described as a strong subjective drive to use the substance. Tolerance is the need for greatly increased amounts of the substance to achieve intoxication or control disordered mood and/or withdrawal symptoms (p. 176).

A specifier termed "on agonist therapy" indicates that the client who has not used the addictive substance for at least a month is receiving a prescribed agonist medication (i.e., a drug which mimics the action of the substance such as methadone, which mimics heroin) or "on antagonist therapy", indicating that he or she is receiving an antagonist medication such as naltrexone, which blocks the effects of an opiate. A second specifier is "in a controlled environment," which refers to a location (e.g., a jail, therapeutic community, or hospital unit) where access to alcohol and controlled substances is restricted.

Clients who abuse substances develop a maladaptive pattern of substance use that causes impairment or distress in at least one of the following: social, physical, legal, vocational, and educational functioning and has occurred in the last 12 months (Evans, 1998). Substance abuse does not have to meet the criterion of tolerance, withdrawal, or compulsive use. The distinction between substance abuse from substance dependence should be quickly ascertained during interview procedures.

Assessment:
Substance use disorder symptoms are tolerance, withdrawal, more use than intended, excessive time in acquisition, activities given up, and failure to meet obligations, use in dangerous situations (risky), and use despite impairment (harm).

Step 1: Make a tentative diagnosis. Evans (1998) suggested the use of a behavioral observation, intake interview, and mental status examination for this step. Evans (1998) and Caetano (1992) stress the importance of careful wording in the interview. Counselors should avoid the use of negative connotations with their questions which may cause clients to become defensive. The counselor should

be aware that substance abusers might not be truthful in their answers. Therefore, obtaining information from a variety of resources is required. The interview should include assessing for frequency, quantity, setting, and effects, as well as recent or past history of using or abusing other substances or prescription drugs. The interviewer should attend to behavioral characteristics such as body language, presence or lack of affect, and particularly the level of agitation. Evans recommends the use of a technique to minimize defensiveness by requesting the client to describe someone else who is a user.

Another useful interviewing technique is to phrase questions in an open-ended manner, rather than close-ended: An indirect question such as "I am interested in knowing whether you have ever used drugs or alcohol" allows the client to approach the subject without denying substance abuse. But if he or she were asked "Do you abuse drugs or alcohol?" the easy answer is "no." The interviewer may also get more accurate information when asking "when was your last drink?" rather than "Do you have a problem with alcohol?" which is easier to deny. The interviewer may then continue to proceed with more open-ended questions which presume the use of a substance until more evidence is acquired.

Step 2: Have a thorough knowledge of the 11 classes of substances previously mentioned, effects of each, how each causes their effects, and the physical and behavioral tolerance, cross-tolerance, and synergism.

Step 3: Interview for the past and current use of substances, to include prescription medications which have become a more frequent source of dependency and abuse. This step should include the client's expectations about the use of the substance and the setting in which the substance is used. The interviewer also should apply techniques like direct questioning, confrontation, clarification, awareness of counter-transference (frustration and anger in the interviewer), and eliciting a response to important moral and ethical issues. Substance abusers frequently are unable to change their behaviors, maintain good health, and escape encounters with the law, work, family, and interpersonal relationships.

Step 4: Be aware of the most frequently utilized forms of noncompliance, such as denial, rationalization, justification, and minimization.

Step 5: Assess for the physical history of the client and determine if any of the drugs or prescription medications has caused symptoms which mimic those caused by substance use, abuse, or other mental disorders.

Diagnosis:
A diagnostic interview is to determine information for:

1. Duration
2. Frequency
3. Type of alcohol and amount
4. Time of drinking

5. Setting
6. Attempts to alter state of mind or mood
7. Attempts to induce relaxation and/or sleep
8. Attempts to fit in with peers
9. Associated with driving problems
10. Associated with criminal behavior or arrests
11. Causes family distress or abuse
12. Causes problems on the job
13. Causes health problems

Criteria for Acute Intoxication

A. Dysfunctional behavior - manifested by at least one of the following:
    1. disinhibition
    2. argumentativeness
    3. aggression
    4. lability of mood
    5. impaired attention
    6. impaired judgment
    7. interference with personal functioning
B. At least one of the following signs must be present:
    1. unsteady gait
    2. difficulty in standing
    3. slurred speech
    4. nystagmus (rapid eye movements)
    5. decreased level of consciousness (e.g., stupor, coma)
    6. flushed face
    7. conjunctival injection (redness or inflammation in the eyes)

Criteria for Pathological Intoxication

The general criteria for acute intoxication must be met, except that pathological intoxication occurs

after drinking a small amount of alcohol. Drinking alcohol triggers verbal aggressiveness or violent behavior not typical when the individual is sober, usually occurring within a few minutes after the drink (APA, 2013). In addition, at least one or more of the following symptoms occur shortly after alcohol use: slurred speech, incoordination, unsteady gait, stupor/coma, impaired memory, and/or nystagmus (Criterion B).

Alcoholism

"Substance-use disorders affect virtually every sector of society" (O'Brien & McKay, 1998, p. 127) and are the most common of mental disorders. Alcoholism, a term with multiple and sometimes conflicting definitions, historically refers to any condition resulting in the continued consumption of alcoholic beverages despite the health and social consequences it causes. Alcoholism has, however, now come to be defined either as alcohol abuse or alcohol dependence, both of which are major public health problems in the United States. Their destructive effects are not limited to adverse health consequences (Burge et al., 1997). The social, occupational, legal, and psychological costs are as serious as the physical costs alcoholics forge upon themselves. While the percentages of health care resources used up by alcoholics' inpatient and outpatient clinical visits are substantial (approximately 50% to 60%), the rates of diagnoses of alcohol dependency and abuse are generally less than 50% of all clinical visits in most settings, while the intervention rates are a dismal 5% to 10% (Clement, 1986). A number of studies investigating intervention effectiveness have shown that early-stage problem drinkers respond well when health care providers make straightforward drinking-focused interventions such as: "I'm concerned that alcohol is having detrimental effects on your health, your family, and your life in general. In my professional opinion, you should take the necessary steps to stop using alcohol, even if it means seeking professional help or attending AA meetings." (Persson & Magnusson, 1989). Unfortunately, physicians seem to be reluctant to intervene with these types of patients (Burge et al 1997).

Alcohol Use Disorder

Interview and Definition:
Alcohol use disorder includes alcohol use disorder, alcohol intoxication, alcohol withdrawal, other alcohol-induced disorders, and unspecified alcohol-related disorder. According to Rienzi (1992), the interview and diagnostic procedures by mental health clinicians often are problematic with regard to alcoholism. She reported that clinicians did not uniformly ask clients if they used or abused substances during the intake interview, nor did they attempt to address it in the treatment plan, even when alcohol abuse or dependency was diagnosed. Substance abuse is a pattern of substance use "manifested by recurrent and significant adverse consequences related to the repeated use of substances" (APA, 2013). In this maladaptive pattern, alcohol abusers may repeatedly fail to fulfill obligations, use alcohol in dangerous situations, and experience drinking-related legal, social, and/or interpersonal problems. To qualify for a diagnosis of alcohol abuse, individuals must have these problems repeatedly in the same 12-month period and, unlike substance dependence, there is no tolerance, withdrawal, or compulsivity of use.

Alcohol use disorder criteria is defined as a problematic pattern of alcohol use leading to clinically significant impairment or distress, manifested by at least two of 11 symptoms over a 12-month period (APA, 2013). Symptoms include taken in larger amounts, persistent desire to cut down, great deal of time in activities to obtain, craving, recurrent alcohol use, continued alcohol use, social, occupational, or recreational activities given up, alcohol use is continued despite physical or psychological problems, tolerance (increased amounts and diminished effect), and withdrawal (withdrawal syndrome and alcohol use to avoid withdrawal symptoms; APA, 2013, p. 490-491).

Dependence on alcohol can be indicated by assessing tolerance or withdrawal. Withdrawal is the development of withdrawal symptoms after the reduction of intake following heavy use. While withdrawal symptoms may be severe (e.g., delirium tremens (DT's), grand mal seizures), only about 5% of alcohol-dependent individuals ever experience withdrawals so severe (APA, 2000).

Alcohol Intoxication

The diagnosis of alcohol intoxication is defined and assessed as recent ingestion of alcohol and problematic behavioral or psychological changes that developed during or shortly after the alcohol ingestion. One or more of the following symptoms are to be met for alcohol intoxication: slurred speech, uncoordination, unsteady gait, nystagmus, impairment in attention or memory, and stupor or coma (p. 497).

Alcohol Withdrawal

Alcohol withdrawal is the cessation or reduction in alcohol use that has been heavy and prolonged and two of the following symptoms apparent within several hours to a few days after the reduction in alcohol: sweating or pulse rate greater than 100 bpm, increased hand tremors, insomnia, nausea, visual, tactile or auditory hallucinations or illusions, psychomotor agitations, anxiety and generalized tonic–clonic seizures. These symptoms cause significant impairment in social, occupational or recreational activities (APA, 2013, p. 499).

Incidence:
According to the APA (2013), alcohol use disorder are among the most prevalent disorders in the general population. APA (2013) cites prevalence to be 4.6% among 12 to 17 year olds and 8.5% among adults age 18 years and older. Statistics reported by the APA (2000) for the 1990s were a rate of 5% and lifetime risk for alcohol dependence to be 15% in the general population.

Instrumentation:
A number of instruments attempt to assess alcoholism from non-alcoholism, including the following:

1. The MacAndrew Alcoholism Scale-Revised (MAC-R) a supplemental scale of the MMPI-2 (Newmark, 1996)
2. Michigan Alcohol Screening Test (Pokorny, Miller, & Kaplan, 1972)

3. Drug Abuse Screening Test (Skinner, 1982)
4. CAGE Alcohol Interview Schedule (Schutte & Malouff, 1995). The CAGE was developed by E. W. Ewing and B. A. Rouse to assess alcohol abuse. The CAGE is a four-item interview schedule and the letters are known as cut, annoyed, guilty and eye-opener (Mayfield, McLeod, & Hall, 1974).
5. Michigan Alcoholism Screening Test (Zung & Charalampous, 1975)
6. The Addiction Severity Index (McLellan, Loborsky, Woody, & O'Brien, 1980)
7. The Inventory of Drinking Situations (IDS; Victorio-Estrada, & Mucha, 1997)
8. Substance Abuse Subtle Screening Inventory-3 (SASSI-3; Lazowski, Miller, Boye, & Miller, 1998)

Treatment:
The standard treatment for alcohol use disorder begins with the acute management of withdrawal symptoms in detoxification programs. This is followed by long-term management of dependence and prevention of relapse (Klerman et al., 1994). In a review of empirical studies on treatment effectiveness, Finney and Moos (1998) summarized that cognitive behavioral approaches are more effective in alcoholics with antisocial personality disorders or more impaired individuals in general, whereas, relationship-oriented approaches are more effective for clients who are functioning better (i.e., weaker urges, lesser psychiatric severity, and better social skills).

Counselor variables also have been studied in the treatment of alcoholism as early as 1972 (i.e., McLacklan). Najavits and Weiss (1994) reported from reviews of previous studies that clients of therapists who were more interpersonally skilled, less confrontational, more empathic, or had all of these traits experienced better outcomes.

The duration of treatment appears to have a significant effect on outcome. Lower intensity over a longer duration of time appears to be the most effective treatment strategy (Finney & Moos, 1998).

Additionally, the quality and effectiveness of the treatment site or program also seems to significantly affect the outcome. Finney and Moos (1998) recommend the following suggestions from a compilation of previous studies:

1. Provide outpatient treatment for most individuals with sufficient social resources and no serious medical/psychiatric impairment;
2. Use less costly intensive outpatient treatment options for patients who have failed with brief interventions or for whom a more intensive intervention is warranted but who do not need the structured environment of a residential setting; and
3. Retain residential options for those with few social resources and/or environments that are serious impediments to recovery and retain inpatient treatment options for individuals with serious medical/psychiatric conditions (p. 162-163).

Historically, the 12 Step program developed by Alcoholics Anonymous was the first recovery approach that offered any hope for alcoholics to maintain sobriety. In recent years, the professional community

has developed excellent treatment programs for the more seriously impaired alcoholics, particularly those with dual diagnoses (i.e., alcohol dependence or abuse plus anxiety disorder, mood disorder, behavior disorder or psychotic disorder). Some researchers believe that cognitive behavioral approaches are equally effective with 12-step programs if they include the common threads of providing coping skills, social support over time, and a general orientation toward life (Finney & Moos, 1998).

Relapse and the relapse process should be a component of the treatment program for addictive disorders. Relapse studies exist for non-addictive disorders such as depression, obesity, compulsive disorders, schizophrenia, panic disorder, bipolar disorder (Witkiewitz & Marlatt, 2004). Relapse prevention (RP) has been studied for nicotine, alcohol, marijuana, and cocaine addiction and has looked at such things as the relationship of relapse to high risk behaviors and or situations, poor self-efficacy, probability of relapse, first use of addictive substance, abstinence, and ineffective coping responses. Witkiewitz and Marlatt (2004) describe the specific behaviors and components of an RP program which include self-efficacy, positive outcome expectancies, report onset of craving, motivation, effective coping techniques, recognizing emotional states and being aware of positive and negative interpersonal factors.

Substance Use in Adolescents

Definition and Interview:
Substance use disorder criteria remained the same for children and adolescents except for the removal of legal problems. The use of abuse and dependence in the DSM-IV-TR has been removed into the combined disorder of substance use. In reviewing the symptoms in the DSM-5™, 1-3 and 8-10 refer to the term dependence and 5-7 to abuse. Adolescent substance abuse has significantly increased over the last several years (Jaffe, 1998). It is, therefore, important for practitioners to have an understanding of the interview process with this group. Jaffe recommends a number of factors to consider in the interview as well as specific questions to ask. Questions to ask in the interview might include the following:

1. Do you drink on school grounds?
2. When you are truant, do you ever go drinking?
3. Do you miss school because of drinking or having a hangover?

A "yes" answer to any of these questions indicates an alcohol problem (Jaffe, 1998, p. 72). Additional questions were offered by Bergman, Smith, and Hoffman (1995): Do you prefer to go to places where alcohol is available? Do you ever drink more than you planned? Does it take you more alcohol to get you "high" than it used to?

It is also important for the interviewer to be aware that adolescents and pre-adolescents suffering from learning disorders are more vulnerable to substance abuse, a co-morbid factor that has often been overlooked (Karacostas & Fisher, 1993; Yu, Buka, Fitzmaruce, & McCormick, 2006).

Non-Substance-Related Disorders

Gambling Disorder

Gambling is a new category that used to be listed within impulse-control disorders and is now a new behavioral addiction. Gambling is characterized as a behavioral pattern similar to addicted to substances within the brain. The newer definition highlights the risk involved in the persistent and recurrent problem in gambling. The person risks something of value for a greater value. The gambling addiction can result in a number of destructive outcomes including: deception about the extent of losses caused by gambling, family and job dysfunctioning, theft, repeated high risk gambling, and repeated futile attempts to recover losses while gambling (APA, 1994, 2013).

Interview and Assessment:
The interview and assessment for a gambling disorder should consider four or more symptoms of nine in Criterion A. These symptoms include gambling with increasing amounts, restless or irritable when cutting down, repeated unsuccessful efforts to control, preoccupied with gambling, gambles when feeling distressed, after losing money gambling, often returns another day to get even, lies to conceal, has jeopardized or loss significant job, relationship, etc., and relies on others to provide money (APA, 2013, p. 585).

APA (2013) cites a prevalence rate of 0.2%-0.3% while incidence reported by APA (1994) reveals a prevalence rate of 1% to 2%. The DSM-IV-TR reports a prevalence rate of .4%-3.4% in the community while APA reports a lifetime general population rate of 0.4%-1.0% (APA, 2013).

Treatment:
Gamblers Anonymous, with its 12 step program, has been a popular source of help for compulsive gamblers and quite helpful when they stick with the program (Petry, 2003; Petry, Ammerman, et al., 2006).

There have also been a number of treatments developed for compulsive gamblers to help them develop skills to prevent relapse and manage high risk situations and moods. Walker (1992) reviewed results across and between treatment modalities (e.g., Gamblers Anonymous, psychotherapy, psychoanalysis, behavior therapy, win therapy, case studies). Of the 2, 031 individuals treated, 72% were in control of their gambling at 6 months posttreatment (based on a subsample of 1, 568), 50% were in control at 1 year posttreatment (based on a subsample of 225), and 27% were in control at 2 years posttreatment (based on a subsample of 237).

Treatments found to be most helpful were behavioral and cognitive interventions such as exposure-response prevention, group cognitive restructuring, and combined treatments such as cognitive interventions and pharmacological treatments which used Serotonin Reuptake Inhibitors to reduce compulsivity. Of interest is the fact that cognitive-behavioral therapy had the best overall success in treating gambling disorder. (Petry, Ammerman, Bohl et al., 2006; Toneatto & Ladouceur, 2003)

Neurocognitive Disorders

Neurocognitive disorders (NCD) replaces the DSM-IV-TR category of delirium, dementia, amnestic and other geriatric cognitive disorders. There is primary deficit in cognition and those deficits are what distinguishes them from a neurodevelopmental deficit from birth and early childhood. The major neurocognitive disorders are delirium, major neurological disorders, and minor neurological disorders. Subclassifications by cause or etiology are Alzheimer's disease, Lewy body disease, frontotemporal neurocognitive impairment, vascular neurocognitive impairment, traumatic brain injury, HIV infection, Huntington disease, substance use disorders, Prion disorders, and other causes (APA, 2013). This category contains only disorders with cognition as a core feature. Dementia is renamed as major or mild neurocognitive disorder.

Delirium

Disorders of cognition include delirium and major and minor neurological disorders (NCD). These disorders are defined as NCD due to another medical condition, use of substance or medication, or combination of the two.

Making a diagnosis of cognitive disorder is often more difficult in the elderly because it may be difficult to differentiate the normal vicissitudes of emotional and cognitive changes caused by aging from the abnormal cognitive functioning typical of mental disorders (Gintner, 1995).

Definition and Interview:
The APA (2013) defines delirium as a disturbance in attention or awareness and further defined as a reduction in the ability to direct, focus, sustain and shift attention (Criterion A, p. 596).

APA (2000) defines delirium as a disturbance in consciousness (i.e., reduced ability to focus, sustain, or shift attention) and disturbance in cognition affecting memory, orientation, language, or perception. These symptoms are commonly accompanied by disorientation (for the correct year, month, day, or hour) and lability of mood (i.e., crying or irritability), and are common. The disturbance has a rapid onset (hours to few days, Criterion B) and may fluctuate with periods of normal mental functioning or may continue for days or weeks. There is usually evidence that the disturbance is a physiological consequence of an underlying medical condition, substance intoxication or withdrawal, use of a medication, or a toxin exposure (APA, 2013, Criterion E).

The causes of delirium can be a general medical condition, substance use or withdrawal, multiple etiologies, and unspecified etiology. Specifiers include substance intoxication, substance withdrawal, medication-induced delirium, delirium due to another medical condition, and delirium due to multiple etiologies. The specifiers usually last about 1 week in a hospital setting (APA, 2013). Delirium types commonly are referred to as central nervous system disorders (i.e., head trauma), metabolic disorders (i.e., hypoglycemia), cardiopulmonary disorders (i.e., respiratory failure), substance-induced (i.e., alcohol withdrawal) and systemic or central nervous system illnesses (i.e., encephalitis; APA, 1999).Reactions to medications or combinations of medications are not uncommon sources of

delirium in the elderly. Gintner (1995) outlines four steps or questions to follow during a differential interview for delirium. Step 1 is to determine if the psychological symptoms are accompanied by any metabolic problem, such as fluctuating blood sugars found in poorly managed or previously undiagnosed diabetes. Step 2 is to determine if there is a worsening, chronic physical disorder such as a cardiovascular or respiratory problem causing diminished oxygenation of the brain. Step 3 is to determine if a prescription drug could be inducing the symptoms, and Step 4 is to determine what cognitive impairments are present.

Incidence:
Community rates for prevalence are considered low (1%-2%) although increases with age to approximately 14% by age 85 (APA, 2013). The prevalence of delirium varies considerably when reviewing different populations. For example, the APA (2000) reported ranges for the hospitalized medically ill patients to be 10% to 30%, hospitalized elderly 10% to 15% on admission, and 10% to 40% may be diagnosed with delirium while in the hospital. Prevalence rates indicate that in the general population is low, 0.4%; however, increases with age and by 55 years of age is 1.1%. Typical delirium symptoms resolve within 10 to 12 days, yet for some last up to six months. Elderly patients are likely to experience more prolonged symptoms. The prevalence in the general population is 0.4% in adults age 18 years and older and 1.1% in those ages 55 and older (APA, 2000).

Treatment:
Delirium is considered a medical emergency with a high mortality rate if the client is not correctly referred for medical diagnosis and treatment. In most situations, the risk to clients with delirium can be reduced if the condition is promptly diagnosed, treated, and managed in an orderly manner. This involves searching for the underlying cause, treating the condition, monitoring the client's safety, developing alliances, educating the client and family members regarding the illness, and providing for environmental and supportive interventions. Wise (1995) views delirium treatment as reversing the reasons for delirium and controlling the agitation which often accompanies the patient's confusion and paranoia. Treatment requires the presence of a physician to determine the cause of the delirium and prescribe treatment, including pharmacological intervention. It is important that an individual suffering from a delirium be sheltered from excessive stimulation and surrounded with familiar things. Psychoeducation, i.e. information about the disorder and symptom management is recommended for the client and family members.

Instrumentation:
Instruments to consider in assessing delirium (APA, 1999):

a. Delirium Symptom Interview (DSI)
b. Confusion Assessment Method (CAM)
c. Delirium Scale (D scale)
d. Global Accessibility Rating Scale (GARS)
e. Saskatoon Delirium Checklist (SDC)

Major or Mild Neurocognitive Disorder (Dementia)

Definition and Interview:
Major or mild neurological disorder (MND, dementia) is a progressive, multifocal cognitive deterioration that impairs daily activities (Klein & Kowall, 1998). According to the APA (2013), MND (dementia) is a cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-mortor, or social cognition (APA, 2013, Criterion A, p. 602).

The decline is to be based on concern of the individual or a substantial impairment in cognitive performance. Criterion B stipulates that the decline interferes with independence in daily living; however, these deficits do not occur in the context of delirium and not explained by another mental condition. MND is an ongoing decline of multiple cognitive deficits with preserved consciousness that can be "due to…a general medical condition, the persisting effects of a substance, or multiple etiologies (e.g., the combined effects of cerebrovascular disease and Alzheimer's disease)" (p. 133). A clinical description of major or minor neurological disorder includes frequently inappropriate and disorganized behavior, retarded and impoverished thinking, speech typified by meaningless noises and lost words, and mood characterized by episodic anxiety, depression, and irritability.

Mild NCD features include psychosis, paranoia and other delusions (disorganized speech and disorganized behavior are not characteristic of pscychosis), mood disturbances, depression, anxiety and elation. Additional features can be agitation, confusion, frustration, sleep disturbances, apathy, wandering, disinhibition, hyperphagia, and hoarding (King, 2013b).

Diagnosis:
Memory loss and cognitive deficits are priority symptoms for assessment. Behaviors that disrupt the daily living of the client are issues for treatment and are to be included during assessment.

Assessment:
Assessment for dementia is usually conducted in phases. The first phase, often referred to as a neuropsychiatric assessment, involves interviewing the client and one or more individuals who are aware of the changes in the client's cognition. The second phase is a family assessment and the third involves diagnostic testing. During the fourth and concluding phase, the counselor holds a conference to report the evaluation results and recommendations for treatment.

When conducting the interview for Alzheimer's disease as a cause of dementia, memory impairment is a first-order question. Short-term memory is noted in the early phase of Alzheimer's disease, and long-term memory eventually is affected, particularly with agnosia, apraxia, and loss of executive functioning (Benson & Cummings, 1986; Cummings & Benson, 1983). Because memory disturbance is the most common initial symptom, Alzheimer clients have an impaired ability to learn new information or to recall previously learned material. There are also difficulties acquiring and retaining information as well as impairment in the recollection of short-term and recent events (Parker & Penhale, 1998). One or more of the following cognitive abnormalities must also be present: aphasia

(language disturbance), apraxia (sequential motor activities), agnosia (familiar objects), and disturbances in executive functioning (i.e., abstract thinking, organizing; APA, 2000, p. 148).

Orientation becomes increasingly disturbed (i.e., disruption in the client's sense of time, place, and person). Judgment and problem-solving abilities become more severely impaired and the client has difficulty in making sense of events taking place. Individuals with dementia also develop abnormal behaviors, incontinence, wandering, noisiness, aggression, vacant facial expressions, and the loss of capacity to self-monitor, speak coherently, and interact normally.

Whenever dementia is suspected, the client may be too impaired cognitively to provide an accurate personal history. In that case, the counselor should interview a family member or other caretaker about the client's abilities, deficits, and daily functioning. Because dementia may not be present in a pure form, the interviewer needs to be familiar with the different subtypes (delirium, delusions, depressed mood, and uncomplicated). It is also important to know that symptoms of dementia can be superimposed on other disorders such as delirium, depression, and physical conditions such as hypothyroidism and Parkinson's disease (which may also cause dementia).

Incidence:
Reviewing data from the APA 2013 and 2000 reports the data varies. APA (2013) cites prevalence rate by etiological type and estimates are only available for older populations. The data cited by APA is for dementia to be 1%-2% at age 65 and as high as 30% by age 85 (APA, 2013). It is estimated that between 2% and 4% of the population over 65 has dementia of the Alzheimer's type, the most common subclassification of NCD form of MND (APA, 1994). The incidence of dementia in the 85 and older age group is reported to be approximately 23% and increasing to 58% in those over 95 (Ebly, Parhad, Hogan, & Fung, 1994). Kukull, Higdon, Bowen, McCormick, et al. (2002) indicate that an estimate for dementia at age 70 is approximately 6% of the population but increases to 50% at age 85. The second most common form of dementia is caused by "strokes" and is referred to as multi-infarct or vascular dementia (Read, 1991).

Treatment: Major or Mild Neurologoical Disorder (Dementia)
Logsdon, McCurry, and Teri (2007) conducted a review of evidence-based treatments for disruptive behaviors. Their review included psychosocial (caregiver support and education, environmental modification, and caregiver counseling) and psychological intervention (based on behavioral and social learning theory).

The authors reviewed the effects of environmental interventions, including bright light therapy, pet therapy, aromatherapy, and music or white noise therapy; educational interventions (in residential care settings) involving nursing staff assisting with dressing, bathing, and providing other miscellaneous interactions. Their findings indicated that these interventions did not reveal any significant change in the incidence of disruptive behaviors.

The authors also reported that individualized treatment plans and in-home counseling designed to support cognitive-limitations and provide pleasant activities in a structured setting with regular routines resulted in a significant reduction in disruptive behaviors.

Logsdon, McCurry, and Teri (2007) concluded that behavioral and social learning theory programs typically used structured treatment manuals. The structured guide specified goals, homework assignments, and handouts. The program effectively reduced disruptive behaviors of patients with dementia by teaching problem-solving and behavioral-activation, and training family members or staff to note and observe problem behaviors and to adjust or modify the environment (developing a schedule and contributing to interpersonal interaction).

Finally, daily living skills eventually become so impaired that hospitalization or direct personal care is required. Whenever there is evidence of rapid onset cognitive impairment, the counselor should consider a vascular catastrophe or "stroke." Rapid onset of signs and symptoms (i.e., the sudden loss of ability to recall common words used the day before or the loss of capacity to perform common tasks such as driving a car) are more often associated with vascular dementia (APA, 1994). Family members observe many times "silent" strokes or mini-strokes not easily recognized by the patients. Finally, a high percentage of dementia clients also suffer from depression, psychosis, or delirium, which can complicate their diagnoses.

The assessment for Alzheimer's dementia should include a good mental status examination with emphasis on the client's orientation to time, place, person, and purpose, and special attention to memory. The interviewer should also assess for receptive and expressive language deficits, which are also common to dementia. Receptive language deficits are apparent when the client has difficulty understanding words while expressive language deficits are manifested by difficulty in speaking words (anomia-name of an object), describing ideas and later identifying objects (agnosia). Demented individuals also lose the ability to sustain attention, lose the ability to start a task (inertia), and lose the ability to end a task (perseveration). Other areas for assessment include deficits in insight, judgment, abstraction, perception, and motor organization. It is also important to assess the degree of deterioration. The most severe loss of function will result in the client eventually losing all capacity to understand what he or she hears, follow instructions, and communicate needs.

Instrumentation:
Caution should be exercised when using performance-oriented tests with older adults. These types of instruments may not consider sensory or psychomotor deficits (Hinrichsen, 1990).

The Mini-Mental Status Questionnaire (Folstein, Folstein, & McHugh, 1975) is often used to screen for cognitive functioning, which includes orientation, attention, memory, language, ability to identify objects, and the ability to perform different types of sequential movements. The Clock Drawing Task (Clock Test) is a good initial screening instrument for dementia (Mendez, Ala, & Underwood, 1992; Tuokko, Hadjistavrpoulos, Miller, & Beattie, 1992). The Blessed-Roth Dementia Scale as Strang, Bradley, and Stockwell (1989) pointed out can be used for assessing competence in personal, domestic, and social activities and changes in personality, interests, and drive.

A number of specific instruments for assessing sensory-perception, attention, memory, language, manipulatory, motor output, and neuropsychological functioning are available. Some are:

1. Luria-Nebraska Neuropsychological Battery (LNNB; Macciocchi & Barth, 1996) motor, touch, rhythm, visual, speech, writing, reading, arithmetic, memory, and intelligence

2. Bender Gestalt Test (BGT; Hutt, 1977) brain impaired, apraxia
3. Halstead-Reitan Test Battery (Reitan & Wolfson, 1993)
4. Blessed-Roth Dementia Scale (Strang, Bradley, & Stockwell, 1989)
5. Cornell Scale for Depression in Dementia (Alexopoulas, Abrams, Young, & Shamoian, 1988)

Treatment: (Alzheimer's)

Major or mild neurological disorder due to Alzheimer's dementia is a persistent, progressive, and eventually life-threatening disorder. Treatment with selected medications, when prescribed during the very early stages of the disease, has been shown to reduce the progression of the disorder and prolong functional memory, possibly slowing the deterioration process but never curing it. Although medication may slow disease progression, there is no known cure. Donepezil (Aricept), rivastigmine (Exelon), and galantamine (Reminyl), are the most frequently prescribed medications, called acetycholinesterase inhibitors. These medications delay the breakdown of acetylcholine in the brain, a key neurotransmitter which is important for memory. Another type of medication, memantine (Namenda), most commonly used to treat moderate to severe forms of dementia, shields the brain from a neurotransmitter called glutamate which contributes to the death of brain cells in Alzheimer's disease. Patients with Alzheimer's disease may be prescribed an acytylcholinesterase alone, memantine alone, or both together for the purpose of reducing disease progression.

The preferred treatment for individuals with dementia is to provide a caring, predictable, structured, and orienting environment – preferably in the family home for as long as possible. As the disease progresses, it typically is more difficult for family members to continue home care without help. Professional caregivers should regularly assess the patient for self-care and daily living abilities within the environment and, based on the severity of the progression of the disease, be ready to transition him or her to more structured personal care.

Personality Disorders

This supplement presents a limited amount of information regarding personality diagnoses. The overall prevalence for these disorders is probably unknown; however, at some time approximately all adults have experienced depersonalization, as well as one-third of those exposed to life-threatening dangers and 40% of hospitalized patients for mental disorders (p. 531). The 10 personality disorders were left untouched regarding symptoms and definitions (APA, 2013). The DSM-5™ (APA, 2013) lists 10 personality disorders which result in impairments in social and occupational functioning. This diagnostic category uses a polythetic approach that utilizes taxonomy for diagnosis, which is based upon a clustering of traits. According to the DSM-5™, personality disorders are defined as "inflexible and maladaptive patterns of behavior of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress" (p. 647).

Individuals with personality disorders suffer from stable patterns of behavior that adversely affect how they relate to others, how they think about themselves and the world around them, how they experience emotion, how they function socially, and how well they can control their impulses. Personality disorders are characterized by the chronic use of inappropriate, stereotyped, and maladaptive ways of responding to other people and to stressful circumstances. Personality disorders are enduring and persistent styles of behavior and thought, not atypical episodes, that encompass a group of behavioral disorders that are different and distinct from the psychotic and neurotic disorders.

The official psychiatric diagnostic manual, the DSM-5™ and DSM-IV-TR (Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, 2004), defines a personality disorder as an enduring pattern of inner experience and behavior that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

The general diagnostic criteria for a personality disorder is an enduring pattern of behavior whereby the client markedly deviates in two of four areas (cognition, affect, interpersonal functioning and impulse control). The enduring pattern is characterized by a long-lasting inflexible and pervasive impairment in personal, social, and occupational situations which is likely to have started during adolescence or early adult years. The behavior is not to be a result of a substance or a medical condition.

Turkat (1990) estimates that at least 50% of clients who have a clinical (previously referred to as Axis I) diagnosis concurrently have a personality (previously referred to as an Axis II) disorder. In assessing a personality disorder, behaviors must be manifested by abnormalities in two or more of the following: cognitive, interpersonal functioning, affect, or impulse control. In addition, there is an inflexibility and pervasiveness to the disorder, which has to cut across personal and social situations. Finally, a resulting impairment in functioning is to be noted in social, occupational, and other important areas of life (p. 630). An important goal in assessing for a personality disorder is to determine that it is manifested by trait-enduring characteristics rather than a state (transitory feeling, i.e., fear or worry) (Gregory, 2000). Fong (1993, 1995) identifies two other features necessary in the diagnosis of a personality disorder. The first is to determine if the problem is perceived by the client as ego dystonic (not part of self) or ego syntonic (integral part of self). Clinical problems as opposed to personality disorders are ego dystonic whereas personality disorders are ego syntonic. The second feature is to determine if the personality disorder reveals a dysfunction in occupational or social functioning. Finally, Overholser (1989) notes that personality clients will repetitively utilize the same maladaptive coping skills.

Fong (1995) states that during the interview the counselor should be aware of the manner in which personality disorder clients present the problem and the context in which they seek help. Furthermore the following signs should be suspect: a) the client will abruptly discontinue therapy if some progress is made, b) is unaware of his or her impact on others, c) is unresponsive or noncompliant to the schedule or terms of the treatment, and d) becomes entangled in some manner with institutional systems.

Distinctive features of personality disorders are early onset (childhood), chronic course (patterns) and ego-syntonic features (Widiger, 2003). Ego-syntonic features are a part of the identity.

There are ten recognized personality disorders, typically arranged into three clusters.

1. Cluster "A" - Paranoid, Schizoid, and Schizotypal Personality Disorders.
2. Cluster "B" - Antisocial, Histrionic, Narcissistic and Borderline Personality disorders.
3. Cluster "C" - Avoidant, Dependent and Obsessive-Compulsive Personality Disorders.

It is possible for people to have traits or symptoms of more than one personality disorder at the same time, while not meeting criteria for any one of them. In this case of "mixed personality disorder" the diagnosis of personality disorder other specified or unspecified is made, and the traits are listed out.

Each of the ten personality disorders can also be defined by cognitive features, affective features, interpersonal features, and capacity for impulse control, as follows:

Cognitive features

Paranoid-301.0 (F60l0): A pervasive distrust and suspiciousness of others.

Schizoid-301.20 (F60.1): Cognitive functioning is somewhat restricted although individuals with this disorder tend to have a rich fantasy life without any apparent overt cognitive abnormalities. Because they lack capacity to establish interpersonal relationships their speech tends to be impersonal and with little or no emotional content.

Schizotypal-301.22 (F21): These individuals have thinking peculiarities with illusions and a vivid fantasy world. Speech may be idiosyncratic with unusual phrasing or terminology.

Antisocial-301.7 (F60.2): Cognitive patterns are marked by poor decision making but often glib and sometimes persuasive speech. Researchers have found neurophysiological findings that confirm this. There are deficiencies involving the prefrontal cortex associated with stimulation seeking, bad decision making, rule breaking, and irresponsible behavior (Raine, Lencz, et al, 2000).

Histrionic-301.50 (F60.4): The cognitive style of individuals with HPD is manifested by superficial thinking that lacks detail. Speech patterns are also vague and devoid of specificity.

Narcissistic-301.81 (F60.81): Cognitive styles of narcissistic individuals reflect a grandiose sense of self, fantasies of unlimited success, power, brilliance, beauty and uniqueness.

Borderline-301.83 (F60.3): Borderline traits are reflected in cognitive styles that reveal no obvious abnormalities except for dramatic shifts between over-idealization and devaluation of people with whom they are intensely involved.

Avoidant-The cognitive style of this disorder reflects a negative self-image accompanied by verbiage that indicates feelings of ineptness and inferiority.

Dependent-301.6 (F60.7): Dependent personality traits are reflected by a lack of self-confidence and inability to make decisions.

Obsessive-Compulsive-301.4 (F60.5): Individuals with obsessive-compulsive personality traits are rigid in their thinking and focus on details, rules, lists and order (Skodol, 2005).

Affective features

Paranoid: Paranoid individuals are emotionally over-reactive and have a pervasive distrust and suspiciousness of others.

Schizoid: Schizoid individuals lack affective responsiveness and their speech tends to be impersonal and with little or no emotional content.

Schizotypal: These individuals have thinking peculiarities with illusions and a vivid fantasy world. Speech may be idiosyncratic with unusual phrasing or terminology.

Antisocial: Individuals with this disorder may mask a hidden aspect of the personality by appearing credible and calm while beneath that veneer is often tension, irritability, and even rage.

Histrionic: This disorder is characterized by shifts from shallowness to exaggerated and highly reactive and emotionally dramatic expressiveness.

Narcissistic: Narcissistic personality traits are characterized by haughty self-absorption with an inability to be emotionally empathic toward others.

Borderline: Borderline traits include labiality of mood and outbursts of anger, particularly when threatened with loss or separation.

Avoidant: Avoidant personality traits are characterized by anxiety, shyness, and emotional distance from others.

Dependent: This disorder is characterized by superficial compliance due to a fear of offending others and by anxiety when threatened with or experiencing separation from a significant other.

Obsessive-Compulsive: Obsessive individuals reflect troubling feelings such as apprehension, anxiety, disgust, tension, or a sensation that things are "not just right." Compulsive behaviors are directed at attempts to relieve anxiety. Individuals with this disorder also have difficulty expressing affection and loving feelings toward others and often demonstrate excessive rigidity and an unwillingness to discard worthless items (Skodol, 2005).

Obsessive Interpersonal features

According to Widiger (2003) all individuals with personality disorders experience interpersonal difficulties. These difficulties manifest themselves in two oppositional relationship styles: dominance versus submission and affiliation versus detachment. Interpersonal dominance is noted for antisocial, histrionic, narcissistic and obsessive-compulsive personalities. Individuals with avoidant and

dependent personality disorders are prone to submissive behaviors. Individuals with histrionic, narcissistic and dependent personality disorders have a greater degree of affiliation behaviors that reflect more distress when threatened by the loss of relationships. Individuals who guard against affiliation and remain detached are those with paranoid, schizoid, schizotypal, avoidant, and obsessive-compulsive personality disorders.

Attachment features

Research studies have been done to measure attachment styles associated with differing personality disorder clusters. Some studies have also shown that Cluster A (odd or eccentric disorders) and Cluster C (anxious or fearful disorders) pathology are more strongly associated with attachment than Cluster B. However, interpreting personality data as either dimensional or categorical is of major importance to the conclusions that can be drawn. Lastly, it is important to control for the influence of co-morbid personality pathology when examining the relationship between Cluster B personality pathology and attachment.

Control features

Individuals with personality disorders display behavioral and emotional symptoms that can be categorized as either over-control or under-control:

Over-control:
Dependent personality disorder (DPD) is reflected by behaviors in the areas of decision making and starting new projects.

Avoidant personality disorder (AvPD) is reflected by behaviors in emotional expression and healthy risk-taking.

Obsessive compulsive personality disorder (OCPD) often demonstrates excessive rigidity and an unwillingness to discard worthless items (Skodol, 2005).

Under-control:
Antisocial personality disorder (ASPD) is reflected by angry outbursts.

Borderline personality disorder (BLPD) is reflected by behaviors of anger and episodes of hypersexuality.

Defense Mechanisms:
'Normal' individuals use 'mature' psychological defense strategies based on an accurate understanding of social reality and an ability to cope with life in flexible ways while individuals with personality disorders use more primitive and less adaptive defensive modes that lack flexibility. One example of a mature defense is the use of humor to break up negativity and force people to look at a brighter side of their predicaments while maintaining distance from negative emotions.

Primitive psychological defenses are used to cope with reality and avoid negative memories or emotions. Among the more primitive psychological defenses is denial, the most famous of the classical

defense mechanisms when individuals refuse to accept matters of truth about themselves in spite of any reality which states otherwise. Examples of denial are individuals with dependent (DPD), histrionic (HPD), avoidant (AvPD) or borderline personality disorder (BLPD) who deny feelings of helplessness or fear of separation or evidence of a relationship about to break apart. Individuals with BLPD who use 'splitting' as a defense tend to over-idealize rather than deny the presence of negative qualities in self and others.

Acting out is considered a psychological defense when negative emotions are impulsively converted into destructive or self-destructive behaviors as seen when an individual with antisocial personality disorder acts out with an abusive rage attack. Individuals with borderline traits may act out sexually or have episodes of self-mutilation and explosive tempers.

Projection is a psychological defense mechanism wherein individuals project onto other people the feelings they deny exist within themselves. For example, individuals with personality disorders (DPD, OCPD, BLPD, ASPD) often have problems accepting their own angry feelings while accusing others of being angry.

Displacement has been described as a "kicking the dog" defense. For example, an individual who was provoked on the job displaces his or her anger by taking it out on a friend or family member, thus transforming his or her psychological position from one of powerless humiliation to dominant control. This defense can occur with any individuals, particularly those who tend to repress or suppress their own angry feelings.

Repression was originally described by Freud as an unconscious psychological defense that held uncomfortable thoughts beneath the surface of consciousness. Repressed thoughts or memories about unacceptable or traumatic events from the past might result in anxiety or depression in individuals with HPD or OCPD, for example.

Suppression is a more voluntary defense whereby an individual consciously pushes thoughts out of consciousness. This might occur, for example, in someone with OCPD or DPD who suppresses thoughts of retaliation after being criticized by someone.

In intellectualization, individuals tend to cope with painful or anxiety producing events by retreating into a cognitive analysis of the event and thus maintain distance from the emotions surrounding the event. A similar defense, Rationalization, occurs when people make up reasons after the fact to explain away a course of action they have taken about which they feel conflicted. These defenses are often used by individuals with OCPD, APD, and BLPD.

Reaction formation is manifested by behavior which is in stark contrast to that which an individual believes about himself or herself. For example, an individuals with DPD may tend to be excessively dominant and controlling in their relationships although, at the same time, denying they are afraid of losing those relationships.

Splitting occurs when positive and negative representations of self and other are dissociated or 'split' apart inside a person's mind. This is a mental mechanism, frequently associated with child abuse that

enables an abused child to 'split-off' painful and negative images of self and parent. This defense makes it possible to idealize the same parent and defend against negative feelings of fear and anger toward him or her. This defense is often seen in individuals with BLPD or NPD who tend to view others in either 'black or white' terms. They also tend to 'split' members of a therapeutic team into either good or bad therapists. These individuals often begin relationships by over-idealizing the other and begin therapy by over-idealizing their counselors until feelings of anger or disappointment emerge at which point, they suddenly devalue the other person and break off the relationship or terminate therapy.

Dissociation is a psychological defense that disconnects certain unpleasant memories and emotions from conscious awareness. Dissociation is a typical response to severe traumatic experiences and is associated with near death experiences (NDEs). Individuals who have experienced dissociation as a response to severe trauma or abuse may have a specific disorder such as acute stress disorder (Millon, 1981).

In summary, defense mechanisms typically found in certain personality disorders include 'acting out' and displacement with APD and BLPD and dissociation with BLPD and in some individuals with NPD. Narcissistic individuals are prone to acting out and using denial and splitting. Individuals with DPD use denial and sometimes dissociation while individuals with AvPD have traits which include reaction formation, denial, and dissociation (Valliant & Drake. 1985). Defense mechanisms employed by obsessive-compulsive personality disorder are reaction formation, isolation and undoing (Millon & Davis, 1996) and those with histrionic personality disorder may use dissociation, repression, and displacement.

Interviewing:
Personality disorder clients do not provide objective data regarding their personality traits. A general consensus is that the interviewer observes patterns of behaviors in the areas of social relations and work functioning (Western, 1997). Structured interview instruments may include the Personality Disorders Questionnaire-4 (Hyler, 1994), the Millon Clinical Multiaxial Inventory-III (Millon et al. 1997), and the Minnesota Multiphasic Personality Inventory-2 (Somwaru & Ben-Porath,1997). Clinical interviews may be the Structured Interview for the DSM-IV Personality Disorders (Pfohl et al. 1997), the International Personality Disorder Examination (Loranger, 1999), Structured Interview for the DSM-IV (assesses all 10 personality disorders and uses a five year window), personality disorders (First et al. 1997) and the Personality Disorder Interview-IV (Widiger et al. 1995). The Diagnostic Interview for DSM-IV Personality Disorders assesses 10 DSM-IV-TR personality disorders.

There are several self-administered assessments for personality disorders such as Coolidge Axis II Inventory (CATI; Coolidge & Merwin, 1992), Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley & Jackson, 204), Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, et al. 1997), Narcissistic Personality Inventory (Raskin & Terry, 1988), Personality Diagnostic Questionnaire-4(Hyler, 1994) and Wisconsin Personality Inventory (Klein, et al. 1993).

Evaluation and Instruments/Inventories:
Clinicians who evaluate personality disorder clients are faced with limited objective data and must rely

on their observations of behavioral patterns and reports of social relations and work functioning (Western, 1997). The use of instruments and structured interviews can improve the diagnostic process.

Following are instruments, questionnaires and inventories that are used for personality disorders.

Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998)

The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; DiNardo, Brown, & Barlow, 1994)

The Inventory of Interpersonal Problems (IIP-64; Horowitz, Alden, Wiggins, & Pincus, 2000)

The Personality Disorders Questionnaire-4 (Hyler, 1994)

The Millon Clinical Multiaxial Inventory-III (Millon et al. 1997)

The Minnesota Multiphasic Personality Inventory-2 (Somwaru & Ben-Porath,1997)

The Structured Interview for the DSM-IV Personality Disorders (Pfohl et al. 1997)

The International Personality Disorder Examination (Loranger, 1999)

The Structured Interview for the DSM-IV (assesses all 10 personality disorders and uses a 5 year window; First et al. 1997)

The Personality Disorder Interview-IV (Widiger et al. 1995)

The Diagnostic Interview for DSM-IV Personality Disorders assesses 10 DSM-IV-TR personality disorders

The Coolidge Axis II Inventory (CATI; Coolidge & Merwin, 1992)

The Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley & Jackson, 2004) a self-administered questionnaire

The Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, et al. 1997)

The Narcissistic Personality Inventory (Raskin & Terry, 1988) a self-administered questionnaire

The Personality Diagnostic Questionnaire-4 (Hyler, 1994) A self-administered questionnaire

The Wisconsin Personality Inventory (Klein, et al. 1993). A self-administered questionnaire

Young Schema Questionnaire (YSQ-SF; Young & Brown, 2003)

Instruments for Specific Personality Disorders

Antisocial Personality-Composite International Diagnostic Interview (CIDI; Robins et al. 1988)

Avoidant Personality Disorder- The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV). The ADIS screens for all mood and anxiety disorders rating are from 0-8 with four and above as the clinical threshold. The Inventory of Interpersonal Problems (IIP-64) is a screening tool for AVPD and provides a

rating on affiliation and dominance. The disorder is associated with interpersonal behaviors that are low in dominance and low in affiliation.

Borderline Personality Disorder-The Revised Diagnostic Interview (DIB-R; Zanarini et al. 1989). This instrument provides scales for impulse action patterns, affects, cognition and interpersonal relations.

Narcissism-The Diagnostic Interview for Narcissism (Gunderson et al. 1990). This instrument measures for grandiosity, interpersonal relations, reactiveness, affects, and mood states and social and moral judgments.

Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997).

Comorbidity:
Cluster A: delusional disorders, schizophreniform disorder, schizophrenia
Cluster B: mood and impulse control disorders, substance use disorders, and bulimia
Cluster C: anxiety disorders, agoraphobia, social phobia, obsessive-compulsive disorders

Differential Diagnosis:
The primary purpose of making a differential diagnosis of personality disorder is to determine whether the individual's symptoms represent a state or trait disorder. The state personality disorder's key feature is episodic personality dysfunction while trait personality disorder is non-episodic and reflects a stable personality disorder.

Assessment and Ethnicity:
Of importance to clinicians considering a personality diagnosis is ethnicity. Chavira, Grilo, Shea, et al. (2003) researched four personality disorders (borderline-BPD, schizotypal-STP, avoidant-AVPD, obsessive-compulsive-OCPD) across three cultural groups (African Americans, Hispanic Americans, and Caucasian Americans). Their findings indicated that higher rates of BPD in Hispanics than in Caucasians and African Americans; higher rates of STPD among African Americans than Caucasians. Their subjects (554) were drawn from the Collaborative Longitudinal Personality Study. The concluding comments showed that Caucasians, African Americans, and Hispanic Americans may show different patterns of personality pathology and that caution is to be exercised until additional research is available.

In assessing for pathology with culture and ethnicity it is important to understand how the individual perceives a problem, expresses a problem, the interaction between the clinician and the person, and if the person decides to seek treatment. Therefore it is important the clinician to become familiar with language, behavior and the interpersonal style of clients of culture.

Interview Process:
A personality diagnosis, although sometimes suspected during a first interview, is generally made in phases or increments and confirmed only after several clinical interviews. The person doing the interviewing begins to identify the cluster and disorder by the end of the first interview. In most cases the interviewer will defer making a specific personality diagnosis in order to refrain from labeling or

establishing a bias although a cluster identification can sometimes be made in order to facilitate treatment.

During the first part of the interview the diagnostician will observe variations in functioning (client cognition, affect, behavior, and physiology). Cognitive observations may be vagueness to include derealization, paranoia, projections, and magical thinking. The client may experience an inability to modulate affect or a range of emotions (intensity of emotion).

Adler (1990) highlights that clients diagnosed with a personality disorder experience interpersonal and occupational impairments (inability to find success or satisfaction in loving and working-demanding, intolerant, competitive, or even oppositional).

Everly (1989) identified primarily for Clusters B and C markers such as cognitive distortions, irrational expectations, and rigid coping mechanisms, and susceptibility to major stress-related syndromes.

Instrumentation:

1. Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1967)
2. Millon clinical Multiaxial Inventory II (MCMI-II; Millon, 1987)
3. Milville-Guzman Universality-Diversity Scale (Milville, Gelso, Panny, Liu, Touradji, Holloway, & Fuetes, 1999). This scale will monitor for adaptive narcissism
4. Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979).

Treatments:
Clients diagnosed with a personality disorder often seek treatment for symptoms such as depression and anxiety rather than their personality disorders. When those symptoms subside clients diagnosed with a personality disorder frequently interpret this as a sign of progress and will abruptly quit therapy. These clients may also feel threatened by a reality-based therapeutic process that challenges their beliefs and behaviors. Thus, they typically prefer to avoid testing their beliefs in order to sustain their disorders.

It will be a challenge for a counselor to help a client feel validated and agree to pursue more adaptive strategies when he or she maintains an attitude of denial about his or her maladaptive behaviors. Counselor must be careful to demonstrate genuine non-defensiveness and non-competitiveness while, at the same time, being sensitive to how the client is perceiving the counselor's verbal and non-verbal communication. If the client perceives the counselor as critical, he or she will feel rejected and become defensive.

Cognitive and Interpersonal therapies have been found to be effective with many personality disorder clients.

Couples therapy, when one member is diagnosed with a personality disorder, has been found to have favorable outcomes (Links & Stockwell, 2002). Glikauf-Hughes and Wells (1995) recommend the importance of first assessing workability when one member of the couple has a narcissistic disorder.

Workability has to do with the capacity to resolve or ameliorate three characteristics: acting out, defensiveness and vulnerability, and narcissistic gratification.

Ronningstam, Gunderson, and Lyons (1995) identified three specific events that have been found to have a positive impact on an individual with narcissistic personality disorder (corrective achievements, corrective disillusionments, and corrective relationships). If an achievement is valued and reflected upon, a change in the narcissistic self-concept can be expected. The authors suggest that if these achievements take place a realistic self-evaluation will lessen the need for fantasies and exaggerations. A corrective relationship involves the establishment of a stable, mature relationship and less of a need for dependency.

The following treatments have been recommended for some personality disorders where there is a good likelihood that trust and a degree of alliance between the counselor and client can be established.

1. Schema Therapy is an innovative psychotherapy developed by Jeffrey Young that integrates elements of cognitive therapy, behavior therapy, object relations, and gestalt therapy into one unified approach to treatment. This therapeutic approach has recently been blended with mindfulness meditation for clients who want to add a spiritual dimension to their lives. Schema therapy is recommended for clients whose disorders are significantly impacted by underlying personality disorders of which BLPD is a prime example (Young et al. 2003). Treatment is usually mid-term or long. According to Young a core theme is early maladjustment from early childhood with an emphasis on interpersonal relationships. Three concepts of this approach are coping styles, schemas and modes. Modes represent the coping responses and schemas presently active. Schema healing represents a diminishing of memory intensity, emotional charge, bodily sensations strength, and maladaptive cognition attached to the schema. Behavioral changes are targeted at learning new coping styles to replace the three maladaptive styles which are surrender, avoidance and overcompensation. Research on effectiveness of treatment has focused primarily on mood and social functioning.

2. Dialectical behavior therapy (DBT), developed by Marsha M. Linehan at the University of Washington (Linehan, M. M. (1993), is a biosocial treatment approach which focuses on helping patients stabilize psycho-physiological dysregulation by applying modalities of Zen mindfulness meditation, problem solving, exposure techniques, skills training, contingency management and cognitive modification. This treatment approach combines standard cognitive-behavioral techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness largely derived from Buddhist meditative practice.

   DBT is the only therapy that has clinical trials for borderline personality disorder (BLPD). Mindfulness is used within the framework of DBT as the basis for regulating emotions by controlling one's attention in order to become more aware of current thoughts and feelings. When successful, Mindfulness increases an individual's ability to manage negative emotions, decrease physical symptoms, and increase coping skills and a sense of wellbeing. Regulating

emotions is a major component of DBT, since it is a treatment modality for BLPD that focuses on reducing vulnerability to negative emotions by increasing feelings of competence and enhancing positive emotions.

3. Interpersonal psychotherapy (IPT): IPT has literature-based support to treat a number of diagnoses - mood disorders, depression, bulimia, and anxiety disorders (Bleiberg & Markowitz, 2008; Weissman et al. 2000). The main focus of IPT is to emphasize social and interpersonal experiences (Seligman & Reichenberg, 2010). However, there is limited support for IPT's effectiveness to treat personality disorders (Markowitz, 2005) although it has been found to be somewhat more useful for Clusters B and C. The research has been more associated with theoretical rather than treatment outcome.

4. Psychodynamic psychotherapy has been a successful treatment approach when the following factors are present. Gabbard (2001): 1. The patient's motivation for deep change with accompanying psychological mindedness 2. A capacity for transference work 3. A propensity to regress 4. An ability to control impulses, adequate frustration tolerance and 5. Ample financial resources.

5. Clients diagnosed with a personality disorder are candidates for psychodynamic therapy are obsessive-compulsive, hysterical, narcissistic, avoidant, and dependent personality disorders. Randomized controlled trials demonstrate effectiveness support for Cluster C personality disorders (Gottdiener, 2006).

6. Attachment-based psychotherapy is recommended for Cluster B personality disorders (Bateman & Fonagy, 2003). Treatment is directed at a more secure attachment through stabilization of the self structure, formation of a coherent sense of self and enhanced capacity to form relationships.

7. Transference-Focused Psychotherapy (TFP) is a highly structured, twice-weekly modified psychodynamic treatment based on Kernberg's object relations model of borderline personality disorder. (Clarkin, J. F., Yeomans, F., Kernberg, O. F., 2006). It views the individual with borderline personality organization (BPO) as holding unreconciled and contradictory internalized representations of self and significant others that are affectively charged. The defense against these contradictory internalized object relations leads to disturbed relationships with others and with self. The distorted perceptions of self, others, and associated affects are the focus of treatment as they emerge in the relationship with the therapist (transference). The intended aim of the treatment is focused on the integration of split-off parts of self and object representations, and the consistent interpretation of these distorted perceptions is considered the mechanism of change. While TFP represents one of a number of treatments that may be useful in the treatment of BPD, only TFP has been shown to change how patients think about themselves in relationships. (Levy, K.N., et al., 2006).

8. Mentation-based psychotherapy is a type of psychotherapy that focuses on the ability to "mentalize," or recognize thoughts, feelings, wishes, and desires, and see how these internal states are linked to behavior.

9. Supportive Psychotherapy: Supportive therapy's aim is to relieve anxiety. Goals of supportive psychotherapy are restorative and maintenance of functioning. The therapist should respond to the client's questions, avoid confrontation and interpretation, fosters verbal expression of thoughts and feelings, and find something for the client to like and respect. Histrionic clients respond best to supportive therapy when compared to other personality disorders (Blum, 1973).

10. Group Treatment: Group treatment provides a cohesive social milieu and interpersonal learning. There is a lack of randomized control studies for group effectiveness. For those studies that have been conducted the support mostly favors the borderline, avoidant and dependent personality disorders. Different personality disorders present specific issues for group process including a dislike for or competition about sharing the leader, outbursts, aggressive behaviors, safety, confidentiality, understanding, and even suicidal threats (Piper & Ogrodiniczuk, 2004). The therapist during group treatment is likely to see demonstrated the pattern behaviors of personality disordered individuals. Therapists will observe interpersonal behaviors that typify individuals with dependent, histrionic, or borderline personality disorder. Some personality disordered clients challenge the norms and guidelines, weakening the cohesion for group work (antisocial, borderline, obsessive-compulsive). The most difficult to treat in a group are individuals with borderline and narcissistic personality disorders. Avoidant personality disordered clients fear the possibility of humiliation and criticism in the group setting. If they are motivated to be in a group, friendship formation can be observed and reinforced. The settings and types of group work include short-term outpatient, long-term outpatient, day treatment and inpatient/residential. For each personality disorder, a rating for group suitability is as follows: Cluster B: Borderline (effective), narcissistic (problematic), histrionic (helpful), antisocial (not suitable). Cluster C: Avoidant (effective and useful), dependent (effective and treatment of choice), obsessive-compulsive (helpful for some)

11. Family Therapy: There is limited research using family or couples therapy to treat personality disorders. Obsessive-compulsive personality disorder and histrionic personality disorders were first studied in families because of the belief that the OCPD member would provide organization and intellect to the marriage while the histrionic would provide the vitality (Berman, Lief, & Williams 1986). Sholevar (2005) describes Cluster B as the primary clusters studied in families because family members within this cluster are most highly resistant to interventions. Individuals with borderline personality disorder have been helped to modify behaviors that are disruptive to the family using Dialectic Behavioral approaches within a family therapy setting. (Fruzzetti, A., E., et al., 2007).

12. Psychoeducation: There are no effective psychoeducational programs for Cluster A personality disorders. Limited numbers of effective psychoeducation programs have been developed for some Cluster B personality disorders such as avoidant (social skills training) and borderline (mindfulness, emotion regulation, distress tolerance, interpersonal effectiveness) which utilizes a psychoeducational component in DBT. There are no studies referencing psychoeducation for antisocial personality disorders. A 2010 review of different types of psychotherapy for borderline personality disorder found that the highest quality evidence

from clinical trials of psychotherapeutic interventions supports dialectical behavior therapy and mentalization-based therapy (Paris, J., 2010).

Treatments:

Narcissistic Personality Disorder:
Psychoanalysis is generally ineffective. Psychotherapy can be effective particularly when psychotherapists treat symptoms related to crises associated with the client's diagnosis rather than to treat the personality disorder per se. Developing a positive transference and therapeutic alliance should not be relied upon with narcissistic patients when long term therapy is attempted since the transference is unstable with a tendency to devalue the therapist. Goals for psychotherapy should be modest and may best be achieved when combined in a supportive way with group therapy since a group can be more confrontational than an individual therapist and the transference issues are less significant.

Antisocial personality disorder is not amenable to psychoanalytic-based therapies. Cognitive therapy is a more preferable approach with the major focus on helping the patient understand how he creates his own problems and how his distorted perceptions prevent him from seeing himself the way others view him. This is often ineffective, however, since APD patients devalue the therapist, blame others, have a low tolerance for frustration, are impulsive and have difficulty forming trusting relationships. Therefore, doing therapeutic work with these individuals is difficult. Furthermore, APD patients often lack the motivation to improve and are notoriously poor self-observers and do not see themselves as others do. Therapists undertaking such a treatment process must be aware of their own feelings and remain vigilant to their negative counter-transference (emotional responses to their patients) and not allow it to disrupt the therapy process. Generally speaking, only therapists with a special interest and experience with APD will have any success.

Histrionic Personality Disorder:
These patients are (unlike those with other personality disorders), are much quicker to seek treatment and tend to be more emotionally needy. Solution-focused supportive therapy with short-term alleviation of difficulties within the person's life is preferable to long term psychotherapy. Clinicians should be alert to counter-transference issues and not be 'seduced' to the possibility of being placed in a "rescuer" role where they are asked directly or indirectly to constantly reassure and rescue clients from daily problems which are often expressed in dramatic ways. Therapists will frequently be over-idealized by histrionic clients and perceived as sexually attractive so that boundary issues and a clear delineation of the therapeutic framework are relevant and important aspects of therapy.

Obsessive-Compulsive Personality Disorder:
Traditional psychotherapy based on psychoanalytic principles has rarely been successful. Understanding and working through the symbolic meaning of obsessions may improve a patient's understanding but is generally insufficient to change obsessive-compulsive behavior. Rather, as discovered by the English psychiatrist Isaac Marks, behavioral techniques of exposure and response prevention turned out to be more effective. Exposure consists of confronting the patient with situations that evoke obsessional distress; response prevention consists of teaching patients with OCD

to abstain from compulsive rituals and helping them learn how to master anxiety provoked by obsessions without performing rituals until the obsessions eventually disappear.

Avoidant Personality Disorder:
The most effective treatments for this disorder are behavioral and cognitive-behavioral techniques (Brown, et al., 1995). However, psychotherapy may be helpful if the therapist is able to form a good therapeutic relationship with the patient. Individuals who have avoidant personality disorder will often avoid treatment sessions if they distrust the therapist or fear rejection. Treatment can employ various techniques, such as social skills training, cognitive therapy, exposure treatment to gradually increase social contacts in order to challenge exaggerated negative beliefs about themselves, group therapy for practicing social skills, and sometimes prescribed psychoactive medication (Comer, 1996).

Dependent Personality Disorder:
Psychodynamic psychotherapy can be effective when the focus is on solutions to specific life problems. Achieving a personality change would take a lengthy therapeutic process, something that is not recommended since it reinforces a dependent relationship upon the therapist. Assertiveness training and other behavioral approaches have been shown to be most effective in helping individuals who have difficulty with boundary setting, saying 'no' and determining self-determination goals. Challenging unhealthy dependent relationships should generally be avoided at the onset of therapy but, when done carefully, are important as treatment progresses. Restraint must be used if the individual is not ready to give up these unhealthy relationships. After the goals of the treatment have been reached, the therapist should take the initiative to terminate therapy since DPD patients often don't know "how much is enough." As the end of the therapeutic work approaches, the patient is likely to re-experience feelings of insecurity, lack of self-confidence, increased anxiety and perhaps even depression - issues which should be confronted at the time in therapy.

Monitoring:
Monitoring improvement can be through instruments such as the Narcissistic Personality Disorder Scale, Narcissistic Personality Inventory, and the three events noted previously (corrective achievements, corrective disillusionments, and corrective relationships). If the client has a significant other participating in the therapy or in couple's therapy, reports by the significant other would be recommended.

Specific Personality Disorders

Avoidant Personality Disorder

Definition:
Avoidant personality disorder (AvPD) (301.82) is a Cluster C personality with features of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluations (APA, 2000). Shyness, fear and isolation begin in early childhood. AvPD clients reported that their parents' discipline style

was to make statements that induce shame and guilt and interact with very little warmth and tolerance (Meyer & Carver, 2000). A pattern of avoiding interpersonal interactions that results in a heightened social withdrawal can be observed in work and school activities. The pattern will include avoiding occupational activities because of a fear of criticism, disapproval or rejection, unwillingness to get involved with others unless he/she is liked, restrained intimate relationships for fear of being shamed or ridiculed, preoccupation with rejection or criticism in social situations, and feelings of inadequacy in new interpersonal situations. The APD client frequently feels inept, unappealing, or inferior to others and is reluctant to take personal risks.

The client diagnosed with an AvPD has a chronic and pervasive fear of negative evaluations by others and characteristically will avoid interpersonal interactions revealing a psychosocial impairment or deficit. Features common to AvPD clients include shyness, social inhibition and anxiety, interpersonal reticence, and social avoidance. The client has difficulties recognizing and discriminating emotions as expressed by others. Rosenta, Kim, Herr, Smoski, et al (2011) in their study of facial recognition specific to emotions of anger, disgust, sadness, fear, surprise and happiness found that AvPD clients were less accurate than controls.

Incidence:
Prevalence of AvPD in the general population is between 0.5% and1.0% and as much as 10% in outpatient centers (APA, 2000). Herbert (2007) cites several studies suggesting that AvPD ranged between 5%-6.6%. and may be most common of the personality disorders receiving treatment in mental health centers.

Interviewing:
Clinicians interviewing individuals with AvPD should consider the following as critical to the evaluation: establishment of rapport, psychodiagnosis, assessment of symptom pattern, phobic stimuli and impairment in functioning (Herbert, 2007). During the initial interview the client is likely to be guarded, disengaged circumstantial, anxious, hypersensitive to rejection, and observing the counselor's proclivity toward being accepting or rejecting. Although this client has a consistent style of responding in terms of acting, feeling, coping and defending it is possible to eventually establish some degree of trust. Cooperation will come as the process reveals the client's testing of the counselor who successfully responds with empathy and support. After trust is developed the client will share some of his/her fears. But if trust fails to develop, the treatment may terminate early.

Diagnosis:
The definition of avoidant personality disorder (301.82) involves four of the following criteria: (1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection; (2) is unwilling to get involved with people unless certain of being liked; (3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed; (4) is preoccupied with being criticized or rejected in social situations; (5) is inhibited in new interpersonal situations because of feelings of inadequacy; (6) views self as socially inept, personally unappealing, or inferior to others; (7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing (APA, 2000, p. 721).

The AvPD subtypes are the conflicted avoidant, hypersensitive avoidant, phobic avoidant and self-deserting avoidant. Individuals with the self-deserting avoidant type draw more and more into themselves as a means of avoiding the discomforts of relating to others. As a result they become aware of their inner psychic content. Turning inward centers them on their pain and anguish of past issues. They create a protective barrier from the real world. The self-deserting type merges avoidant and depressive features which leads to social aversion and self-devaluation (Millon & Davis, 1996).

Comorbidity with personality disorder is greatest with schizoid, depressive, dependent, and paranoid personalities. Co-morbidity exists with social phobia and social anxiety disorder, anxiety syndromes, phobic syndromes, obsessive-compulsive syndromes, somatoform syndromes, dissociative syndromes, depressive syndromes and schizophrenic syndromes (Millon & Davis, 1996).

The differential diagnosis of avoidant personality disorder is most commonly with social phobia because the two diagnoses are difficult to differentiate. Typically found during assessment is that clients with social phobia are strongly associated with panic disorder while AvPD are associated with eating disorders (Hummelen, Wilberg, Pedersen, & Karterud, 2007). Other co-occurrences are found with anxiety disorders, panic disorders, obsessive-compulsive disorder, generalized anxiety disorder and social anxiety disorder (Herbert, 2007). The assessor should also be alert to panic disorder with agoraphobia. Avoidance of humiliation and rejection are common behaviors that set AvPD apart from dependent personality disorder whereas they both share common characteristics of inadequacy, hypersensitivity to criticism and a need for reassurance.

Instruments:
The most common instrument for interviewing all personality disorders is the Structured Interview for Axis II Personality Disorder (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). A self-report inventory for AvPD is the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, Millon & Davis, 1994).

Treatments:
There are very few studies regarding the treatment of AvPD. Most of the literature studies of treatment outcome are with generalized anxiety and social anxiety disorder. The treatment of individuals with AvPD is long in duration and the focus is improving social inhibition, feelings of inadequacy and hypersensitivity to negative criticism. The prognosis has been poor and the challenges are to retain the client in therapy and to be aware of transference-countertransference issues associated with the client's need to be liked and not receive negative evaluations. The counselor should frame all interventions in a way that reduces the client's fear of rejection. Sperry (1999) recommends Schema therapy for schema change and style skill change because individuals with this diagnosis labor with the self-perception of defectiveness, inadequacy, and unlikability. As a result they find it difficult to show their feelings, approach others closely, or establish intimacy. The change process is initiated through experiments, guided observation, and reenactment of early schema-related incidents (Sperry, 1999). An early treatment goal is to increase emotional tolerance. The interviewer during assessment may find the client's lack of emotional self-awareness reflected by statements such as 'my mind went blank,' I don't know what I felt,' or 'I'm not sure what I felt.' The next step in therapy is regulation training whereby the client is taught to experiences awareness and staying with the distressing thoughts. The cognitive style for clients with AvPD is hypervigilance and cognitive avoidance. Thus treatment should

include teaching the client to reduce hypervigilance through social skills training and assertive communication.

Alden (1992) recommends a four step integrative approach to treatment which includes the following. 1) recognition of treatment process issues (withhold information), 2) increased awareness of cognitive-interpersonal patterns (self-observation-self-protective behaviors), 3) recognize and understand his/her cognitive interpersonal patterns and styles (try new behaviors) and 4) behavioral experimentation and cognitive evaluation.

Group treatment is difficult because the client fears risks involved in the interaction with others. If the client can be encouraged to participate and will participate in a therapy group this can be an effective change agent. A critical issue in the group work is self-disclosure and is usually facilitated through structured activities.

Borderline Personality Disorder

Borderline personality disorder is one of the Cluster B category personality disorders. It is one of a number of personality disorders associated with maladaptive personality traits that cause functional impairment or subjective distress. Borderline personality disorder is characterized by repetitive self-defeating or self-destructive behavioral patterns, particularly associated with interpersonal relationships, self-image beginning in early childhood (APA, 2013). There are frequently concomitant symptoms, including substance abuse, anxiety, mood swings, and frequent behavioral changes (Kaplan & Sadock, 1998). Typically, individuals with BLPD are argumentative one moment, depressed another, sometimes panic-stricken, and emotionally numb at other times. Their emotional roller coasters are related to the fact they cannot tolerate being alone but also cannot tolerate close relationships. They try to fill chronic feelings of boredom in destructive ways, frantically searching for someone to fill the emptiness, yet provoking others in ways that precipitate loss or victimization. Thus, borderline individuals suffer repeatedly the pain of destructive and tumultuous interpersonal relationships. These individuals often have a history of an early-life abandonment or victimization and abuse by a parent (Kaplan & Sadock).

Historically, the diagnosis of borderline personality disorder (BLPD) emerged over 30 years ago because clinicians were uncertain about correctly diagnosing clients with symptoms that vacillated between psychosis and neurosis. Uncertain as to what they were seeing, they used diagnoses such as pseudoneurotic schizophrenia and ambulatory schizophrenia for clients with symptoms that included brief psychotic episodes, unstable affects and behaviors, primitive defense mechanisms of denial and projection, and serious identity disorders. The diagnosis also emerged from the psychodynamic literature (Masterson, 1981; Rinsley, 1981) and eventually became standardized in the APA's Diagnostic Manual (APA, 1994).

Individuals with a diagnosis of BLPD almost always appear to be in a state of crisis. Their behaviors can change quickly, ranging from angry outbursts, depression, helplessness, or emotional coldness, to blasé indifference. Short-lived breaks from reality may be associated with self-destructive acts and self-mutilations. Their interpersonal relationships are usually tumultuous because they are very dependent

and cannot tolerate being alone, yet will withdraw or angrily provoke friends or spouses from whom they fear rejection or abandonment. Because of this, it is not uncommon for clients with BLPD to have repeated brief sexualized relationships with self-destructive consequences as an attempt to cope with the intense need for emotional closeness. Their personality disorders generally do not stand alone and are commonly associated with other diagnoses, particularly mood and anxiety disorders, including bipolar disorder and post-traumatic stress disorder. Individuals with BLPD also frequently use or abuse drugs or alcohol as an attempt to control symptoms.

Etiology:
The etiology of BLPD may include the following: familial trauma, loss or separation during the first three years of life, adoption, incest, violence, hostile environments, and ADHD (Gunderson & Zarini, 1987).

Incidence:
The prevalence of borderline personality disorder is estimated to be 1.6% to 5.9% (APA, 2013). 10% in out-patient clinics, and 20% among psychiatric in-patients (APA, 2013, p. 665).

Treatment:
Individual psychotherapy has been called the cornerstone treatment for this disorder. Important parallel treatment components are protective 'holding environments' which are generally necessary from time to time, including hospitalization or partial hospitalization.

Treatment must be long-term with an experienced therapist who can establish an empathic relationship with the patient, meet regularly, set limits and structure, maintain stability over time, uncover and resolve past traumatic emotions, conflicts, and disturbing emotions. Therapeutic techniques involve dealing with resistance, transference, and counter-transference, while providing key interventions along a continuum ranging from supportive interventions such as advice, praise, validation, and affirmation to more expressive interventions such as interpretation, confrontation, and clarification (Gabbard, 1994).

The therapist's work is to help 'borderline individuals' learn to integrate ('good-self' and 'bad-self'). Because they have never experienced self-acceptance, 'borderlines' are driven by a compulsive need to change (Linehan, 1993) and find healing for the internal 'split' between an over-idealized ('good-self') and a devalued ('bad-self'). The 'borderline' individual, who failed to experience normal separation-individuation, perpetually seeks out an 'idealized' relationship to replace the 'rejecting' mother who failed to provide adequate emotional nourishment. For this reason, the therapist's challenge is to initially be the 'good-enough mother' and accept the projected over-idealized 'good-self'; but also to be able to set limits and manage the fractured relationship that inevitably results when the projected 'bad-self' emerges during therapy.

An example of how this could enfold may be a female 'borderline' client who appears to have established a relationship with her therapist and others, succeeds in her life for a period of time but then become self-defeating, unreasonably angry toward the therapist, and threaten the therapeutic process, thus losing whatever success she had gained. The therapeutic task is to help the client learn to recognize the emergence of the 'bad-self' which causes self-defeating behavior and the projection of

unreasonable anger toward the therapist. It will be a tough task but if this 'borderline' patient remains in therapy long enough she will be able to learn how to maintain validity of a range of emotional experiences while learning to interpret those experiences differently (Linehan, 1993).

Dialectic behavioral therapy (DBT), a recommended treatment for individuals with borderline personality disorder, has been described more extensively in this report on personality disorders. DBT has also been useful for clients with 'borderline traits', drug abuse, eating disorders, and antisocial personality disorders. The research on DBT effectiveness has primarily been conducted with women. DBT focuses on helping the client learn ways to stabilize her emotional instability which requires a year or more of commitment by the client and counselor. Linehan (1993), who uses a manual and a structured approach in DBT, developed a program which has the following components:

1. Weekly individual therapy sessions - a combination of one to two sessions per week for 50-60 minutes or longer.
2. Weekly didactic skills training groups and the use of a training manual. Skills training include shaping, modeling, repeated practice, behavioral rehearsal, homework, reinforcement of socially appropriate behaviors, mindfulness training, distress tolerance training, emotional regulation, and teaching interpersonal effectiveness, limits setting, and contingency management skills for suicidal ideation.
3. Telephone contact, as needed, for patients to call therapists at any time in order to avoid self-harm and sustain or repair therapeutic relationships.
4. Consultation meetings for individual therapists and skills trainers to meet and review the treatment.

Since there are several types of treatments for BLPD Waldinger and Gunderson (1987) have identified the following areas of agreement regarding essential components of treatment:

1. Providing a stable treatment framework
2. Having highly active and involved therapists
3. Establishing a connection between the client's actions and feelings
4. Identifying adverse effects of self-destructive behaviors
5. Paying careful attention to counter-transference feelings

Several therapeutic principles have been found to be useful (Gunderson & Links, 1995):

1. Therapists should identify, confront, and treat a co-morbid substance abuse disorder or a major depression.
2. Clinicians need to develop a means for differentiating non-lethally motivated self-harm from true suicidal intention, because the lifetime risk of suicide in these patients is 10%.

3. While establishing the importance of safety, the therapist must stress that psychotherapy is a collaborative enterprise and that the therapist is not all-powerful.
4. Management of counter-transference is significant and the therapist must be on guard against harboring, acting out, or expressing seductive, passive-aggressive, or angry feelings toward the patient. The failure to do this is detrimental to the patient, who may act out destructively or self-destructively.
5. The therapist should provide a different means of interacting with the patient than what has been the patient's previous experience. The therapist should be aware of the possibility that he or she may tend to 'hold, contain, or cleanse' the patient's projections, rather than responding more directly and therapeutically. The patient's self becomes transformed by the corrective effect of the new interaction in the therapeutic relationship.
6. The therapist should seek consultation readily.

Antisocial Personality Disorder

Antisocial personality disorder is one of four Cluster B disorders. The other three in this cluster are borderline, narcissistic and histrionic. These four disorders share behavior descriptors of dramatic, erratic and emotional (APA, 2000, 2013). The DSM-5™ defines the APD as one of being a pervasive pattern of disregard for and violation of the rights of others and beings in childhood since age 15.

DSM-5TM diagnostic manual further describes the disordered anti-social individual as reflecting an "enduring pattern of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts" (APA, p. 659).

Prevalence:
The 12-month prevalence rate as cited in the DSM-5TM is approximately 0.2% to 3.3% (APA, 2013). DSM-IV-TR Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, 2000 APA Press). A family predisposition appears to exist because there are five times greater first-degree males with the disorder than with controls (Kaplan & Sadock, 1998).

Prognosis:
The prognosis for individual therapy is generally poor however when clients are on probation or court ordered treatment the prognosis is improved (Dolan & Coid, 1993). Furthermore, well-motivated clients with impulsive character traits who seek treatment voluntarily in outpatient group therapy show improvement (Lion & Bach-y-Rita, 1970).

The prognosis is poor for individuals who suffer from severe dehumanizing experiences during the formative years. These youngsters grow up with reduced chances of normal socialization and they frequently go on to experience antisocial personality traits or antisocial personality disorder (ASPD) (Stone, 2006). Key factors for improvement during therapy are motivation, self as the issue, safety, relational development, and positive risk-taking to change.

Individuals with anti-personality disorder typically have no regard for the rights of other people and their behavior does not conform to established laws and social norms. They tend to be deceitful and take advantage of or 'con' others without any concern except for their own personal profit. They are irresponsible and cannot sustain any kind of consistent work pattern or honor financial obligations. Instead, they tend to make impulsive decisions and fail to plan ahead. They have a reckless disregard for the rights or safety of others. They tend to be selfish, lack capacity to make meaningful relationships, and may pick fights to establish power over others. They lack capacity to experience remorse or shame or to express guilt feelings about destructive behaviors. Instead they are indifferent and rationalize those behaviors that hurt, mistreat, or steal from others. Although, as young adolescents, they had likely displayed similar behaviors and been diagnosed with conduct disorder, they must be at least 18 years of age to have the diagnosis of anti-social personality disorder.

Case reports frequently mention a strong need for stimulation such as novelty seeking and risk-taking behavior (Cloninger, 1986), low harm avoidance, lack remorse (not all clients), violation of social norms and a repeated tendency to break the law. They are likely to commit economic crimes and be potentially dangerous. The underlying issue is a blatant disregard for others. Hare (2003), at the severe end of his Psychopathy Checklist-Revised (PCL-R), describes a risk taker, a repeat criminal, stock-fraud swindler, arsonist for hire, and serial killer.

Instruments/Assessment:
The ASPD client is capable of masking sanity by appearing credible and calm. Beneath that veneer are often tension, irritability, and even rage. When assessing for ASPD the examiner is to be aware of co-morbidity. The common other disorders are likely to be substance use disorder, depression, anxiety and most prevalent is another Cluster B disorder. Kaplan and Sadock (1998) recommend a full workup including a neurological examination. Research findings suggested from EEG and soft neurological signs suggest that an individual with this disorder may have suffered minimal brain damage during childhood.

Symptoms likely to be found in a person diagnosed with ASPD include a pervasive disregard and violation of the rights of others, lack of empathy, callous demeanor, cynical worldview, contempt for the feelings of others, arrogance, inflated self-image, opinionated viewpoints, cockiness, glibness, a charming facade, verbally facile, impulsivity and a history of aggressive or violent behavior (Rotgers & Maniacci, 2006).

Hare and associates (1991) utilized the Cleckley descriptors and developed the Psychopathy Checklist-Revised (PCL-R). The PCL-R is a 20 item list of true descriptors of personality that has two factors. Factor I traits consist of 'aggressively narcissistic traits (superficial charm, grandiose self-worth, pathological lying, manipulative, lack of remorse, shallow affect, lack of empathy, failure to accept responsibility); Factor 2 traits reflect a 'socially deviant lifestyle' (need for stimulation/proneness to boredom, parasitic lifestyle, poor behavioral control, lack of realistic long-term goals, impulsivity, irresponsibility, juvenile delinquency, early behavior problems and revocation of conditional release). Traits not correlated with either factor are sexual promiscuity, many short-term marital relationships, criminal versatility, and acquired behavioral sociopathy.

Diagnosis:
An adult client diagnosed with ASPD is likely to have displayed behaviors before age 15 that include lying, truancy, running away from home, thefts, fights, substance abuse, illegal activities and been diagnosed with conduct disorder. Upon reaching 18 years of age or more, if this person demonstrates such behaviors that include conning, swindling, manipulating, promiscuity, spousal abuse, child abuse, drunk driving, irresponsibility, shameless behaviors that do not meet social norms and run into conflict with the legal system, he meets criteria for the diagnosis of ASPD.

The subtypes of ASPD are covetous, reputation-defending, risk-taking, nomadic and malevolent behaviors (Millon, 1996). ASPD overlaps frequently with narcissistic and sadistic patterns.

Prognosis:
The prognosis for antisocial personality disorder is poor and considered to be chronic and lifelong. The degree of chronicity can be modified in terms of the gradient of severity for this disorder. Stone (2006) indicates a direct relationship using the range of deviation along the range of severity in the diagnosis. Stone contends that clients with a combination of 2-3-6 of deceitfulness, impulsiveness, irresponsibility respectively pose less threat of harm while clients manifesting 4-5-7 (irritability, reckless and lack of remorse) are prone to assaultiveness. Stone developed a graduation of antisociality on an 11 point scale starting with some antisocial personality traits (1) to psychopathy with prolonged torture followed by murder (11). Motivation is a key factor in the desire and willingness to see self as the issue and for change while lack of motivation is a poor prognostic factor.

Treatment:
Treatment depends on the motivation and the ability to take seriously the destructive nature of his/her antisocial attitudes and behavior. Clients who are potentially treatable require the absence of a) pathological lying/deceitfulness, b) absence of callousness/lack of compassion, c) lack of remorse or guilt, d) absence of conning/ manipulativeness (Gunderson & Gabbard, 2002. Meloy's recommendations for treating the violent client include the therapist's awareness of a difficult pattern of behavior that includes: a) history of sadistic behavior with injury, b) complete absence of remorse, c) an IQ that is either superior (a higher IQ equates to more covert deceitfulness) or retarded, d) a lack of ability to make attachments and e) intense therapeutic countertransference (primarily anger or predation) Strasburg (1986) points out situations that are difficult for the therapist: a) fear of assault or harm; b) helplessness or guilt; c) loss of professional identity; d) denial of danger; e) rejection of the patient; and f) a wish to destroy (p. 297). Strasburg goes on to indicate that the harder core antisocial patient is often one who inspires hatred or fear, commits offenses of shoplifting, driving under the influence, and evokes counter-transference reactions in the therapist such as contempt, envy, and annoyance.

Beck, Freeman, Davis and associates (2004) use cognitive therapy to improve social functioning, social problem-solving, improve moral functioning in relationship to others, and confront cognitive distortions. Six examples exemplify these distortions, 1) feeling justified in getting what one wants, 2) thinking is believing, 3) personal infallibility, 4) unquestioning acceptance of one's feelings as providing a correct basis for action, 5) view of others as impotent or worthless and 6) minimization of

possible untoward consequences. Their contention is that the ASPD client is capable of making risk-benefit evaluations of life situations.

Psychodynamic psychotherapy: Historically the background history for many clients diagnosed with ASPD is filled with childhood physical and psychological abuse, broken or non-existent relationships and poor if any attachments to parents or other caregivers. These broken forms of development result in fragmented traumatic memories and their associated affective contents. Psychodynamic psychotherapy can potentially provide emotional healing. This would require establishing trust in the therapist to not abandon or torture him/her, setting boundaries to control fragmentation and destructive behaviors based on repetition compulsion, containing the emerging repressed or split-off affect, facilitating integration of cognition with un-verbalized affect, processing the affect and returning the affect to the client within an environment wherein the client feels safe and is motivated to make healthier new attachments.

Benveniste (2006) cites Van der Kolk's Trauma theory's concept of derailment where memories are stored in the primitive brain and not accessible to the frontal cortex as an important consideration for therapy. "This person does not have conscious access to the effects of traumatic memories. When asked to talk about a traumatic event, there is no affect apparent in the presentation, yet when unconsciously triggered, affects appear and are overwhelmingly terrifying. Because they are not processed in the frontal cortex, they are also not anchored in time. All affects and memory fragments feel as if they are occurring in the present but simultaneously as if they have always been there. Additionally, defenses used to repress traumatic events prevent the person from relating in a genuine and spontaneous way." Dysfunction occurs because of a lack of adequate attachments; therefore relationship development is a goal of therapy. Benveniste suggests that attachment, relational and object relations each have significant contributions for therapy in treating antisocial disordered clients. "The focus of relational therapy is on the transference-countertransference interplay within the therapeutic relationship. The therapist's affective responses to the client and how they are communicated are considered as integral to the client's improvement and healing as the client's communications to the therapist." Since behavioral dysfunction in ASPD occurs because of a lack of adequate attachments, relationship development is a goal of therapy and treatment is focused on interpreting transference pertaining to past attachments as they relate to boundary problems, veiled aggression, the use of seduction as a means of complimenting and gaining control, and other behaviors meant to induce humiliation.

Other treatment approaches include the Therapeutic Community in which individuals with ASPD can receive treatment utilizing a multi-modal model approach with group therapies, individual cognitive therapy and skills training. The skills training involves a five-step model including recognition, motivation, understanding, insight and testing (Dolan 1997). Cognitive behavioral therapy combined with hormonal pharmacotherapy to reduce libido for suppression has been recommended for clients guilty of sexual offenses (Gunderson & Gabbard, 2000). Unfortunately, individuals with ASPD are likely to prematurely discontinue therapy (Hilsenroth, Holdwick, Castlebury, & Blais, 1998).

Histrionic Personality Disorder

Histrionic personality disorder (HPD) is categorized as a Cluster B personality disorder (dramatic, emotional or erratic) characterized by enduring patterns of self-centeredness, seductiveness, shifting emotional expressiveness, over- dramatization, superficial expressions of intimacy, excessive suggestibility, and over-generalizations of speech. The core components are egocentricity, seductiveness, theatrical emotionality, denial of anger and hostility and a diffuse cognitive style (dichotomous thinking) (Horowitz, 1991). Traits such as gregariousness, manipulativeness, low frustration tolerance, pseudo-hypersexuality, suggestibility, and somatizing tendencies have also been identified (Andrews & Moore, 1991).

Assessment and Interviewing:
According to Horowitz (1997) the histrionic client uses the defense mechanism of denial and ignores detail during an assessment interview. Of interest is the fact that this client will often present with depression during the intake interview rather than typical histrionic characteristics. Feelings of loneliness, isolation, and despair about feeling lost may also be present (Kellett, 2007). The histrionic individual is apt to have an exaggerated emotional reaction to even the mildest form of confrontation. He or she tends to dominate social interactions through attention seeking, theatrical behaviors, and unusual personal presentations.

Nichols (2007) describes the client with histrionic personality as portraying a confident and self-assured manner that often masks underlying shallow feelings and deep insecurities. In displaying a need for affection, attention, and approval the client with this disorder will demonstrate temper tantrums, charm, and drama. Horowitz (1997) also portrays the HPD individual as being prone to shifting ego states, i.e. moving from victim to aggressor to rescuer. Turkat (1990) characterizes the HPD interactional style as controlling interpersonal and reactive approval seeking.

According to Renner, Enz, Friedel, Merzbacher, and Laux (2008) the HPD client will present with as-if behaviors that construe or shape daily events and interactions as opportunities for dramatic situations and for the purpose of impression management. The HPD client's as-if behaviors can also be viewed as acting out 'make-believe' roles for the purpose of creating or reducing tension.

DSM-5™ lists eight symptoms that form the diagnostic criteria for HPD:

1. Center of attention: Patients with HPD experience discomfort when they are not the center of attention.
2. Sexually seductive or provocative: Patients with HPD display inappropriate sexually seductive or provocative behaviors towards others.
3. Shifting emotions: Their expressions of emotions tend to be shallow and to shift rapidly.
4. Physical appearance: They consistently employ physical appearance to gain attention to themselves.

5. Speech style: Their speech patterns lack detail as they tend to generalize and try to please and impress others.
6. Dramatic behaviors: Patients with HPD display self-dramatization and exaggerated emotional expressiveness.
7. Suggestibility: They are easily influenced by others and by circumstances.
8. Overestimation of intimacy: Patients with HPD tend to overestimate the level of intimacy they have established in relationships. (p. 667)

Incidence:
APA (2013) cite data from the National Epidemiologic Survey to be 1.84%. Studies have shown HPD to occur more frequently in females than males. Female characteristics are also found in samplings of HPD more frequently than male characteristics. This supports arguments that there is sex-bias in the diagnosis of HPD. The estimated incidence is approximately 2% to 3% of the general population and 10% to 15% of the mental health population (Nichols, 2007).

Research studies have been done to measure attachment styles associated with differing personality disorder clusters. Some studies have also shown that Cluster A (odd or eccentric disorders) and Cluster C (anxious or fearful disorders) pathology are more strongly associated with attachment than Cluster B. However, interpreting personality data as either dimensional or categorical is of major importance to the conclusions that can be drawn. Lastly it is important to control for the influence of co-morbid personality pathology when examining the relationship between Cluster B personality pathology and attachment.

Types:
The following list includes HPD sub-types (Millon, 1996).

Theatrical histrionic - especially dramatic, romantic, and attention seeking.

Infantile histrionic - including borderline features.

Vivacious histrionic - synthesizes the seductiveness of the histrionic with the energy level typical of hypomania.

Appeasing histrionic - including dependent and compulsive features.

Tempestuous histrionic - including negativistic (passive-aggressive) features, out-of control, stormy, impassioned, and turbulent manner.

Disingenuous histrionic - – egocentric, antisocial features, a coating of friendliness and sociability, impulsive tendencies, and relationships are shallow.

Instruments:

1. The Shedler-Westen Assessment Procedure-200 (SWAP-200 Shedler & Westen, 1998)

2. Shedler-Westen Assessment Procedure (SWAP-II; Westen & Shedler, 2007)
3. The MMPI (Hysteria Scale; Gordon, 2006)
4. Millon Clinical Multiaxial Inventory (Millon, 1983)
5. Psychopathic Personality Inventory (PPI; Lilienfeld & Andrews, 1996)
6. Personality Diagnostic Questionnaire (PDQ-4+; Hyler & Rieder, 1994)
7. Coolidge Axis II Inventory (CATI; Coolidge, 1993)

Treatments:
Few, if any, empirical clinical trials of the treatment of HPD are evident in the literature. However, therapists have learned that in preparation for treatment it's important to be aware of the client's interpersonal style, maintain empathy with stated issues, and avoid responding to his/her emotional and seductive behaviors. The therapist should also be aware that the client will demonstrate difficulties with facts, details, and decision-making (Ward, 2004). Intervention strategies also include maintaining awareness of the therapeutic alliance and the client's physical appearance, interpersonal style, emptiness, and child-like feelings.

Horowitz (1997) recommends a three phase approach to include 1) stabilization, 2) modifying communication style, and 3) modification of interpersonal reactions, patterns, and schemas.

Cognitive-behavioral and psychodynamic oriented out-patient individual therapy: This treatment approach has been reported by Leichsenring and Leibing (2003) and reduces symptoms of personality pathology and increases or improves social functioning.

Functional Analytical Psychotherapy: Functional Analytic Psychotherapy (FAP), developed by Robert Kohlenberg and Mavis Tsai at the University of Washington (1991), is based on B.F. Skinner's behavior analytic, or functional contextualistic approach to human behavior. FAP results in psychotherapeutic relationships that are more intense and personal than are typically found in cognitive-behavioral treatments. It is an interpersonal oriented psychotherapy which uses basic behavioral concepts to specify the process of clinical change as a function of the therapeutic relationship. Using this therapy Callaghan, Summers, and Weidman (2003) are convinced that the interpersonal problems clients experience with others outside of session can also occur during the session with the therapist. In addition the therapist has direct access and the best ability to help change client behaviors that occur during the therapy hour. The therapist does not confront the interpersonal dynamics but rather assists in shaping appropriate responses. The therapist responds to clinically relevant behaviors (CRBIs) such as interpersonal difficulties the client demonstrates during therapeutic sessions by pointing out that these are the same as experienced on the outside with others.

Cognitive Analytic Therapy (CAT): This treatment has been described by Kellett (2007) as being somewhat successful to reduce HPD symptomatology. The distinctive value of CAT is due to its intensive use of reformulation, its integration of cognitive and analytic practice and its collaborative nature, involving the patient very actively in his/her treatment. It is a time-limited focal psychotherapy with procedures that will help clients identity target problems (Ryle, 1997, 2004). These, as described

to the client, include a need to be noticed (attention), relationship issues, physical appearance, trust issues, and any other characteristics observed during the assessment. Clients receive 24 weekly sessions and four sessions of follow-up, with the follow-up sessions spread over a six month period. Psychotherapeutic effectiveness is enhanced when therapists adhere to the following guidelines:

1. Listen with respect.
2. Help the client become more logical and focused on problem solving.
3. Empathize with emotional pain or distress but remain clinically objective about the client's descriptions of alleged injustice/abuse.
4. Avoid over-reacting to intense emotions.

In addition to individual psychotherapy, other treatment approaches have included group psychotherapy, out-patient individual psychotherapy, day hospital psychotherapy, and in-patient psychotherapy.

Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder (OCPD) is a Cluster C disorder that includes a number of features meant to reduce or control anxiety and included in the eight symptom list. These include inflexibility, lack of spontaneity, excessive orderliness, perfectionism, and a need to maintain mental and interpersonal control (APA, 2000). Obsessive-compulsive personality disorder (OCPD) clients seek control, display stubbornness, and tend to focus on work and productivity rather than friendship and interpersonal contact and are concerned with perfectionism. As a result they prefer to work alone or delegate the work to others. Control is frequently at the forefront of their behaviors and they can become cognitively preoccupied and consumed by detail, rules, procedures, lists and schedules. If they lose something, the search for the lost object can dominate every action to the point that frustration and anger can become the outcome unless or until the lost object is found. They tend to control all emotional expression however so that angry outbursts may erupt that are out of proportion to the event or circumstances. Generally speaking, the OCPD client tends to restrict any display of emotions and is not comfortable in the presence of someone who has no difficultly expressing or showing emotions. Perfection drives his/her behaviors to the point the OCPD client will hold back until such time he/she can perform to his/her standard. While individuals with OCPD tend to be perfectionistic and excessively orderly, they can also save items for possible use even when considered worthless. Excess and control are associated with internal and external standards toward perfectionism so that the result for many enterprises is a lack of decision-making and uncompleted tasks.

Assessment:
The DSM-5™ (APA 2013) and DSM-IV-TR (APA 2000) criteria for OCPD is a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four or more of the following: (1) is preoccupied with details, rules, lists, order,

organization, or schedules to the extent that the major point of the activity is lost; 2) shows perfectionism that interferes with task completion; (3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships; (4) is over-conscientious, scrupulous, and inflexible about matters of morality, ethics, or values; (5) is unable to discard worn-out or worthless objects even when they have no sentimental value; (6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things; (7) adopts a miserly spending style toward both self and other; money is viewed as something to be hoarded for future catastrophes; (8) shows rigidity and stubbornness (APA, 2013, p. 678-679). Suggestions for interviewing the OCPD client and instruments that assess for OCPD are found within the previous section on instruments and interviewing.

A prominent OCPD clinical feature regarding expressive behavior is a disciplined seriousness. The client is rigid and tense in posture and mannerisms. Interpersonal conduct is one of respect yet expecting others to conform to their rules and style. They have few friends. They often seek approval from authority figures with more power but will resist the authority figures that have contrary opinions or have less power in their view. As a result they want to know how they stand in relation to authority figures. The cognitive style is constricted and uncomfortable in confronting unsure directions or new events. Time standards are adhered to with rules and regulations. Recreational and leisure activities are of lesser importance than work. The OCPD client views self as industrious, loyal to the work standards, but also can be self-denigrating. The typical defense mechanisms are reaction formation, isolation, rationalization, intellectualization and undoing (Kaplan & Sadock, 1998). The mood is usually solemn, joyless and grim.

Comorbidity for other diagnoses include anxiety, phobic, mood, compulsive-obsessive, somatoform, and dissociative disorders.

Differential Diagnosis:
Obsessive-Compulsive and obsessive-compulsive personality disorder. The focus for a differential diagnosis is to review occupational and social effectiveness. Millon (1996) categorizes adult compulsive types as either conscientious, puritanical, bureaucratic, parsimonious or bedeviled.

Treatment:
Treatment is often long and transference issues are common and should be addressed during the therapeutic process. Millon (1996) recommends treatment modalities in the form of goals. Reestablishing polarity balances (self-identity from perception of others, a self-other balance), countering perpetuating tendencies (self-criticism, guilt indecision, anxiety), and modifying domain dysfunctions (cognitive, expressive behaviors and interpersonal conduct). Millon states that the OCPD client prefers a structured therapy so that progress can be measured. Specific therapy models include behavioral methods for phobic avoidance and ritualistic, restrictive and rigid behaviors.

Couples and family therapy are recommended to come to grips with early family interactions, misunderstandings and problematic relationship issues. Group therapy is not recommended because the OCDP client aligns with the group leader therapist (Kaplan & Sadock, 1998).

Cognitive reorientation therapy is recommended (overintellectualization) to address emotional reactivity and relaxation training may be useful to diminish tension and psychodynamic approaches can be helpful to uncover early life conflicts. Pharmacological intervention can reduce the intensity of compulsive symptoms and alleviate anxiety and depression (Millon, 1996).

Dependent Personality Disorder

The DSM-5™ (2013) defines a dependent personality disorder as a "pervasive and excessive need to be taken care of that leads to submissive and clinging behaviors and fears of separation beginning in early adulthood" (p. 675). It is a Cluster C personality. Five of eight symptoms are to be met for this diagnosis. Millon (1996) categorizes the dependent and histrionic personality styles or patterns as need- directed toward others while the narcissistic and antisocial are needed-directed toward self (selfish). These are imbalances and problems for each of these four patterns. Social approval and affection-needs are priorities achieved through the desires of others. This client will bend over backwards to see that someone else is not displeased and rarely will allow himself or herself to make demands or attempt to directly take control. Instead, the dependent individual is likely to take a passive stance.

Dependency and submissive behaviors are pervasive features along with a strong need to please and be accepted by others. The dependent client is likely to enlist the support of others to make decisions or manage his or her life's decisions. This client will avoid disagreeing with others because of a fear of losing support or approval. A lack of self-confidence is evident as the client has difficulty in assuming or initiating projects or doing things on his or her own. The client will do undesirable tasks just to maintain the approval and nurturance of others even if it is unpleasant. Loneliness is unwanted and will be quickly replaced with a relationship. Frequently this client is self-depreciating, self-effacing and diminishing of self or accomplishments. If this client finds an all purpose partner to depend on he or she will more likely appear to be functioning well socially, reveal warmth, affection and generosity. If the partner abandons or is not available the dependent characteristics will resurface. The dependent personality person will search for a replacement. A fear of abandonment is prominent. In summary, deriving from attachment theory, the key elements of the dependent personality is the need to elicit guidance, assistance and approval from others (Livesley, Schroeder, & Jackson, 1990). Beck describes the DPD as exhibiting inadequate and helpless behavior with an inability to move toward self-direction. The DPD individual sees the world as cold, lonely or dangerous. Beck's second characteristic is to find someone who can protect and manage the cold, lonely, dangerous world. Leary's term for the DPD was the 'docile-dependent'(Leary, 1957). Another characteristic of the DPD is agreeableness (Costa & Widiger,1993).

The DPD client may surface in the counseling office after experiencing rejection and abandonment. The internal and external threats are ever more prominent. The counselor becomes the immediate replacement.

Prevalence and Frequency:
APA (2013) cite data from the 2001-2002 Epidemiologic Survey to be 0.49%. DPD is the most

frequently reported personality disorder. The DSM-IV-TR (2000) reports a frequency rate of 15% and 25% in hospital (Oldham, et., al, 1995) and 0% to 10% in out patient (Klein, et al., 1999). In 1997 the rate for women was (11%) and 8% for males (Bornstein, 1997). Torgersen et al.(2000) in studying clients diagnosed with a dependent personality disorder in monozygotic and dizygotic twin pairs found that a greater likelihood was to be found in monozygotic twins. This study supports a genetic factor and reason to consider family predisposition. Further studies point out that parenting styles of overprotectiveness and authoritarian are associated with increased likelihood for later in life (Head, Baker & Williamson, 1991).

Assessment and diagnostic criteria:
This disorder, as described in the DSM-5™ (APA 2013) and DSM-IV-TR (APA 2000), is manifested by a pervasive and excessive need to be taken care of along with submissive and clinging behavior and fear of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. Needs others to assume responsibility for most major areas of his or her life
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval
4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than to a lack of motivation or energy)
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
6. Feels uncomfortable or helpless when alone, because of exaggerated fears of being unable to care for himself or herself
7. Urgently seeks another relationship as a source of care and support when a close relationship ends
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself (p. 678-679)

The adult subtypes (Millon, 1996) include disquieted (submissive dependent, self-effacing, non-competitiveness), accommodating (agreeableness, need for affection, nurturance, security), immature (childlike, lack of ambition, passive), intellectual (lack of vitality, low energy level, fatigability) and selfless (gives up identity, submit to beliefs and values of others).

There appears to be an unusual attachment during the early years and has been characterized as a separation-anxiety (DSM-III (1980) and child symbiosis (Mahler, 1967).

Interview:
Sperry (1999) reports that individuals with dependent personality disorder tend to bond easily during

the initial interview and first therapy hour. They will also be able to describe the conditions and situations very well but tend to go silent and wait for the assessor or therapist to ask questions. They also become uncomfortable when therapists pursue the subject of submissiveness. If interviews with dependent individuals do not go well they are likely to change therapists. One of their positive characteristics however is a willingness to reveal deep feelings and accept confrontation although interpretations are more difficult.

Interviewing techniques include observing posture, voice, and mannerisms as signs of self-confidence since self-image is typically weak and inadequate, child-like, lonely and abandoned (Millon, 1996). The interviewer should also observe for a possible attitude of acquiesce, an excessive need to be agreeable and avoid the risk of rejection, and the presence of helplessness or a clinging quality toward the counselor. Similarly, the interviewer should determine the client's boundaries which may be narrow and reflect a limited self-awareness with a cognitive style that's naïve, unperceptive, and uncritical. Furthermore, in keeping with child-like helplessness, dependent individuals tend to ally themselves with individuals they perceive as all-powerful and protective while avoiding conflict and smoothing over difficulties by means of denial.

Clinical disorders comorbidity with dependent personality includes disorders of mood and anxiety which include phobic, obsessive-compulsive, somatoform, factitious, dissociative, schizophrenic-schizoaffective and adjustment disorders; and four personality disorders - borderline, histrionic, masochistic and avoidant disorders;. Differential diagnosis difficulties overlap with dysthymic disorder and agoraphobia.

Treatments:
The treatment of an individual with dependent personality disorder (DPD) targets affective, behavioral-interpersonal and cognitive systems (Cloninger, 1986). The DPD cognitive style is to avoid upsetting thoughts and anxiety because of a limited ability to be assertive and solve problems. As a result, independent living is difficult. The long range goal of therapy is to improve the excessively dependent individual's ability to function independently while being able to effectively ask for and accept help to do so. This means enhancing a desire and willingness to make decisions, take responsibility for his or her own behaviors, feel comfortable with being alone, and seek to learn new skills and become increasingly competent. Treatment strategies include teaching assertiveness and challenging dysfunctional beliefs about being inadequate. Individuals with this disorder are more likely to respond to treatment than those with borderline or narcissistic patterns and to learn from skills training such as exposure strategies, anxiety management, assertive training and problem solving. Therapeutic techniques also must include confronting resistance and refusal to take responsibility for change as well as addressing transference issues such as excessive compliance, clinging helplessness, and fear of challenging authority; and counter-transference issues around power, unwillingness to confront, and being over-protective. The dependent individual will make progress if he is able to take responsibility for change, follow through with medication requests, and make decisions on his or her behalf.

A number of different therapeutic approaches can be used, sometimes together, to bring about personality growth and move from dependency to increasing individuation. Some psychodynamic

psychotherapeutic approaches have been recommended to facilitate personality change and corrective emotional experiences, particularly when the client reveals past experiences of trauma and abandonment. In addition to individual therapy, group therapy can enhance interpersonal communication, assertiveness, and the verbal capacity to establish self-identity with others. Family or couples therapy is also known to be helpful to maintain the goals worked on during therapy. Finally, the use of psychopharmacological treatment for modification of target symptoms such as depression and anxiety, can facilitate the therapeutic process.

Termination is a critical aspect of the treatment since the client with DPD has experienced difficulty with separation and loss in the past and faces distressing emotions and a fear of being alone once again. The therapeutic task is to support the client's emotions of loss such as anger, depression, and grief as well as to interpret the client's defenses that may emerge to avoid these emotions such as avoidance, missing therapy sessions, new somatic symptoms, and rationalization. Specific techniques can also be used to help clients with termination. These include spacing sessions, developing a self-plan for continuing psychological growth, and planning how to deal with the possibility of recurring symptoms after therapy has been completed.

Paraphilic Disorders

Paraphilic disorders include voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, sexual masochism disorders, sexual sadism disorders, pedophilic disorder, fetishistic disorder, and transvestic disorder.

Definition and Interview:
Paraphilic disorders of sexual deviation vary in severity. The basic structure of the diagnostic criteria is essentially the same from the DSM-IV-TR and for the DSM-5™. The DSM-5™ created a distinction between paraphilias and paraphilic disorder. A paraphilia, alone, does not necessitate a clinical intervention. Paraphilia is an "intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with normal, physically normal mature, consenting human partners" (APA, 2013, p. 685). A paraphilia involves "another person's psychological distress, injury or death, or it involves a desire for sexual behaviors with unwilling persons or person unable to give legal consent" (King, 2014, p. 15).

A paraphilic disorder is a parapalia that is causing distress or impairment in someone else or causing harm or a risk of harm to another individual. A client is to meet Criterion A and B to have a paraphilic disorder and in Criterion B the client is acting on an urge with a nonconsenting individual or exhibits the urge to cause distress or impairment. If only Criterion A but not Criterion B is met then it is a paraphilia but not a paraphilic disorder (APA, 2013).

Individuals with paraphilic disorders do not usually seek treatment. The APA (2000) describes paraphilia's as individuals with recurrent, intense, sexually arousing fantasies, urges, or behaviors involving inappropriate objects that last longer than six months and cause clinically significant distress

and/or impaired daily functioning. In addition, the DSM-5™ describes eight specific paraphilic disorders: voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, sexual masochism disorder, sexual sadism disorder, pedophilic disorder, fetishistic disorder, and transvestic disorder. Sexual desire and arousal disorder have been combined into one disorder (sexual interest/arousal disorder). Vaginismus and dyspareunia have been combined to create genito-pelvic pain/penetration disorder and sexual aversion has been removed. Subtypes have been added (lifelong versus acquired and generalized versus situational). According to Morrison (1995) pedophilia is the one disorder most commonly diagnosed followed by exhibitionism, voyeurism, and frotteurism, although it is not uncommon for a client to be diagnosed with more than one type of Paraphilia.

The DSM-5™ orders these disorders according to a common classification scheme, that is, anomalous activity preferences (courtship disorders and algolagnic disorders). The second group is based on anomalous target preferences (directed at other humans and two directed elsewhere).

The current definition for paraphilia is an "intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physical mature, consenting human partners." (APA, 2013, p. 685).

An essential component of the interview process is a risk assessment (Maletzsky, 1998). Paraphiliacs tend to minimize and refuse full disclosure; therefore, the evaluation should include a mental status examination to include superego functioning, self-reports, psychological tests, and corroborating information from previously involved professionals, friends, and family members. The interview should be comprehensive.

According to Seligman and Hardenburg (2000), the interview may have four goals: the diagnosis, treatment, providing information to legal and social agencies, and providing information to the client and families. In addition to interviewing for the disorder, a thorough assessment should include the client's background and present functioning. The counselor should take time to explain to the client clearly the purpose of the interview, counselor's role, and the limits of confidentiality (p. 109).

All sexual dysfunctions have a minimum time frame of six months except for substance and medication induced sexual dysfunction.

The interviewer can formalize the interview by obtaining information on the nature, time of onset, duration, frequency, and progression of the symptoms. Paraphilias, as disorders, usually progress from single acts of masturbation with paraphilic fantasies — exhibitionism and voyeurism (without physical contact with others) to physical sexual behaviors (Perry & Orchard, 1992). The interviewer, in taking control, can sequentially structure the interview to obtain information (Seligman & Hardenburg, 2000) as follows:

1. Assess for fantasies, urges, and behaviors. The interviewer may listen to determine if there is linkage between the client's action and a sense of self, feelings of power, and a derived meaning in his/her life (Goodman, 1993).

2. Determine the average amount of time the client devotes to sexual thoughts, activities, frequency of and stimuli for his/her orgasms.
3. Assess for impulse control and his/her symptoms, which continue the repetitive cycle of increasing tension, release, and regret.
4. Determine if his/her involvement in sexual aggression is planned, indicating he or she has more control.
5. Assess for the triggers for the symptoms, choice, and nature of the contact with victims.
6. Inquire into what the client may say to a victim.

The interviewer needs to understand the client's thoughts, motives, and defenses used in the disorder. The paraphilic client usually desires intimacy and closeness but fears rejection and engulfment, avoids normal expressions of emotion both affection and anger, and acts out behaviorally instead (Levine, Risen, & Althof, 1990). Perry and Orchard (1992) indicate that this client often uses the defenses of rationalization, denial, projection, and cognitive distortions. An individual with a diagnosis of paraphilia disorder may be described as being vulnerable, has impaired self-esteem, is unable to exhibit empathy, has a reduced capacity for insight, has poor social skills, and has poorly developed attachment behavior to his/her parents. Perry and Orchard describe the paraphilic client as one who is well defended, assumes very little responsibility, and has a tendency not to be remorseful.

The interviewer must be knowledgeable of comorbid disorders. Frequently found in conjunction with paraphilic disorders are impulse-control disorders, obsessive-compulsive disorders, personality disorders (Bradford, 1996), substance use disorders, mood disorders, and anxiety disorders (Kafka & Prentky, 1994).

In summary, the interviewer should understand that a paraphilic may exhibit feelings and behaviors of anger, loneliness, impaired self-esteem, reduced capacity for empathy, vulnerability, poor insight, poor social skills, inadequate attachments, self-centeredness, absence of impulse control, emotional guardedness, and defense mechanisms of rationalization, denial, projection, and cognitive distortions.

Incidence:
Specific prevalence percentages for each of the eight disorders are to be located in the DSM-5™. Maletzsky (1998) reports astonishingly high incident rates in a number of populations. However, the prevalence rates for offenders are more difficult to determine because so many cases go unreported. Based on victim reports, Herman (1980) estimated that between 4% and 17% have molested children of one or both genders. Undeniably, offenders are significantly more likely to be males than females (Priest & Smith, 1992).

Treatment:
The first step in treatment, according to Roundy and Horton (1990), is for the counselor to examine his/her willingness to treat a client with this diagnosis, personal biases that may affect treatment, and belief in the treatment process. Secondly, the counselor must ensure that the abusive behaviors are discontinued (Salter, 1988). Additional recommendations include removal of the perpetrator from

environments where behaviors may potentially occur (Salter; e.g., accessibility to children for a pedophile) and the integration of polygraph or plethysmograph (Priest & Smith, 1992) into the treatment process. Interventions that may reduce clients' sexually deviant behaviors include the following: covert sensitization, role-playing, modified aversive behavior rehearsal, cognitive restructuring, and group counseling (Priest & Smith). Many persons with compulsive sexual behaviors may benefit from 12-step type group treatments in organizations such as SAA (Sex Addicts Anonymous). The group process is essentially a peer-moderated cognitive-behavioral approach.

Instrumentation:
Seligman and Hardenburg (2000) in defining the assessment and treatment procedures for paraphilias also list a number of inventories which are useful for sexual assessment. Some of these are:

1. Millon Clinical Multiaxial Inventory (MCMI)
2. Minnesota Multiphasic Personality Inventory (MMPI)
3. The Abel Assessment for Sexual Interest (Abel Screening Inc., 1995)
4. Aggressive Sexual Behavior Inventory (Mosher & Anderson, 1986)
5. The Index of Sexual Satisfaction (Hudson, Harrison, & Crosscup, 1998)
6. The Derogatis Sexual Functioning Inventory (DSFI; Derogatis, 1975)
7. The Sexual Self-Efficacy Scale-Erectile Functioning (SSES-E; Libman, Rothenberg, Fichten, & Amsel, 1985)
8. The Brief Sexual Symptom Checklist (Hatzichristou, Rosen, Broderick, et al., 2004)

Other Mental Disorder

Other Specified Mental Disorder Due to Another Medical Condition

Historically in this country, 60% of all patients with diagnosable psychiatric disorders, mixed medical and psychiatric problems, primary medical problems associated with psychiatric symptoms, and medical problems causing psychiatric illnesses are treated by primary care physicians (Shepherd, Cooper, Brown, & Kalton, 1966). This high percentage reflects the tendency of many individuals to choose their family doctors rather than mental health professionals either because of preference or inadequate insurance coverage.

The connection between "psyche" and "soma" is so significant that physical symptoms nearly always are experienced emotionally and vice versa, as Lipp (1977) stated: "There is no fundamental difference between mind and body … The brain itself is the most sensitive indicator of body physiology. Subtle symptoms of brain dysfunction, occasioned by systemic disease, may precede signs of dysfunction in other parts of the body, often by a considerable lead time… for instance, in pernicious anemia

psychological symptoms may precede hematological evidence of disease by many months" (Lipp, pp. 37-38).

It is important for the mental health professional to understand the mind-body relationship and to be sensitive to the possibility that a physical illness might be at the root of the client's mental or emotional problem (Goldberg, 1987; Peterson & Martin, 1973). It has been known for a long time that a variety of physical and organic symptoms can cause mental illness, including hyperthyroidism and hyperparathyroidism (Gatewood, Organ, & Mead, 1975; Taylor, 1975), brain tumors causing mental changes (Keschner, Bender, & Strauss, 1938), endocrine and metabolic diseases such as Addison's disease and pernicious anemia (Lipp, 1977; O'Shanick, Gardner, & Kornstein, 1987) and other organic maladies (Peterson & Martin).

Anxiety

Anxiety may be associated with autonomic epilepsy, multiple sclerosis, delirium, uremia, hypoglycemia, thyrotoxicosis, hypoparathyroidism, porphyria, toxic reactions to poisons (e.g., mushrooms and heavy metals), withdrawal from sedatives, tranquilizers or other psychoactive agents, and excessive use of stimulants, caffeine, and some sympathomimetic agents found in decongestants and anti-asthma drugs.

Depression

Depression may be associated with Parkinson's disease, multiple sclerosis, myasthenia, chronic infections, uremia, diabetes mellitus, lung and pancreatic cancers, pernicious anemia, hypopituitarism, thyroid abnormalities, Cushing's or Addison's disease, menopause, pregnancy, steroid use, Reserpine use (for treating hypertension), Interferon (used to treat Hepatitis B), some birth control pills, and chronic heavy metal poisonings.

Psychosis and Behavioral Abnormalities

Psychosis and behavioral abnormalities may be associated with psychomotor seizures, multiple sclerosis, Cushing's disease, systemic lupus erythematosis, hypothyroidism, heavy metal poisoning, sudden withdrawal from some psychoactive medications such as benzodiazepines, reactions to medications such as steroids, INH, alkaloids, thyroid supplements, amphetamines, furosemide, and reactions to drugs such as hallucinogens, mushrooms, cocaine, PCP, and other illicit substances.

Instrumentation:
Primary Care Evaluation of Mental Disorders (PRIME-MD) is a two-stage screening and interview procedure used by primary care physicians to diagnose 18 specific mental disorders in five major groups: mood, anxiety, somatoform, alcohol, and eating disorders (Spitzer et al., 1995).

TERMS

The following terms were used with the disorders in this training Supplement. The definitions of the different terms are brief and may require further research.

Addison's disease – an endocrine disease caused by hypofunctioning of the thyroid gland.

Affective functioning – feelings and emotions such as happiness, anger, anxiety, sadness, depression that are observed in a client during a mental status exam. Non-verbal examples include tears, facial expression, voice tone, and bodily posture. Drummond and Jones (2006) indicate that this domain includes dimensions of personality such as attitudes, motives, and emotional behavior, temperament, and personality traits (p. 420).

Al-Anon – an organization similar to AA for spouses and family members of those with alcohol related disorders. The purpose of the organization is to assist the spouse and family members to regain self-esteem, to discontinue feeling blame for the 'user's drinking disorder, and to restructure their lives.

Alateen – an organization similar to Al-Anon for children and adolescents to help them understand their parent's alcohol disorders.

Alogia – an impoverishment in thinking that is inferred from observing impoverished speech and language behavior.

Alzheimer's Type (Dementia) – the gradual and continuing cognitive decline consisting of progressive deficits in memory or cognition, not due to other central nervous system, substance effects, or other systemic conditions known to cause dementia.

Amnesia – the partial or total forgetting of past experiences, which can be associated with organic brain syndromes or functional, non-organic disorders.

Anemia – a pathological deficiency in the oxygen carrying capacity of the blood measured in unit volume concentrations of hemoglobin, red blood cell volume, and red blood cell number.

Anorexia Nervosa – chronic failure to eat for fear of gaining weight; characterized by an extreme loss of appetite that results in severe malnutrition, semi-starvation, and sometimes death.

Antabuse – Antabuse (disulfiram) is a drug used as an adverse conditioning treatment for alcohol dependence by triggering a very distressing (and sometimes dangerous) reaction to alcohol. Therefore 'alcoholics' who agree to use Antabuse as a deterrent must be fully informed about its potential dangers and a physician should monitor its use.

Autonomic Arousal – physiological responses to emotion controlled by the autonomic nervous system (ANS) – that part of the nervous system that governs the smooth muscles, the heart muscle, the glands, the viscera, and the sensory system. The ANS is comprised of the parasympathetic and sympathetic nervous systems and maintains homeostasis in the body generally without conscious

control. This system affects heart rate, digestion, respiration rate, salivation, perspiration, diameter of the pupils, micturition (urination), and sexual arousal. Emotional arousal such as fear or excitement, for example, increases heart and respiration rates, papillary dilation, perspiration, and reduces digestive activity.

Avolition – an inability to initiate and persist in goal-directed activities.

Bipolar Disorder – a mood disorder involving both depressive and/or manic episodes. Manic (and sometimes depressive) episodes are typically bizarre and associated with delusions (fixed erroneous beliefs) that individuals within the person's culture would regard as totally implausible.

Bizarre – strikingly out of the ordinary, odd, extravagant, or eccentric in style or mode involving sensational contrasts or incongruities; can be associated with delusions that involve a phenomenon that the person's culture would regard as totally implausible.

Bizarre Delusions – fixed false beliefs of a pathological nature. Delusions typically occur in the context of neurological or mental illness, although they are not tied to any particular disease and have been found to occur in the context of many pathological states (both physical and mental). However, they are of particular diagnostic importance in psychotic disorders and particularly in schizophrenia. They typically involve a phenomenon that the person's culture would regard as totally implausible.

Brief Psychotic Disorder – a disturbance, lasting at least one day, which involves delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior.

Bulimia Nervosa – excessive overeating or uncontrolled binge eating followed by self-induced vomiting.

Catatonia – a form of withdrawal in which an individual retreats into a completely immobile state, showing a total lack of responsiveness to stimulation.

Cognitive functioning – conscious intellectual activity, thought organization, capacity for reasoning, and memory. Speech behavior may reflect cognitive functioning such as fragmented, fluid, staccato, slow, etc. Cognition is the process of obtaining, organizing, and using intellectual knowledge. This domain reflects the understanding set for daily living. The individual performs acts that acquire information that is stored in memory only to be retrieved at a later time. The interviewer probes for the mental strategies or plans the client is able to access and utilize. This domain includes the activities of input, storage and output of information. In summary, Drummond and Jones (2006) describe the cognitive domain to include the various tasks and levels in perceiving, thinking, and remembering (p. 422). The levels refer to the cognitive domain of learning.

Coitus – the physical union of male and female sex organs.

Compulsivity – actions or behaviors that an individual may consider irrational but feels compelled to do.

Conversion Disorder – a psychiatric disorder characterized by the presence of a conversion symptom such as numbness, paralysis, loss of function, or seizures, but where no neurological explanation can be found. The disorder is presumably caused by an intrapsychic conflict and can emerge suddenly in response to stress in a person's life.

Comorbidity – referring to two or more interactive disease processes. Individuals with a substance use disorder, for example, often have depression or post-traumatic stress disorder or both as one or more comorbid disorders.

Delusional Disorder – a psychotic disorder similar to schizophrenia in which the delusional system is the basic or even the only abnormality. Schizophrenia and delusional disorder are distinct disorders which often share certain features such as paranoia, suspiciousness, and unrealistic thinking. Schizophrenia, however, is associated with a loss of contact with reality and a decline in general functioning. In contrast, delusional disorder, a much less common disorder, preserves contact with reality except for the focused delusional thinking that comprises specific functioning while preserving most realistic activity.

Demand Characteristics – the sum total of cues that convey the counselor's wishes, expectations, and worldviews to clients and influence their behavior. According to Kanter, Kohlenberg and Loftus (2002) demand characteristics plays a role in dissociative identity disorder, repressed memory controversy, and during treatment rationales.

Dementia – the development of multiple deficits in memory or cognition that are due to the direct physiological effects of a general medical condition, to the persisting effects of a substance, or to multiple etiologies including Alzheimer's disease.

Dependence – when pertaining to physical dependence on substances, refers to a state resulting from habitual use of a drug so that negative physical withdrawal symptoms result from abrupt discontinuation; derived from a pattern of substance use that leads to clinically significant impairment indicated by increasingly larger amounts over a longer period of time than intended.

Dependence – when pertaining to non-substance dependence refers to the reliance on or needing of someone or something for aid and support.

Depersonalization – A feeling of estrangement or detachment from oneself.

Depersonalization Disorder – a disorder associated with alterations in the perception or experience of the self so that one feels detached from, and as if one is an outside observer of, one's mental processes or body.

Differential Diagnosis – the consideration of more than one alternative diagnosis with similar features. For example, a counselor interviewing someone with symptoms of depression must consider a variety of diagnoses such as major depression, dysthymic, adjustment disorder with depressed mood, substance induced depression, and bipolar disorder, depressed type.

Dissociative Amnesia – Formerly referred to as psychogenic amnesia, dissociative amnesia is a pervasive loss of memory of significant personal information usually of a traumatic or stressful nature that is too extensive to be explained by ordinary forgetfulness.

Dissociative Fugue – an individual who experiences sudden, unexpected travel away from one's home with the loss of recall for one's past.

Dissociative Identity Disorder – the presence of two or more distinct personalities or identity states that control an individual combined with that individual's inability to recall significant personal information beyond ordinary forgetfulness.

Double Depression – chronic, minor or intermittent depression, as well as major depressive disorder. For example, an individual suffering from dysthymic disorder may have one or more episodes of major depressive disorder as an additional diagnosis. This combination comprises double depression.

Dysfunction – abnormal functioning.

Dyspareunia – a kind of sexual dysfunction characterized by pain during intercourse. Men may suffer from this disorder but it is more typically a female problem.

Dysthymic Disorder – a chronically depressed mood that occurs for most of the day more days than not for at least two years.

Emaciation – the loss of substantial amounts of needed fat and muscle tissue, often due to a lack of nutrients from starvation or disease. It may be present in fashion models that choose the emaciation look and as the result of eating disorders such as anorexia and bulimia. The bones in an emaciated person are distinguishable, shoulder blades are sharp, ribs and spine can be clearly seen, and extremities are not significantly wider than the bones that support them. Although emaciation can be acquired by humans deliberately, it is also found in animals and peoples across the planet due to lack of food and starvation.

Endocrine Diseases – illnesses like hyper or hypothyroidism, acromegaly (gigantism), adrenal hyperplasia, and diabetes mellitus caused by abnormalities of "glands" such as the thyroid, pituitary, adrenal, and pancreas.

Erotomanic – a period of delusion in which the central theme is that another person is in love with the individual.

Etiological Factors – the factors that contribute to or cause disease.

Exhibitionism – Involves exposing one's genitals to a stranger. The onset is usually before age 18 (APA, 1994, p. 525).

Exposure Therapy – exposure to real-life situations as a component of effective fear reduction.

Factitious – the intentional production of physical or psychological signs or symptoms.

Fetishism – involves the use of non-living objects. The person usually masturbates while holding, rubbing, or smelling the object (APA, 1994, p. 526).

Flooding – a respondent conditioning technique in which extinction is achieved by confronting the anxiety-producing stimulus.

Frotteurism – occurring most commonly between the ages of 15 and 25 and involving achieving arousal and orgasm by fantasizing about or touching or rubbing against a non-consenting person (APA, 1994, p. 527).

Gender Dysphoria – persistence and intense distress about his or her assigned sex.

Gender Identity – the basic sense of self as a male or female.

Gender Identity Disorder – a disorder manifested by a strong and persistent cross-gender identification and persistent discomfort with one's given anatomical sex or gender role.

Gender Role – the public manifestation of gender identity.

Grandiose (Grandiosity) – an over-inflated appraisal of one's worth, power, knowledge, importance, or identity.

Habituation – non-associative learning in which there is a progressive diminution of behavioral response probability with repetition of a stimulus. As a treatment technique it is a strategic application of exposure and response prevention (ER) for OCD and Tourette's clients. The client is prevented from performing the repetitive behavior (compulsion) after exposure to the feared stimuli and anxiety levels are reduced.

Hallucination – a sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ.

Hyper – excessive activity compared to the normal.

Hyperparathyroidism – overactive parathyroid gland activity causing abnormal levels of calcium in the body.

Hypersomnia – excessive sleepiness as evidenced by prolonged sleep or daytime sleep episodes that occur daily.

Hyperthyroidism – overactive thyroid gland activity which causes symptoms such as anxiety, agitation, perspiration, and rapid pulse.

Hypo – diminished activity compared to the normal.

Hypoactive Sexual Desires Disorder – a deficiency or absence of sexual fantasies and desire.

Hypochondriasis – recurrent complaints of physical problems or pain because of anxiety or an unrealistic fear of having a serious disease.

Hypoglycemia – abnormally low blood sugar often related to excessive insulin production by the pancreas, sometimes associated with stress.

Iatrogenic – a condition induced in a patient by a physician's words or actions.

Insomnia – a subjective complaint of difficulty falling or staying asleep or poor sleep quality.

Labelle Indifference – an individual's lack of anxiety or other emotional response to a symptom that would be considered distressing by most people.

Malingering – the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives (e.g., avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs). The malinger seeks medical care and presents symptoms deceitfully in a deliberate attempt to deceive for external purposes such as obtaining insurance benefits for a phony injury, getting lighter criminal sentences, avoiding prison, obtaining drugs, obtaining money, or simply to attract attention or sympathy.

Major Depressive Disorder – a type of major mood disorder characterized by a single or recurrent major depressive episodes occurring without intervening manic episodes.

Mania – a severe medical condition characterized by extremely elevated mood, energy, and unusual thought patterns, most often associated with bipolar disorder, where episodes of mania may cyclically alternate with episodes of clinical depression. Although mania and hypomania have sometimes been associated with creativity and artistic talent, mania generally is very undesirable and has the potential to be very destructive. Classic symptoms include rapid speech, racing thoughts, decreased need for sleep, hypersexuality, euphoria, grandiosity, irritability, and increased interest in goal-directed activities. Mild forms of mania, known as hypomania, generally cause little or no impairment but can induce behavior such as spending sprees; more severe forms of mania do cause impairment and may even feature grandiose delusions or hallucinations.

Manic – a period of mania that usually begins and ends suddenly and causes a radical change in an individual's social functioning.

Metabolic Diseases – illnesses related to abnormal functioning of organs such as liver, kidneys, blood, and gastrointestinal system.

Mindfulness – Mindfulness Based Stress Reduction (MBSR) was developed by Jon Kabat-Zinn when combined with mediation is teach (instruct) clients in how to quiet the mind and to become aware of the present moment. During 2012 there were 477 scientific journal articles published on mindfulness practices (Picket, 2014). This training of the brain to focus is a way to cope emotionally and behaviorally with the stressors encountered on a daily basis.

Jon Kabat-Zinn believes the mind can be rewired to allow the client to pause and reset and has been recommended for anxiety issues. The typical program is for once a week for eight weeks meeting two-and-half hours. The concept is based on the fact the mind can adapt and rewired (neuroplasticity). The

strategy to distress through mediation and mindfulness practice. Research tends to support that mindfulness practice does lower cortisol levels and blood pressure, and to increase immune response.

Mixed Episode – a period of time lasting at least one week in which criteria are met for one or more diagnoses. The individual experiences rapidly alternating moods.

Morbidity – relating to or caused by disease.

Munchausen Syndrome by Proxy – a disorder caused by parents who fabricate or induce physical illnesses in their children.

Negative Symptoms – involve the loss of normal functioning and resemble depression type symptoms such as loss of will, range of affect, pleasure and fluency of content of speech.

Neurological consultation – a one-time thorough evaluation by a neurologist which includes a complete neurological (physical) examination and neurologically specific diagnostic modalities. For example, a patient with a serious headache is referred to a neurological consultant by his family doctor. The consultant will consider the diagnostic possibilities such as brain tumor, abscess, hemorrhage, meningitis, hydrocephalus, and blood clot, trauma to the head, sinus disease, malformation, or aneurysm. The consultant will perform an examination and may order a number of diagnostic studies including blood chemistry, urinalysis, CT scan, MRI, sinus x-ray, EEG, and spinal tap. If the results point to a brain tumor, the consultant will report the findings to the referring doctor and recommend treatment by an oncologist and/or neurosurgeon.

Neurological examination – an examination by a neurologist, which may be repeated in follow-up visits, which is more specific and focused on the patient's complaint and may or may not include all of the diagnostic modalities that have been included in a one-time consultation that leads to initial and follow-up treatments. For example, after the initial neurological evaluation, the neurologist may make a diagnosis of migraines and prescribe a treatment. During each follow-up visit the neurologist will monitor changes or improvements in the patient's headaches with further neurological examinations.

Non-specific Chest Pain – pain in the chest, often thought by the patient to be caused by a heart condition or heart attack but which has no specific or clear cause. Such a pain may be muscular in origin or related to spasm in underlying organs such as the stomach or esophagus. Patients with panic disorder often complain of non-specific chest pain, believing erroneously that they are having a heart attack.

Obsessive-Compulsive Behavior – involuntary dwelling on an unwelcome thought (obsession) and/or involuntary repetition of an unnecessary action (compulsion).

Orgasm – the climax of sexual excitement, marked normally by ejaculation of semen by the male and by the release of tumescence in erectile organs of both sexes.

Paraphilia – recurrent and intense sexually arousing fantasies, sexual urges or behaviors that generally involve nonhuman objects, the suffering or humiliation of oneself or one's partner or children or other nonconsenting persons.

Pedophilia – involves sexual activity with a prepubescent child (13 years or younger). The pedophile must be at least 16 years of age and five years older than the child (victim) (APA, 1994, p. 527).

Pernicious Anemia – a metabolic disease whereby lack of absorption of vitamin B-12 in the stomach causes macrocytic (large red cells) anemia.

Persecutory – perception that one is being conspired against.

Persistent Depressive Disorder (Dysthymia) - dysthymia and chronic major depressive disorder was combined into PDD and is a chronically depressed mood that occurs for most of the day, more days than not and accounted for by the client or others for at least two years (APA, 2013).

Pervasive Developmental Disorder – disorders in which severe and pervasive impairment in several areas of development exists.

Plethysmograph – an instrument that measures variations in the size of an organ or body part on the basis of the amount of blood passing through or present in the part.

Polygraph – a physiological recording device equipped with sensors which, when attached to the body, can pick up subtle physiological changes in the form of electrical impulses. The changes are recorded on a moving roll of paper.

Positive Symptoms – symptoms generally ascribed to patients with schizophrenia that demonstrate distortions of normal functioning, i.e. psychotic symptoms which are primarily hallucinations and delusions. These are in contrast to negative symptoms such as depression, affective flattening, alogia, or avolition.

Post-partum (specifier) – a mood disorder or episode that begins within four weeks after delivery of a child.

Premature Ejaculation – ejaculation that occurs before a couple would prefer it to.

Psychiatric Evaluation – A psychiatric evaluation is often requested without necessarily resulting in medications being prescribed. This evaluation is performed by a psychiatrist (who has medical training and possesses an MD degree) who is uniquely trained to understand the relationship between a psychiatric condition as well as one of many different medical conditions, an understanding of medications that the patient may be taking (for either psychiatric or medical purposes), the patient's current medical conditions that may be causing or contributing to the disorder, an assessment of the patient's medications for pain, particularly opiates if they are being taken, and the patient's use/ misuse/ or abuse of substance use/abuse disorders.

Psychosomatic – the interrelationship between mental or emotional activity (psyche) and physical or physiological activity (soma).

Psychosomatic Illness – the presence of physical symptoms such as pain, gastrointestinal problems, cardiovascular symptoms, or neurological complaints caused by the inter-relationship between mental or emotional activity (psyche) and physical symptoms, or physiological activity(soma).

Psychopharmacological Evaluation – An evaluation for psychotropic medication does include a psychiatric evaluation but involves the specific determination as to which medications, if any, would be best prescribed for the patient.

Psychopharmacology – relates to the study of drugs and medications effects on the mind.

Pharmacotherapy – the treatment of diseases and psychiatric disorders with medications.

Purging – to undergo or cause an emptying of the gastro intestinal tract, either upper or lower.

Rapid Cycling – a shifting of affective poles that occurs within a one year period of time (at least four or more episodes). Coryell (2005) approximates that one of six bipolar clients presents with rapid cycling. Care is to be taken in diagnosing and distinguishing ADHD and bipolar rapid cycling in adolescents and children; and distinguishing borderline personality disorder from bipolar rapid cycling for adults.

Secondary Gain – an extraneous benefit from being ill, such as increased attention from others or financial gain from disability.

Schizoaffective (disorder) – a syndrome intermediate between schizophrenia and mood disorders in which individuals suffer a manic or a depressive episode while showing the symptoms of schizophrenia. The diagnosis can be confirmed when symptoms such as hallucinations or disordered thinking persist after the mood disorder (mania or depression) has cleared.

Schizophreniform (disorder) – a schizophrenic episode that lasts for more than two weeks but less than six months, with or without a precipitating event.

Sexual Aversion Disorder – the aversion or active avoidance of genital sexual contact with a sexual partner.

Sexual Masochism – involves the act of being humiliated, beaten, bound, or otherwise made to suffer (APA, 1994, p. 529).This is a chronic disorder.

Sexual Sadism – involves acts in which the individual derives sexual excitement from the psychological or physical suffering of the victim (APA, 1994, p. 530). The satisfaction may be derived from causing others physical or social suffering (humiliation).

Shared Psychotic Disorder – a disorder in which delusions develop in an individual involved in a close relationship with another person, which are similar to or the same as those experienced by the person who already has a psychotic disorder with prominent delusions.

Social Skills Training (SST) – The use of modeling, behavioral rehearsal, corrective feedback, social reinforcement, and homework assignments to teach effective social behavior. It was believed that social phobia resulted from deficient verbal (e.g., appropriate speech content) and non-verbal (e.g., eye contact, posture, and gestures) (Heimberg & Juster, 1995).

Solution-focused therapy – the focus is on solutions rather than causes whereas problem focused therapy focuses on the causes. SFT is a short term approach that empowers the client to orient towards solutions with the assistance of the counselor. SFT is future oriented.

Somatization – physical symptoms that lack good medical explanation, frequently involving some kind of physical pain, gastrointestinal problem, sexual symptom or neurological complaint. The complaints or symptoms of somatization disorder appear when there is no demonstrable organic cause.

Stress Inoculation Training (SIT; developed by Meichenbaum) – the combination of cognitive restructuring with training in verbal self-instruction and behavioral self-management techniques; clients are encouraged to apply these skills to a series of increasingly stressful situations as therapy progresses.

Sundowning – a condition commonly found with Alzheimer's clients neurological deficit characterized by nocturnal episodes of confusion and disorientation in the evening that is known to reverse the sleep schedule (awake at night and sleep during the day). Behaviors associated with sundowning are delirium like behavior changes consisting of agitation, wandering, illusions, hallucinations, and disorganized thinking and speech (McCurry, Reynolds & Ancoli-Israel, 2000).

Thyrotoxicosis – an endocrine disease caused by excessive thyroid activity significant enough to cause a toxic metabolic state.

Tolerance – the need to consume increasing amounts of a substance to achieve intoxication or to control a condition such as the use of narcotics to control pain.

Transsexualism – the desire to live permanently in the social role of the opposite gender via a sex reassignment.

Transvestite Fetishism – involves cross-dressing and usually, while masturbating, imagines he to be both the male and female in the sexual fantasy (APA, 1994, p. 531). This disorder is typically reserved for males who cross-dress in clothing worn by women.

12-Step Programs – Alcoholics Anonymous (AA) was founded in 1935 and has historically been the most successful program to initiate and maintain abstinence for those who have a primary diagnosis of alcohol dependency. AA's success is based on its 12-Step program, spiritual emphasis, group support, frequency and predictability of meetings, and the presence of individual sponsors. Cocaine Anonymous (CA), Narcotics Anonymous (NA), Overeaters Anonymous (OA), Co-Dependents Anonymous and Debtors Anonymous are examples of other 12-Step programs which have developed after AA's original program. The basic principles of 12 step programs include the following: admitting that one cannot control one's addiction or compulsion; recognizing a greater power that can give strength; examining past errors with the help of a sponsor (experienced member); making amends for these errors; learning to live a new life with a new code of behavior; helping others that suffer from the same addictions or compulsions.

Alcoholics Anonymous 12 steps are the following:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.(Alcoholics Anonymous Publishing, Inc. NY, 1955)

Vaginismus – the spasmodic contractions of the outer third of the vagina, which render intercourse either impossible or very painful.

Voyeurism – involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. Onset of voyeurism is typically before the age of 15.

Withdrawal – temporary psychological and physiological disturbances resulting from the body's attempt to readjust to the absence of a drug.

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