NEW

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 (Retired)
Joel O. Brende, M.D., LFAPA

ARTHUR-BRENDE
NCMHCE
STUDY PROGRAM

Arthur-Brende Study Supplement

for the

National Clinical Mental Health

Counseling Examination

DSM-5 Disorders: Diagnosis to Termination

A Companion to the
Arthur-Brende Online Scenario Simulator

Gary L. Arthur, Ed.D., LPC, NCC, CPCS (Retired)

Joel O. Brende, M.D., LFAPA

Gary L. Arthur, Ed.D., LPC, NCC, CPCS (Retired) is a Professor Emeritus in the Counseling and Psychological Services Department at Georgia State University. He served as the Coordinator for the Professional Counseling Program and as clinical coordinator for the internship program. His research interests included clinical supervision, therapist safety, geriatrics, and assessment. He has taught for over 42 years in the graduate program at Georgia State University.

Joel Osler Brende, M.D. is Professor & Chairman Emeritus, Dept. of Psychiatry and Behavioral Science and Clinical Professor Emeritus, Dept. of Internal Medicine, Mercer University School of Medicine, Macon, GA. He is certified by The American Board of Psychiatry and Neurology and a Life Fellow of the American Psychiatric Association. He has extensive experience in medical and psychiatric education and has been actively involved in the teaching and supervision of psychotherapists, marriage and family therapy students, and resident physicians in psychiatry and internal medicine. Dr. Brende is a graduate of the University of Minnesota Medical School and received his psychiatric training at the Karl Menninger School of psychiatry.

Published by Career Training Concepts, Inc.

Contact Toll-Free: 888-326-9229

ISBN # 978-1-877846-29-8

Version 15

1. INTRODUCTION

2. DSM-5 CLASSIFICATION

3. REFERENCES

4. APPENDICES

1. INTRODUCTION

How Best to use this Supplement

In order to benefit from this supplement, the reader can choose those elements which are most useful and applicable to his or her level of training and expertise. The reader will find a fair amount of repetition since the material is geared to meet the needs of several levels of expertise, ranging from school counselors to experienced clinicians who conduct the entire clinical protocol with clients.

This information is subject to change as NBCC adds and deletes information regarding clinical expertise pertaining to the scenarios and is not gleaned from any written material produced by NBCC. The NCMHCE scenarios are not an exact replication of case studies found in actual clinical practice, although they are similar in scope and practice. Therefore, examinees may need to adjust their in-office practice behaviors as they respond to specific questions on the NCMHCE but should always recognize the importance of making choices that will lead to optimum client care.

UNIT 1:

Unit 1 illustrates and provides information for those taking the NCHMCE. This unit includes a description of the testing format of the NCMHCE, along with suggestions for underlying features to consider during the examination. Unit 1 provides shortened and abbreviated information regarding instruments. There are six traditional questions for each scenario (although NBCC indicates most scenarios will contain five to eight questions). There are also suggestions about how to prepare for the exam and strategies for answering selections. Unit 1 will also provide information about incidence of disorders; diagnostic needs (symptoms, comorbidity, and differentials), interviewing strategies (structured/unstructured interviews, clinical interviews, biosocial interviews), predispositions to disorders, treatment definitions, and recommendations. This unit also provides the examinee information about instrumentation, monitoring, discharging recommendations, supervision, and study suggestions.

UNIT 2:

Unit 2 provides detailed information regarding selected disorders, with detailed information regarding disorder definition, assessment, instrumentation, treatment, and pharmacotherapy. If the examinee has had ample experience understanding and providing treatment for clients with more commonly found disorders, he or she may prefer choosing material for those less familiar disorders rather than the more commonly found ones.

There are three sets of references. The first set of references credits those authors whose material is paraphrased in the content of this supplement. The second set of references is for suggested readings located in the professional journals highlighting assessment, instrumentation, treatment, and monitoring. Double asterisks in the first set of references identify the third set of references. These references have been cited in the discussion boxes within the 37 on-line scenarios.

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 comprising 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 supplement has at least one, and sometimes two or more, disorders contained in 20 classifications, adverse effects of medication, and focus of clinical attention. 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

Dr. Brende and Dr. Arthur 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 are 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. This supplement is copyrighted and material is not to be reproduced, posted online, distributed, or sold without the permission of the authors.

Scenarios – Practice Format

The 37 online scenarios are designed following a Practice Format similar to that 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 multiple diagnoses.

In most cases, these scenarios will utilize a process that begins with the client's initial statement of a current problem, distress 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 tentative diagnosis. Sufficient information will be available to help the counselor make a provisional diagnosis. The next steps involve recommending collateral services or selection of appropriate instruments to gather additional diagnostic information for a tentative diagnosis and for later questions requesting 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 consideration of 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?
>
> What instruments would be helpful in gaining additional information for a provisional diagnosis?
>
> Based on the information gathered in questions 1 and 2, what provisional DSM-5 diagnosis is indicated?
>
> What techniques, therapies and/or strategies would be useful during the sessions?
>
> What information or methods 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 provisional diagnosis. When you reach 'the provisional diagnosis question' that is a STOP question. The purpose of a STOP question is to make the correct provisional diagnosis 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. It might necessary to identify a primary differential diagnosis after identifying the provisional diagnosis. A recommended treatment question usually follows the diagnosis question. When 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 degree levels, it will be important to approach these scenarios as though the counselor is trained at the Master's level of education, has successfully completed a practicum/internship program, 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 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 requests one's knowledge in terms of best practice, not selecting answers based upon the qualifications of the examinee (e.g., 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 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 whether 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 confirmation by a clinician trained in this assessment, such as a psychiatrist making a diagnosis for the purpose of prescribing medications, treatment planning, or hospitalization. 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. Nonetheless, making such a choice would be appropriate if the examinee believes evidence exists in the literature that this choice is the correct response.

In reading many of the valued answers, you will recognize numerous 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 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 examined: 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; client commitment; and most beneficial therapeutic modalities based on research findings. Although common sense dictates that specific treatments follow specific diagnoses, there are conflicting data regarding what therapies are most effective for specific diagnoses. Nonetheless the authors have utilized the literature as clearly as possible to report the results of outcome studies and therapies believed to be most effective and helpful. For example, cognitive behavioral therapy is 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. If the paper-pencil version of the NCMHCE is to be administered, be sure you have a clear understanding regarding the latent pen, answers surfacing, asterisks (one or two), 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. NBCC indicates that nine of the ten scenarios are calculated for a pass score. Case scenarios are presented with five to eight topical segments (questions) during the complete scenario that includes the different elements of assessment and treatment that 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 symptoms of various disorders to include questions about specific instruments considered helpful to acquire or validate symptoms or diagnoses.

Subsequent questions may focus on collateral services or 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/supervision/case 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. The scenario or case will emphasize evaluation and assessment (interviewing/mental status evaluation, cultural sensitivity, ethics), diagnosis and treatment planning (goal formation, techniques/ strategies), monitoring client progress (assessing change or 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 procedures or steps, tools, strategies, theories, treatment procedures, counselor tasks or duties, supervision, 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 cognitive disorder (learning, memory, etc.), neurocognitive deficits, substance use, psychosis, mood disturbances, anxiety, avoidance behavior, school-relational problems, couple's issues, physical complaints and social and personality problems.

Evaluating a client with one of these 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 of the Arthur-Brende scenarios is much like the NCMHCE in that it includes questions related either to Information Gathering (IG – usually two to four questions) or Decision Making (DM - usually four 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?" or "What is the provisional diagnosis?" or "What is the rule in/out diagnosis?" Scoring is not provided for the NBCC three subscores.

The examinee should envision that the scenario and first question might resemble an initial interview unless otherwise instructed. The NBCC scenario is frequently a few brief sentences in length. The presenting scenario is typical of statements made by clients when asked what brought them to counseling. The statements likely contain a symptom or clue to the distress or discomfort.

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 (symptoms) 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 (structured interview—clinical interview or biosocial) or they may be more open-ended (unstructured interview). 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. Even though professionals are taught the use of a clinical or biosocial interview, it is likely the assessor would be best advised to use an unstructured rather than a structured interview.

This is not to suggest that by selecting these choices you will necessarily gain all of the information you would like to obtain; 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 found in the family history they would necessarily be the cause of the disorder; rather, it may be that this person grew up in surroundings 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 selecting them 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 phrase "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 +2 to –2. Answers scored +2 are considered essential, while those with lower valuation are less essential and yield lower points. The authors will assign a lesser value 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 are taken away (-1, -2) 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, chosen, or plausible. 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

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 online, similar to this one.

In the actual test situation, you cannot undo what you have marked. However, you will be able to scroll back to previous questions and review the answers you selected for all questions. You will not be able to select additional answers. 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 to eight questions per scenario. The reason for more questions compared to past years is that the NCMHCE has expanded the tasks a counselor performs to include knowledge and behavior required to work with different disorders.

What may appear to be different in the Arthur-Brende scenarios compared to the NCMHCE 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 by the examinee may not be appropriate because of training but should be selected because of best practice. Ethical issues or dilemmas 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 the Arthur-Brende scenarios are different than the NCMHCE examination is in the amount of information received. When selecting 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 users wanted more information so we decided to move toward a more educational approach in question format, 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, but rather to make suggestions that may be helpful under other situations.

The discussion boxes will not be found on 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 treatment goals.

The provisional diagnostic question is a STOP question. The correct diagnosis must be made before the examinee is permitted to continue to the next question.

The training format for the online diagnosis may be similar to the NCMHME STOP question because the remainder of the questions pertain to the correct diagnosis. The correct diagnosis is essential for proper treatment selection. The NCMHCE may, in addition to the STOP question, follow with a request for the primary differential that was ruled out. There may be a question requesting the correct specifier for the identified provisional diagnosis.

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, a structured clinical interview can be helpful when the assessor sequences his/her questions to ask only those options that are likely to produce symptoms. Another approach is to use a more open-ended interview technique by identifying and pursuing key words the client shared in the scenario, such as 'tired, fatigued, sad, down, loss of interest, inadequate sleep, lack of attention or focus, memory failing',

etc. The DSM-5 has included in the manual pre-interview rating scales (adults and parent/guardian for ages 6-17) designating domains rated on a 0 to 4 value (ordinal measurement) for duration, frequency, and severity that can guide the interview during assessment (APA, 2013).

The DSM-5 included a cultural formulation interview (CFI) to assist in the assessment and treatment phases of the case. The purpose of the CFI is to assist counselors in understanding the cultural context of the client's illness experience (APA, 2013). Culture includes "language, religion and spirituality, family structure, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems" (p. 749). The CFI contains 16 questions that tap cultural identity, conceptualization of distress, psychosocial stressors and cultural features, relationships between the individual and client, and overall cultural assessment. Cultural concepts of distress include cultural syndromes, cultural idioms of distress, and cultural explanations or perceived causes. Culture bound syndrome has been replaced by cultural distress. Cultural distress has three components: culture syndrome, cultural idioms, and cultural explanation (explained causes).

Frequently an interviewer asks the client when the distress first started (time dimension) and what took place at that time (discontinued going to bridge group, stopped playing piano, spent even more money, no longer leaving the house, etc.). These statements may be good for treatment, monitoring, and discharge but require more focus for symptom gathering. Perhaps some of these findings can be written down for later use. The scenario will likely contain symptoms, which may be written down on the piece of paper received when entering the testing site. These symptoms might suggest one to three categories or classifications such as mood disorder, anxiety disorder, or risk behaviors that can provide a basis for helping guide the choice of additional questions to acquire more symptoms.

Develop a Strategy

It is recommended that the examinee, after reading the scenario and identifying the key words, review the number of options available. For example, if there are six options, identify the best answer that can be linked to the symptoms previously written on the sheet of paper that will likely expand on one or more of the symptoms on the list. Ask yourself, "Why did I ask that question?" or "What do I expect?" Is there a link between the answer and symptoms on the paper and is there 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? Write the second identified option answer under the first identified choice.

Draw a line under your first two choices and ask yourself, "If I identify 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 selected answer is a best client choice, helpful information (symptoms) will be evident and you will learn something that can be added to what was found in the scenario. Write it on the list with the other symptoms.

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

If the first choice provided information, a symptom (likely scored positive) may be added to the list. Again, if a good choice was made you will learn more or acquire more symptoms. You may now, with the scenario data and symptoms in the first two choices, be fairly confident of a diagnosis. Now ask yourself, "Should I select the third option?"

A possible idea to consider might be if you have counseling experience with the considered disorder, you will know if the third option is a good choice. Trust your acquired learning and experiences. If you have not counseled a client with the disorder in question, it might be 'less is more.' If you are uncertain with your third choice, it may be best to leave it if you have had two or more positive answers before any 'not indicated' responses.

In reviewing the NBCC (2014) examination packet and for those questions that indicate "Select as many as considered appropriate" the percentage of positive valued answers was 45 to 48. This might suggest considering one less than half of the number of available choices or plus or minus one for the number of choices.

Question 2: Collateral services

This question is designed to determine the wise use of collateral services. 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. A question such as, "What instrument would be helpful to gain additional information?" does not indicate what diagnostic instrument (such as the MMPI-2) to use. However, the choice of one of these or other short screener instruments may be a good choice if the instrument includes a scale for the disorder (depression) under consideration, such as the Beck Depression Inventory, Beck Anxiety Inventory, or SASSI. Some instruments identify the scale in the title. When scales are not in the title of the instrument, it is recommended to learn whether the instrument is for adults or children and the specific scales. Frequently surveys of instrument use are literature supported and these lists will be found throughout this supplement. The instruments on this list may be best choices. Several surveys have been conducted that identified 'most frequently utilized' instruments and are included throughout this supplement. It is recommended for instrument preparation to focus on these survey results for certain disorders.

It is our opinion that in an introductory licensure examination, a request or referral for psychopharmacology or treatment recommendations should be deferred until after a diagnosis is confirmed, most often with appropriate psychological testing. There may be situations in a clinical practice when counselors may want to initiate treatment prior to obtaining confirmatory psychological testing results but our thought is to not generally follow that approach in preparing for the NCMHCE scenarios. For example, if a client's symptoms seem to warrant a possible referral to a physician or psychiatrist for medical or medication treatment, the actual referral would be dependent upon gathering available diagnostic information or medical information from the client's physician or from the hospital where treatment had previously been provided.

Question 3: Diagnosis

Barlow, et al. (1986) and Klerman (1990) described four terms and definitions for diagnosis. The first is primary diagnosis and is a temporary diagnosis. The second is causal secondary diagnosis

referring to the diagnosis that is caused by and another pre-existing condition. The third is symptomatic associated with the greatest distress. Principal is the fourth diagnosis established during admission and may be the focus of treatment.

This is a STOP question that requires the correct diagnosis before moving to the next question. It is possible a question after the STOP question might request a specific differential diagnosis. The DSM-5 recommended recording procedure(s) for each disorder. Recording includes the provisional diagnosis (the provisional diagnosis may appear with or without the specifier), specifiers, and severity. It is possible that after the provisional diagnosis question a second or third question requiring specific information is needed to select the correct provisional diagnosis. It is recommended the examinee become acquainted with the differential diagnoses (primary one or two) in the DSM-5, as well as the specifiers for each diagnosis (review DSM-5: for major depressive disorder, p.184; bipolar I, p. 149; bipolar II, p. 134; adjustment disorder, p. 287), the different specifier definitions and the number of specifier symptoms required. In addition, definitions for specified and unspecified are to be found on those pages. It is unknown if the intensity, medical, and stressors are to follow diagnosis (es) for the examination. The recording diagnosis procedure that follows the specifier is the severity level (mild, moderate, moderate-severe, and severe). The DSM-5 recommended that all diagnoses that meet full criteria are to be included with the presenting disorder. The primary diagnosis is to be the treated disorder, although there are exceptions. Be aware of unspecified, other specified, comorbidity, specifiers, and differential for each of the disorders.

Question 4: Treatment, technique, and strategy

It is our opinion that high point choices (best client care choices) will be those treatments (theories) that have effectiveness or efficacy studies in the literature, often labeled as outcome-based results such as CBT for many mood and anxiety disorders and DBT for borderline personality disorder.

It is recommended to consider treatments that provide immediate relief. Managed care or insurance companies approve a limited number of sessions and for that reason the process of therapy, because of time limitations, may accomplish no more than beginning clients on the road to recovery rather than a cure per se. On the other hand, the presence of such time limitations may free up (or constrain) the examinee to select other therapies known to be helpful, such as brief psychotherapy, supportive therapy, psychoeducation, mindfulness, and solution-focused therapy. Since this question frequently states, "Select as many as appropriate", the list of options may include techniques and interventions that are matched to the disorder or to treatment goals. This can be a time to use techniques or interventions 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 selecting best short-term goals, then match from the treatment list a technique or intervention for each of the goals. An example might be recommending stress relaxation techniques, breath-inhalation, muscle relaxation, or even in vivo exercises for the client who stopped going to church or a social club because of anxiety associated with social interaction. A list of techniques, methods, and interventions will be located in the appendices for numerous disorders and theoretical orientations. In reviewing the NBCC examination packet it appears more techniques and strategies are to be found on the list than theories. Erford (2014) listed 40 techniques every counselor needs to know. The 40 technique include scaling, exceptions, problem-

free talk, miracle question, flagging the mind field, I-messages, Acting As If, spitting in the soup, mutual storytelling, paradoxical intention, empty chair, body movement and exaggeration, visual/guided imagery, deep breathing, progressive muscle relaxation training, self-disclosure, challenging/confrontation, motivational interviewing, strength bombardment, self-talk, reframing, thought stopping, cognitive restructuring, emotive imagery, bibliotherapy, journaling, systematic desensitization, stress inoculation training, modeling, behavioral rehearsal, role play, premack principle, behavior chart (food chart), token economy, behavioral contract, extinction, time out, response cost, and overcorrection

Evaluation methodology for Efficacious (Efficacy-Effectiveness-outcome research) treatment:

Treatment research designed and subjected to outcome research evaluation criteria established by Nathan and Gorman (2002), Chambless et al. (1998), Chambless et al. (1996), and Chambless and Hollon (1998) are briefly outlined to highlight the sophistication of studies. Well-established, probably efficacious, possibly efficacious, and experimental refers to the degree each study meets specific criteria. Nathan and Gorman criteria are to meet one of six types (Type I, III, III, IV, V, and VI). Terms or statements for each classification include:

Nathan and Gorman criteria:

Type 1: Randomized, random assignment, blind assessment, clear inclusion/exclusion criteria, state-of-the-art diagnosis, adequate sample size to power analyses and statistical procedures, treatment measures.

Type 2: Clinical trials with comparison groups testing intervention, some significant flaws but not a critical design, can include single-subject designs.

Type 3: Significant methodological flaws, uncontrolled studies using pre-post designs and retrospective designs

Type 4 and 5: Secondary analysis articles

Type 6: Case reports

Chambless et al. (1998) criteria:

"Well-established (we)":

a. treatment manuals, specified participant groups meeting two independent well-designed group studies showing the treatment is better than placebo or alternative treatment or equivalent to established effective treatment

b. None or more single-subject design studies using strong designs and comparison to an alternative treatment.

"Probably efficacious":

Specified participant groups, treatment manual preferable but not required, and either of three no-treatment characteristics:

1. Two strong group studies by same investigator showing the treatment to have better outcomes than no-treatment control group
2. Two studies showing better outcomes than a no-treatment control group

3. Three or more single-subject design studies that have a strong design and compare the intervention to another intervention.

"Possibly efficacious": one "good" study demonstrating the intervention to be efficacious in the absence of evidence to the contrary.

"Experimental treatment": treatments yet to be analyzed

It should be noted that commonalities exist within the two sets of criteria. For preparation purposes for the NCHMCHE, where professional literature exists regarding the rigorous level of the design regarding treatment and is subjected to efficacious criteria, these treatments may be best choices on the examination.

References to treatments subjected to efficacious criteria will be reported throughout the supplement and in the appendices for adults and children for numerous treatments. Silverman and Hinshaw (2008) coordinated an extensive second efficacious study that followed an earlier evidence-based psychosocial treatment for children and adolescents (10-year update). Results from the second 10-year follow-up efficacious study were analyzed for children's and adolescents' disorder treatments in Units 1 and 2 for autism, ADHD, depression, phobic and anxiety, depression, eating problems, eating disorders, trauma, conduct and oppositional defiant, OCD, and substance abuse.

Question 5: Monitoring

Monitoring is the process of observing change in thought, feelings and behavior of a client undergoing treatment. Monitoring may take many different forms, often in direct relation to what the client is experiencing and agreed-upon established goals for treatment. Monitoring is tracking of specific client changes in the treatment goals by the client, and the counselor's task is to help the client recognize change through record-keeping and regular goal assessment reporting. The client and counselor provide feedback via observations including self-reports, surveys, or behavioral reports. Improvement or lack of improvement information should be measurable, achievable, relevant and time-bound. Monitoring can be through idiographic and standard measures. Three methods are:

1. Review measures: Feedback from measures inform direct clinical work by discussing results directly with families and in supervision (Law, 2012). Law (2011) recommended goal based outcomes to implement during practice in order that the child can observe the progress toward a goal.
2. Direct evidence that user-reported symptoms, functioning, and satisfaction to clinicians improves outcomes (Bickman, Kelley, Breda, Andade, & Riemer, 2011), especially for cases which are not 'on track' (Lambert & Shimokawa, 2011).
3. Consistency of care for recovery and reliable change rates for brief session-by-session symptom-specific measures.

Liang (1988) reported that for self-reports to be valid or trusted the respondent must clearly understand what information is being requested, information must be available to the respondent, be willing to provide information, and able to interpret responses accurately.

It is important to monitor symptom reductions or increases for a diagnosis such as an eating disorder. For example, the counselor makes note of and witnesses for an eating disorder (bulimia) a reduction in denial, minimization, compensatory activities, or frequency in eating as well as the choice of food.

According to Prochaska, DiClemente, and Norcross (1992) change can be reflected in the process of counseling, such as stages of change or in the case of a specific theory treatment of choice. The stages of change include pre-contemplation, contemplation, preparation, action, maintenance, and termination (relapse prevention). All theories provide specific strategies, interventions, or the mechanism for initiating therapeutic change and steps for that change or experimentation to elicit or surface internal conflict. Interventions are procedures aimed at discovery. Although certain theories may not be a selected choice for NCMHCE scenarios, some Gestalt intervention strategies may be useful with other theories. Gestalt intervention examples include: location of feelings, confrontation, empty chair, making rounds, dream work, unfinished business, rehearsal, minimization, exaggeration, reversal, exposing the obvious, explanation or translation, retroflection, let the child talk, say it again, I have a secret, and stay with your feeling (Capuzzi & Gross, 2007, pp. 228-231). These types of interventions provide the groundwork and specific conflicts that are the pathways to the change elements but are also helpful to discern what resources the client uses to cope and engage in self-care. Paradoxical intention is both a theory and a strategy. As a strategy, the counselor may observe when the client gives up trying to be what they want to be and when the client stops struggling and change occurs (Fernbacher & Plummer, 2005). The reverse of this concept is that the harder one tries the more one stays the same.

If short-term goals are identified and treated the counselor may initiate awareness strategies or interventions that link to behavioral change and can be measured. According to Yonef (1995), Gestalt interventions or strategies include and are intended to:

> clarify and sharpen what the client is already aware of and to make new linkages.
>
> bring into focus/awareness previously-known peripheral information.
>
> bring into awareness that which is needed but has been kept out of awareness.
>
> bring into awareness the system of control. (p. 280)

Some examples of strategies for cognitive behavior are reinforcement (positive/negative) extinction, shaping (stimulus control, aversive control), all-or-nothing thinking, catastrophizing, and thought stopping.

Specifically, some examples include:

- Verbal reports or self-reports
- Instruments-screeners, monitors--pre/post measurements (BAI, BDI, etc.)
- Level 1 Cross-Cutting Symptom Measure (Adult; Parent/Guardian for child age 6-17)
- Scales-rating scales such as those with Solution or Problem-focused therapies
- Compliance (medication, homework, working during counseling)
- Checklists
- Logging exercises such as emotion lists, frequency of angry feelings or acting out
- Re-engagement in previous activities (running, music, crossword, etc.)
- Physiological measures (blood pressure, heart rate, pulse, galvanic response)
- This may depend on the diagnosis: ADHD (homework, compliance to medication, etc., boundaries).
- Children reporting--some disorders may be in question

- Global measures of outcome-measure across client diagnosis—the manual indicated that the SCL-90-R may be used as a monitoring tool, general symptoms derived from the 9 subscales and Outcome Questionnaire-45 (Lambert et al., 1996)--three subscales and composite score

A client may be experiencing difficulties in expressing him/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 behavior change monitored is dependent upon the treatment goals. For someone experiencing agoraphobia, improvement behaviors may be attending a social functioning, going shopping, mailing a letter, or other 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 meeting 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 again at a later time, thus a comparison (pre-post). 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. The Coping Styles Questionnaire for Social Situations is a psychometric tool for measuring monitoring and blunting for social anxiety disorder. This tool observes for behaviors the client engages in to seek out information for threatening situations and for distractions.

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 MRI is increasingly found to be an effective tool for diagnosing central nervous system disease, including demyelization disorders, neoplastic disorders, and ischemic changes in the brain resulting from vascular insufficiency or occlusion.

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

Monitoring can also be through the client's involvement in and working through the stages of change in resolving or during the curative process. One example may be Prochaska, DiClemente's and Norcross (1992) transtheoretical model and stages of change: pre-contemplation, contemplation, preparation, action, maintenance, and termination (preparation for relapse).

Monitoring strategies are a component of the treatment and goal identification and session work includes establishing specific techniques/methods for client improvement and weekly observations for changes to provide feedback.

Finally, monitoring includes observations for sudden gains (SG) from session to session or post-termination. Sudden gains are defined as 25% or greater reduction in symptoms and stable over time (Tang & DeRubeis, 1999).

Question 6: Discharge

Discharge is a time to review specific changes that took place during the therapy, focusing on specific variables and how each was accomplished. The counselor reinforces the client's participation in making those changes and encourages continued activity for recovery and to avoid relapse. Relapse prevention is included in the final disposition in addition to isolating specific ongoing community connection to outside resources for continued improvement.

Besides recommendations such as self-help groups and continued journaling, one can also consider for discharge the counselor and client tasks of reviewing the treatment goals and feedback for change.

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.

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 vary with client experiences with mental health services. Chavira, Grilo, Shea et al. (2003), in researching diagnostic data for Caucasians, African Americans, Asian Americans, and Hispanic Americans, reported different rates for four personality disorders.

Important information for the clinician is to be aware of how the individual perceives and 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 2014 ACA Code of Ethics section on diversity, supervision, and the Cultural Formulation Interview in the DSM-5 (APA, 2013). Care is to be taken when assessing for ethnicity and personality disorders because the literature has noted boundary issues (characteristic features) are differentiation problems (Chavia, Grilo, Shea et al., 2003; Graham, 2006)

3. Initially focus on the chief complaint(s). Identify symptoms or 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", "memory", "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, severity (intensity), duration, 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 to be aware of medical conditions that appear to be associated with a diagnosis. The medical condition may not be the cause but should always be considered important and worthy of seeking additional information or referral. 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 that warrant history taking regarding medical, mental, family, work, social, and risk behaviors. For example, selecting family history can reveal important information about one or more family members who may have suffered from, or received treatment for, the same condition/disorder. Frequently clues may be found in the scenario to warrant 'family history' to be important for data gathering. Some examples may be alcoholism, mood disorders, eating disorders, tics, etc. 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. It is not possible to know if the NBCC scenarios award positive values for selecting predispositions choices.
8. The mental status examination (MSE) often confirms diagnostic questions pertaining to behavior, memory (short-term, intermediate and long-term), affect, and cognitive functioning. A MSE, whether brief or full scale, is important when the history and symptoms seem to be apparent for major mood disorder, substance use, psychoses, and neurocognitive disorders.
9. Positive scores (+1, +2) will follow pertinent answers pertaining to duration and intensity of symptoms, with higher values reflecting greater importance. All values will be available to the user when the submission button is selected at the conclusion of the scenario with the exception of the NCMHCE. The Arthur-Brende scenarios use +2 to -2 values as does the NBCC Examination booklet use +2 to -2 values.
10. Diagnostic instruments that assess for disorders that are statistically valid and reliable have been used to corroborate interviewers' 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 indicates '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), the Beck Depression Inventory (BDI), Burns Anxiety Inventory, and for personality disorders, perhaps the Millon Clinical Multiaxial Inventory-III.

Peterson, Lomas, Neukrug, and Bonner (2014) published an extensive instrument use survey of 174 commercial standardized tests to 926 CACREP counselors that were randomly selected from 5,000 nationally certified counselors. From the completed useable surveys (926) 98 instruments were ranked in use. In reviewing the NBCC (2014) examination packet the following instruments were choices with the following rankings on this survey:

Beck Depression Inventory (1*), Myers-Briggs Type Indicator (2), Strong Interest Inventory (3), Wechsler Intelligence Scale for Children (7*), Beck Anxiety Inventory (9*), Wechsler Adult Intelligence Scale Revised (WAIS-R; 11), Wide Range Achievement Test (WRAT-3; 14*), Burk's Rating Scale (14), MMPI-2 (15), Child Behavior Checklist (22*), Thematic Apperception Test (40*), Eating Disorder Inventory (52*), Holland's Self-Directed Search (not listed), Eating Disorder Inventory (not listed*). This would suggest that these instruments were within the scope of a master's level curriculum course in appraisal. An asterisk following the ranking was a positive choice. When reviewing the list of instruments the possible uses of these tools would suggests disorders such as contained in neurodevelopmental, anxiety, mood, and personality.

Monitoring for client improvement using instruments, the clinician might consider using the Beck Depression Inventory (BDI), Burns Anxiety Inventory or the Substance Abuse Subtle Screening Inventory (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. The use of instruments or scaling questions pre-post inquires best represent change. When medications are prescribed it is essential the counselor monitor for compliance and for adverse side-effects (Ashton & Young, 1998).

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 remaining 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.
12. This training supplement, in progressing to later scenarios, will be requesting for multiple 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 multiple diagnoses 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. When recording more than one diagnosis on the NCMHCE, one may find both disorders listed on the same option line. Normally, the diagnosis that requires the most professional assistance is listed first, followed by the second diagnosis, if it meets full criteria. In addition, the disorder may contain the replacements for NOS, specified and unspecified. Specifiers and severity terminology may also be included for the disorder. Be sure to read NBCC's website for any up-to-date changes.
13. The next question usually pertains to treatment or a session question regarding the counselor's task, ethics, counseling process and requesting a counselor response. Sometimes more than one treatment is valued. When multiple diagnoses are confirmed the treatment question can be approached by prioritizing the immediate need (safety, medication, mood),

followed by decisions about treatment in order of 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 Arthur-Brende later scenarios.

14. For recommended treatments, strategies, and techniques for different disorders found in the scenarios, the examinee should become familiar with the literature citing evidence-based research, which has been recommended by medical personnel and psychologists trained in scientific research to be a minimum of two independent randomized control trials for effectiveness. More recently the field has expanded this requirement to also include six levels of evidence. For a more in-depth understanding of effectiveness or efficacy studies the examinee should consult Trinder and Reynolds (2000). One example of a research article reporting outcome research was reported by Simon Gowers (2006), in which cognitive behavior therapy (CBT) produced significant change results for eating disorders. A controlled clinical trial refers to a study that meets the criteria for experimental design research in which the treatment or technique is exposed to rigorous research criteria. This type of research usually involves comparing the effectiveness of a particular therapy or intervention with a control group, wait list or different technique/treatment. Levitt, Hoffman, Grisham, and Barlow (2001) cited several controlled clinical studies in which the treatment of panic disorder was found to be effective using CBT in 8-12 treatment sessions. An effort has been made to include this type of recommendation in the supplement (appendices) as well as the online scenarios, whenever possible.
15. In addition to treatments that meet evidence-based outcome studies, consider treatment selections that provide immediate relief. Due to the limited number of sessions clients receive (insurance, finances, managed care, cost effectiveness, transportation), effecting change for improved conditions is to be considered time-limited.
16. A third component of treatment includes techniques and interventions that are most appropriate for select disorders. Be prepared to select techniques such as bibliotherapy, journaling, stress inoculation, relaxation training, muscle relaxation, breath inoculation, in vivo, paradoxical intention, social skills training, empty chair, and reframing. An example might be stress inoculation and the miracle question for adjustment disorder. Play therapy and sand tray therapies are appropriate for young clients. A technique list for selected disorders is located in the Appendix.

Medical Associations with Psychological Disorders

Counselors are not physicians and so are not expected to diagnose a physical problem. Limited medical information is provided so that when the interviewer is acquiring information, either in the interview or information of a medical nature located in the chart, there may be an associated psychological issue to explore or a referral that should be made to a medical practitioner or other professionals. Although counselors are not expected to diagnose physical problems, they should not avoid seeking information about medical conditions that may be associated with psychological problems. Seeking more specific medical information from or referral to the client's medical practitioner or medical specialist might best expand general medical information that may become apparent during the initial interview.

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. Nonmedical 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. The DSM-5 highlights the importance of biological and environmental markers in assessment and for treatment. While this list of examples is not fully inclusive, consider the following:

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 laboratory findings rule 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, nonspecific 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 Nonspecific Somatic Symptom Disorder Complaints and Chronic Posttraumatic Stress Disorder

Posttraumatic stress disorder is often overlooked by physicians whose clients, particularly women previously abused as children, seek medical attention for physical symptoms such as pelvic and abdominal pain, gastro-esophageal reflux disease, and noncardiac 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 autoimmune demyelization 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 client with a history of psychological disorder and/or psychological trauma. Multiple sclerosis should be suspected when symptoms of weakness or muscle paralysis recur 30 days or more later but are different because demyelization occurs in a different anatomical location. A MRI sometimes provides objective evidence of demyelization.

Evidence of immunoglobulin 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 demyelization.

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, certain prescribed psychoactive medications, and some muscle relaxants.

Substance Use Disorders

Withdrawal symptoms from alcohol, anxiolytics, and some other illicit drugs can cause withdrawal agitation and may also include depressed mood, apathy, and behavior symptoms. Methamphetamines and other illicit substances such as K-10 can induce psychotic hallucinations, delusions, and symptoms. Amphetamine withdrawal can cause significant weight loss, sleep disturbance, and withdrawal lassitude. Discontinuing prescribed opiate painkillers can cause agitation, muscle aching, sweating, abdominal cramps, nausea, and diarrhea.

Physical Symptoms and Medication Side Effects

Medication side effects can result in physical symptoms. For example, some antipsychotics may give rise to muscle rigidity, akisthisia, and muscle tremors. Excessive weight gain and elevated blood lipid may be caused by some medications, particularly certain antipsychotic medications. Various side effects from different psychoactive medications include fatigue, sleep disturbances, weight loss, thyroid gland irregularities, constipation, gastro-intestinal distress, and liver function abnormalities. The abrupt discontinuation of some medications such as short-acting antidepressants like Paxil and Effexor has led to flu-like symptoms and anxiety.

Diabetes and Bipolar Disorders (Hirschfeld, Young, & McElroy, 2003)

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

Eating Disorders

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

Sleep-Wake Disorder

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, or multiple wake tests.

Depressive Disorder Due to Another Medical Condition vs. Primary Depressive Disorder with Medical Symptoms

Twenty-five percent 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 that caused their depression.

Organic Mood Syndromes vs. Medical Illnesses Causing Mood Disturbances

Mood disorders can be caused by endocrine conditions such as thyroid disorders (hypothyroid and "apathetic" hyperthyroidism), parathyroid disorders (hyper and hypo), adrenal disorders (Cushing's or Addison's diseases), neurosyphilis, and diabetes mellitus.

Bipolar disorder rapid cycling has been linked to thyroid abnormalities (Gyulai, Bauer, Bauer, Espahana-Garcia, & Whybrow, 2003; Oomen, Schipperijn, & Drexhage, 1996).

Chronic medical conditions such as cancer (especially pancreatic and other gastrointestinal malignancies) and porphyria, an inherited condition caused by a buildup of chemicals called porphyries in the body causing psychiatric symptoms and chronic pain. Uremia and chronic renal diseases may cause fatigue, nausea, vomiting, cold, bone pain, itching, 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 neurosyphilis, Fahr's syndrome, hydrocephalus, and Wilson's disease.

Autoimmune diseases such as rheumatoid arthritis, Sjorgen's arteritis, temporal arteritis, multiple sclerosis, and systemic lupus erythematosus.

Infections: Tuberculosis, acquired immune deficiency syndrome (AIDS), neurosyphilis, 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:

Drugs that can cause mania: Corticosteroids (including hydrocortisone, triamcinolone, and prednisone) prescribed for treating excessive inflammation, acute respiratory distress, rheumatoid arthritis, and autoimmune diseases. Corticosteroids may also cause changes in mood and cognition, are generally dose related, and can precipitate psychosis, hypomania, mania, depression, cognitive and memory problems.

Mania may also be induced by cyclosporine, prescribed to prevent rejection of transplanted organs; levodopa for the treatment of Parkinson's disease; all antidepressants, including SSRIs and MAOIs; Lioresal, which is often used to treat multiple sclerosis and spinal cord injuries; stimulants used to treat attention deficit hyperactivity disorder (ADHD); synthroid, commonly prescribed as a thyroid hormone replacement; certain antibiotics, such as ciproflozacin and gentamicin; antimalarial drugs, such as mefloquine and chloroquine; antineoplastic drugs, such as 5-fluorouracil and ifosfamide

Depression and Medication Side effects

Drugs which can sometimes cause depression: Interferon, used to treat Hepatitis C clients, has a high prevalence of associated depression (reported to be between 10 and 40%.); accutane (for severe acne); selected anticonvulsants and barbiturates; benzodiazepines such as lorazepam, clonazepam, clorazepate, diazepam, chlordiazepoxide, and alprazolam; anti-hypertensive: Reserpine, beta blockers (particularly Propranolol and Metoprolol), Angiotensin-converting enzyme (ACE) inhibitors, Clonidine and calcium channel blockers –used for treating hypertension, arrhythmias, and other cardiac problems; certain birth control pills; opioids and narcotics prescribed for pain control; statins prescribed for reducing blood cholesterol, varenicline prescribed for smoking cessation, and zovirax prescribed for shingles and herpes.

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. They recommended reducing sugar intake and taking probiotics to restore normal intestinal flora (Gucciardi, 2011).

Anti-viral agents and HIV drugs may cause depression (Everall, Drummond, & Cataian, 2004).

Anabolic androgenic steroids are associated with mood and behavior changes.

Cold preparations that 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.

Antimigraine 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 but 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, Becanu, et al. (2003) cited evidence that there is a genetic link in family and environmental elements for anorexia nervosa, bulimia nervosa, and binge eating disorders. They cited seven studies from 1983 to the present linking genetic components to familial transmission of eating disorders.

3. **Tics**

   Kaplan and Sadock (1998) commented on twin studies and 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. This research suggested that sons of mothers with Tourette's

disorder are 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, & Jimenez-Shahed, 2008).

4. **Alcohol**

A genetic predisposition to alcoholism researched in family studies, twin studies, adoption studies, ethnic differences and biological risks supports risk factors for alcoholism (Pandy, 1990). Pandy points out the identification of high-risk individuals who often have a genetic predisposition to alcoholism. His work suggests biochemical traits of two categories: alcohol abuse (state markers) and vulnerability to alcoholism (trait markers). This research supported Goodwin's work and evidence of the familial nature of alcoholism. The Institute of Medicine in 1987 published a report that the 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 indicated predisposition is not an easy question to answer as both genetic and environmental factors are involved.

5. **ADHD**

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

6. **Borderline Personality Disorder**

Stepp, Whalen, Pilkonis, Hipwell, and Levine (2011) cited an overview of research by White et al. (2003) regarding first-degree relatives and transgenerational transmission of borderline personality disorder. Their research indicated that there was a four- to twenty-fold increase in prevalence of morbidity for BPD compared to the general population. This data summary indicated there is evidence to suggest that core features of borderline personality are inherited independently. Specific features of affective instability and impulsivity were also found (Silverman et al., 1991).

7. Social Anxiety

Several studies and professional papers have concluded there is statistical evidence for social anxiety genetic transmission for first-degree clients with SAD (Fyer, Mannuzza, Chapman, Liebowitz, & Klein, 1993; Scaini, Belotti, & Ogliari, 2014).

Instrumentation

This section will focus on the instruments that may be used for screening, monitoring and assessing (diagnosing) behaviors. 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. For example, the DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure-Adult may be considered a screener (pre-interview) for one or more of the 13 domains in the adult rating scale version. If the client was rated mild or greater on the Level 1 symptom measure, a Level II longer form may be administered.

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 for preventive measures or to determine readiness for certain interventions. Some examples of screening instruments, if administered on a pre-post measure, that may be used as monitoring tools include:

SCL-90-R

PANAS Scales (PANAS-X is the expanded version-60 items)

Alcohol Use Disorders Identification Test (AUDIT)

Inventory of Interpersonal Problems (IIP-64; Horwitz, Alden, Wiggins, & Pincus, 2000)--Screening for avoidant personality inventory measuring low in dominance and affiliation

Traumatic Events Screening Inventory (TESI-C; Ribbe, 1996), Children and TESI-P (Ippen et al., 2002)

Primary Care PTSD Screen (PC-PTSD; Prins et al., 2003)--past month

The following four anxiety instruments are popular and widely used and have been linked to PROMIS anxiety (Schalet, Cook, Choi, & Cella, 2014):

1. PROMIS Anxiety (Cella et al., 2010)
2. Mood and Anxiety symptom Questionnaire (MASQ; Watson & Clark, 1991)
3. Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006)
4. Positive and Negative Disorder Scale (PANAS; Watson et al., 1988)

Researchers surveyed widely-used instruments for different assessments. These researchers and topic areas included:

1. psychologists and addiction counselors (Hogan, 2005; Hogan & Rengett, 2008; Juhnke et al., 2003)
2. depression (children; Muller & Erford, 2012)
3. oppositional defiant disorder (Erford, Paul, Oncken, Kress, & Erford , 2014)
4. posttraumatic stress disorder for children and adults (Elhai, Gray, Kashdan, & Franklin, 2005)
5. substance instruments used by addiction counselors (Juhnke, Vacc, Curtis, Coll, & Paredes, 2003)

The widely-used instruments will be found with the disorders in this supplement.

Peterson, Lomas, Neukrug and Bonner (2014) surveyed 5,000 nationally certified counselors regarding the frequency of instrument use from a list of 174 instruments found within four textbooks.

Of the surveys sent, 926 met criteria for analysis. The authors ranked 98 instruments, from most to least frequently use. When comparing the ranking with the instruments included in NBCC's (2014) practice scenarios packet, the answers (instruments) were ranked 1, 2, 3, 7, 9, 11, 14, 15, 22, and 52. It would appear NBCC panel is selecting instruments that would commonly be taught and possibly in use in the different settings of counselor work.

Supporting Peterson et al. (2014) findings (rankings), an earlier study of instruments that counselors self-reported as widely used was conducted by Koocher, Norcross and Hill (2005). These instruments are frequently utilized for disorders, vocational interests, intelligence measurement, and personality assessments. The ranking included:

1. Minnesota Multiphasic Personality Inventory
2. Strong Interest Inventory
3. Wechsler Adult Intelligence Test
4. Wechsler Intelligence Scale for Children
5. Sentence Completion Test
6. Thematic Apperception Test
7. Sixteen Personality Questionnaire
8. Bender Visual Motor Gestalt Test
9. House-Tree-Person Projective Technique
10. Millon Clinical Multiaxial Test
11. Rorschach Ink Blot Test

Many of these instruments are choices on different NCHMCE scenarios.

Hogan and Rengert (2008) extended this study to determine what instruments are most frequently used for research. A selected number of instruments will be listed, as they appear on other lists and on the NCHMCE. This list included:

1. Beck Depression Inventory (18)--first on the list
2. Center for Epidemiological Studies Depression Scale (7)--tied for fourth on the list
3. Eating Disorder Inventory (5)--tied for sixth on the list
4. Child Behavior Checklist (4)--tied for eighth on the list
5. Positive and Negative Affect Schedule (PANAS) (4)--tied for eighth on the list
6. Symptom Checklist 90-R (4)--tied for eighth on the list

Juhnke, Vacc, Curtis, Coll, and Paredes (2003) instrument survey was mailed to 672 MACs with 350 reports meeting usable and rank reported for most frequently used instruments included the SASSI (1), MAST (2), BDI (3), MMPI-2 (4) and Addiction Severity Index (ASI) although considered most important ranking indicated SASSI (1), BDI (2), MMPI-2(3), ASI (4), and MAST (5).

A rule out/in question may request selecting appropriate instruments that will gain additional information or validate the provisional diagnosis being considered after completion of the data gathering question. It is likely knowing the acronyms for different instruments may be helpful, as several instruments are identified by a disorder or the author, such as the Beck Depression Inventory (BDI).

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 a disorder. Decisions based on assessment should not be viewed as definitive and should be revised with new information or validated through other sources (Sattler, 2008). Instruments identified as screeners or diagnostic 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. McHugh and Behar (2009) reviewed the readability of 105 instruments that included depression (14) and anxiety (91). The ninety-one instruments included GAD, panic and agoraphobia, specific phobia, social phobia, OCD, and PTSD.

There are several methods to monitor client improvement. There are a few instruments whose administrator manuals indicate the instrument can be utilized for monitoring change, such as the SLC-90-R. Nevertheless, it is possible that instruments that have a few questions or even screeners might be used for this purpose. Monitoring can take some form of measuring for duration, latency, frequency, and amplitude (intensity) of certain behaviors.

The order of these instruments in the Arthur-Brende supplement 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, the focus is on identifying the purpose of the instrument, population served (children/adults) and scales measured. For some instruments additional information may be provided.

Although the following reported surveys are dated (1988 and 1989), the instruments were ranked according to frequency of use in mental health centers (mh), by counseling psychologist (cp), and for 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 of use.

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. Mac Andrew Alcoholism Scale (A13)
11. Children's depression Inventory (MH30)
12. Symptom Checklist-90R (MH29)

To review the entire list of instruments, locate each from the following sources: Aiken (1997), Archer et al. (1991), Piotrowski and Keller (1989), and Watkins, Campbell, and McGregor (1988).

DSM-5 Rating Scales:

The DSM-IV-TR was developed using a categorical approach; however, the DSM-5 added a dimensional approach to the measurement of distress, disability and severity (APA, 2013). Dimensional assessment measures for the frequency, duration, and severity of symptoms. The categorical approach was nominal in that a disorder was present or not present (met the full criteria). Three assessment issues in diagnosing were noted to be comorbidity, boundary issues, and an

excessive use of not otherwise specified (NOS). Added to the DSM-5 manual were pre-interview rating scales (APA, 2013; Jones, 2012). Carpenter (2014) discussed boundaries issues existing between schizophrenia and bipolar disorders, mood disorders and psychotic features, and anxiety disorders and neurodevelopment disorders.

The three rating measures are the DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult, Parent-Guardian Rated; DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Ages 6-17, and Clinician-Rated Dimensions of Psychosis Symptom Severity (APA, 2013; Jones, 2012). A similar cross-cutting measure, the Clinician-Rated Dimensions of Psychosis Symptom Severity, is included when cognitive symptoms are present that are suggestive of psychotic disorders. This rating scale has identified eight domains (hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression, mania) scaled on a 5-point (0-4) ordinal scale (APA, 2013). A final measure is the World Health Organization Disability Assessment Schedule 2.0 (WHODAS-2).

It has been known that a wide variety of distressed clients often exhibit similar symptoms (comorbidity) during the assessment phase (Andrews, Slade, & Issakidis, 2002). The two cross-cutting rating scales consist of 23 and 25 questions, adult and child, respectively, which result in 13 and 12 domains, respectively. The questions are answered according to ordinal scaling values from 0-4 for duration, frequency, and severity on a continuum (none, slight, mild, moderate, severe). The APA (2013) suggested that when any domain-scaled sum meets mild or greater except for substance, suicide ideation, and psychosis, a Level 2 cross-cutting measure would be administered (p. 734).

Understanding race, ethnicity, and culture when assessing for symptom-related issues and disorders is necessary for a collaborative and informative interview. In order to assist in an understanding of a client's race, ethnicity, and cultural heritage and background, the Cultural Formulation Interview (CFI) is available for use (APA, 2013). The CFI includes 16 questions designed to obtain information during the interview when culture impacts key aspects during a clinical presentation. Important during the interview is an awareness of the replacement for cultural syndrome. The replacement is referred to as cultural distress consisting of cultural syndrome, cultural idiom, and cultural explanation or perceived causes (APA, 2013, pp. 14, 758).

Instruments:

A rule out/in question may request selecting appropriate instruments that will gain additional information or validate the provisional being considered after completion of the data gathering question one. It is likely the acronym for some instruments will be helpful as some are identified by a disorder or the author such as the Beck Depression Inventory (BDI).

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

This self-rating is recommended for a pre-interview. The rating scale consists of 23 questions that assess for 13 domains including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance abuse (APA, 2013, p. 735). Each client response is rated on a 5-point ordinal scale (0-4) and each succeeding point is labeled as none, slight, less than a day or two, mild, moderate, and severe (every day). The client responds to how often and how much he/she was bothered by each problem during the past two weeks. The point values are summed for each of the 13

domains and identified as none, slight, mild, moderate, and severe. If a designation reaches mild or greater the interviewer focuses the interview toward those domains and considers whether a Level 2 instrument is to be administered.

Parent/Guardian-Rated DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6-17

This pre-interview measure consists of 25 questions that assesses for 12 domains including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, inattention, repetitive thoughts and behaviors, irritability, and substance abuse (APA, 2013, p. 736). Each client response is rated on a 5-point ordinal scale (0-4) and each succeeding point is labeled as none (0), slight (1), less than a day or two (2), mild (3), moderate (4), and severe (every day--5). Nineteen of the 25 items are rated on a 0-4 point ordinal scale (0-none, 1-less than a day or two, 2-several days, 3-more than half the days, 4-nearly every day).

Clinician-Rated Dimensions of Psychosis Symptom Severity

This self-rated pre-interview assessment measures for the primary symptoms of psychosis and includes eight domains (hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression, and mania). The scaling is rated on a 0-4 scale from not present to severe.

Neuropsychology II (NEPSY-II)

Purpose, Use, and Age:

The NEPSY-II, second edition, is to assess neuropsychological development in preschool and school age children, ages 3-16. It is useful for aiding in diagnoses and intervention planning for particular disorders including ADHD and LD (Kemp, Korkman & Ursula, 2000). 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).

Bender Gestalt II (Bender Visual-Motor Gestalt Test)

Purpose use and age:

The Bender Gestalt Visual-Motor Gestalt Test measures visual-motor integration skills in children and adults ages 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 Gestalt II has been used for the identification of intellectual disabilities, reading difficulties, and personality dynamics; diagnosis of organic brain abnormality, psychotic dysfunction, anxiety states, psychosomatic conditions, sexual disturbances, cultural differences, and psychoneurotic conditions; and 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 (Brannigan & Decker, 2003)and Canter's Background Interference (Canter, 1996).

Interpretation:

The majority of interpretations are directed at organic brain pathology.

Minnesota Multiphasic Personality Inventory-2

Purpose, use and age:

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).

Minnesota Multiphasic Personality Inventory-Adolescent

Purpose, use and age:

The MMPI-A is recommended for adolescents ages 14-18. 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 (Butcher et al., 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)

Millon Clinical Multiaxial Inventory (MCMII-III)

Purpose, use and age:

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. The MAPI is an adolescent and counseling inventory and recommended for age range 9-12; the pre-adolescent inventory (M-PACI), and the adolescent inventory (MACI) for age range 13-19 are additional forms.

Clinical Scales:

Anxiety, Somatoform, Bipolar: Manic, Dysthymia, Alcohol Dependence, Drug Dependence, Posttraumatic 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.

Millon and Davis (1996) stated that the transaction between personality disorders and stressors produces a diagnosis. The assessor is to interview for a separation in moderate versus severe personality scales. A correlation of .66 was found between the Narcissistic scale of the MCMII-III and the Narcissistic Personality Inventory (Torgersen & Alnaes, 1990).

Positive Affect and Negative Affect Scales (PANAS Scales)

The PANAS is considered a mood questionnaire. The characteristics of positive affect (PA) are high energy, enthusiasm, and full concentration, active and alert. Negative affect characteristics may be distress in the form of anger, contempt, disgust, guilt, fear, and nervousness, as well as possibly a lack of coping skills (Watson, Clark, & Tellegen, 1988). The PANAS-X is the 60-item expanded version. The norms include adults and psychiatric population (Watson & Clark, 1994).

Clinician-Administered PTSD Scale (CAPS)

The CAPS is considered one of two instruments most commonly used for assessing PTSD diagnostic accuracy (Blake et al., 1995; Blake, Weathers, Nagy, et al., 1990). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) is considered the goal standard (Weathers, Blake, Schnurr, Kaloupek, Marx, & Keane, 2013). The CAPS assesses for 20 DSM-5 PTSD symptoms. The items focus attention to the onset and duration of symptoms, subjective distress, and impact of symptoms on social and occupational functioning.

PTSD Checklist (PCL)

The PTSD PCL is self-report checklist of 17 items measuring for symptoms in criteria B, C, and D. There are three versions of the PCL: PCL-M (military), PCL-C (civilians), and PCL-S (specific). A critical review of the PCL was conducted by McDonald and Calhoun (2010), who found the PCL to be the most frequently used self-report. The self-report items are to be responded for the past month and on an ordinal scale of 1 (not at all) to 5 (extremely bothersome).

Beck Depression Inventory (BDI-II)

Purpose, use and age:

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 it 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.

Burk's Behavior Rating Scale (BHRS-Revised; Burk, 2008)

Purpose, use and age:

The purpose of the BHRS-2 is to diagnose children and adolescents (age range 4-18) with behavior problems. The BHRS scales include disruptive and emotional scales, social withdrawal, ability deficits,

physical deficits, and weak self-confidence, and attention and self-control problems. Parent and teacher forms are available.

System Check-List-90 (SCL-90-R)

Purpose, use and age:

The SCL-90-R measures change in outcome studies and screens for mental disorders and integrates data into the interview. Schmitz et al. (2000) indicated the SCL-90 is a widely-used symptom inventory. The SCL-R-90 has been researched with clinical trials. Norms are available for adult psychiatric outpatients, adult none clients, adult psychiatric inpatients, and adolescent nonpatients (age range 13-19). Frequently the client has provided stimuli of distress (why in counseling), unsure why they are there, and indicates 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.

Substance Abuse Subtle Screening Inventory (SASSI-3)

Purpose, use and age:

The SASSI-3 is a structured self-report and screens for substance dependent disorder. The adolescent SASSI-A2 (ages 12-18) is designed to provide a probability for substance use disorder. The SASSI-3 was the most widely and important used instrument by addiction counselors (Juhnke, Vacc, Curtis, Coll, & Paredes, 2003).

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 bases and causes of their problems.

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

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

Purpose, use and age:

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). SCID-II has three components: an interview portion for 11 personality disorders, categories of depressive personality disorders, and passive-aggressive personality disorder. It can be used as a screening tool.

Scales:

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

Bipolar Spectrum Diagnostic Scale (BSDS)

Purpose, use and age:

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 a bipolar disorder in individuals ages 5-17 and the Tri-Axial Bipolar Spectrum Screening Quiz is for individuals 18 and older. 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, Boiman, & Goodwin, 2000).

Mood Disorder Questionnaire (MDQ)-SCREENING

Purpose, use and age:

Description: The MDQ is a single report. It is an easy to use screening tool for the detection of bipolar I disorder. Hirschfeld, Williams, Spitzer et al. (2000) developed the questionnaire. The MDQ has three questions, each of which is subdivided 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). The signs and symptoms for a bipolar disorder include depressed, hyperactive, insomnia, mood swings, anxious, irritable, delusional/paranoid, low energy/fatigue, unable to focus, alcohol/substance abuse, legal problems, impulse-control problems, and no complaints (Hirschfeld). The clinician should inquire about past episodes of mania, hypomania, and mood swings.

The Drug Abuse Screening Test (DAST-10, 20) and Short Michigan Alcoholism Test (SMAST)

Purpose, use and age:

Doctors and counselors, to determine if an individual is reflecting symptoms of an addict, often use the DAST. The DAST-10 and DAST-20 (adolescents) are screening tools for adults involved with drugs. The DAST-20 is specifically for adult and female drug users (Stevens & Smith, 2009). 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 5 or less indicates a normal score, while 6 or higher indicates a drug problem.

The Cage Questionnaire

Purpose, use and age:

The CAGE was originally designed for adults and 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.

The Dissociative Experiences Scales (DES)

Purpose, use and age:

The DES is a self-report screening instrument for the identification of clients at high risk for dissociative disorders, especially dissociate identity disorder. The DES is used in tandem with the Structured Clinical Interview (SCID-D). The DES is a 28-question self-test. The SCID-D is the first diagnostic instrument developed for the assessment of five dissociative symptom areas (Steinberg, Rounsaville, & Cicchetti, 1991). An adolescent version of the dissociative experience scale is the Adolescent Dissociative Experiences Scale-II (A-DES; Armstrong, Putnam, Carlson, Libero, & Smith, 1997).

Posttraumatic Stress Disorder

Elhai, Gray Kashdan, and Franklin (2005) reviewed 102 inventories (81 adult, 21 child/adolescents) and reported that the four most popular for clinical use include:

1. Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycoxs, & Perry, 1997)--16%

   The PDS is a 49-item self-report measure that assesses for all symptoms in the DSM-IV, Criteria A-F. The assessment is for the past nine months.
2. Life Events Checklist (LEC)--10%; the LEC was updated to the LEC-5 (Weathers, Blake, Schnurr, Kaloupek, Mar, & Keane, 2013)

   The LEC-5 was updated to meet criteria for PTSD criterion A. The LEC-5 is a self-report that screens for traumatic events during a lifetime. The client responds to 17 items about things (events) that happened to them. The responses include: (a) happened to me, (b) witnessed it, (c) learned about it, (d) part of my job, (e) not sure, and (f) doesn't apply. There are three formats: standard self-report, extended self-report, and interview.
3. Detailed Assessment of Posttraumatic Stress (DAP; Briere, 2004)--9%

   The DAP is a 104-item measure that assesses for trauma exposure and posttraumatic stress. The symptoms measured are for intrusion, avoidance, hyperarousal and associated features.
4. Combat Exposure Scale (CES, Keane, Fairbanks, Caddell, Zerming, Taylor & Mora, 1989)--9%

   The CES is seven-item measure for war-time incidents of wartime stressors. Each item is measured on a 5-point scale ranging from no (1) to more than 50 times (5).

Instruments for Children and Adolescents

Intelligence:

Stanford-Binet Intelligence Scale, 5th edition

Purpose, use and age:

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

Purpose, use and age:

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

Depression

Muller and Erford (2012), in researching assessment instruments administered to school aged children for depression, identified the six most widely utilized depression instruments. These include:

1. Children's Depression Inventory (CDI; Kovacs, 2003)
2. Beck Depression Inventory (BDI; Beck et al., 1996)

3. Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960; Hamilton & Kobak, 1995)
4. Child Behavior Checklist Internalizing Scale and Anxious Depressed Subscale (CES-D; Achenbach & Rescoria, 2001)
5. Center for Epidemiologic Studies Depression Scale (Radloff, 1977)
6. Reynolds Depression Scale-Second Edition (RADS-2; Reynolds, 2002).

The BDI, CES-D, and RADS-2 are self-report inventories. The ASEBA and RAD-2 are norm-referenced tools, while the BDI-II, CES-D are criterion-referenced instruments.

David-Ferdon and Kaslow (2008) evaluated evidenced-based treatments for children and adolescents. In reviewing 28 Type I and 2 efficacious studies they reported that The Children's Depression Inventory was the most often used self-report measure with the Schedule for Affective Disorders and Schizophrenia for Children frequently noted (K-SADS; Chambers et al., 1985).

Children's Depression Inventory (CDI 2; Kovacs, 2003)

Purpose, use and age:

There are four versions to the CDI: a short form of 10 items, a teacher version of 12 items, a parent form of 17 items, and the original form of 27 items. The self-report form is designed for ages 7-17 and is translated into 23 languages.

Instructions for the parent and teacher form are to answer for the past two weeks and administration time is approximately fifteen minutes to be administered. The CDI in Erford's meta-analysis study was the most widely used for depression in children and adolescents. The CDI is self-rated and is to identify depressive symptoms in children. It can also be used as an adjunct for diagnosing clinical depression. These categories are major depressive (MDD), dysthymic disorder renamed Persistent Depressive disorder, depressive disorder (NOS), renamed specified or unspecified, and adjustment disorder with depressed mood.

Children's Depression Inventory is a self-rated scale for parents about their children. The purpose is to identify depressive symptoms in children from ages 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 (PDD), depressive disorder not otherwise specified (NOS) and adjustment disorder with depressed mood.

Revised Children's Manifest Anxiety Scale (RCMAS-2; Reynolds & Richmond, 2008)

Purpose, use and age:

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 ages 6 to 9. The major scales are worry, defensiveness, physiological anxiety and social anxiety.

Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorila, 2001)

Purpose, use and age:

The ASEBA assesses for behavioral and emotional disorders in children (ages 1.5 to 18), school age (6 to 18), and adults to age 90 (Achenbach & Rescoria, 2001). The scales on the ASEBA have been

translated into 61 different languages. Factors assessed are withdrawn/depressed, somatic complaints, anxious/depressed, social problems, attention problems, rule-breaking behavior, and aggressive behavior. Internalizing and externalizing scales are the two broad scales. Subscales include Attention Deficit/Hyperactivity problems, Anxiety problems, Oppositional Defiant problems, Affective problems, Conduct problems, and Somatic problems (Erford, 2013). Specific scales measured are Competence and Adaptive, including activities that are academic, social, work and school behaving. Empirically–based scales are anxious/depressed, withdrawn/depressed, somatic complaints, social problem, and thought problems. Rule-breaking behavior includes aggressive behavior, internalizing, externalizing and total problems. DSM-oriented scales are affective, anxiety, somatic and ADH, including oppositional defiant and conduct problems.

Behavior Rating Inventory of Executive Function (BRIEF)

Purpose, use and age:

The BRIEF was developed in 2000 and covers the broad age range of 6 to 18 years and measures areas of learning disabilities, attention disorders, traumatic brain injuries, lead exposure, pervasive developmental disorders, depression, and other neurological, psychiatric and medical conditions (Gioia, Isquith, Guy, & Kenworthy, 2000).

Behavior Assessment System for Children, Second Edition (BASC-2)

Purpose, use and age:

The BASC-2 can be used to evaluate the behavior and self-perceptions of children ages 6 to11. 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 (Reynolds & Kamphaus, 2004). The BASC was designed for ages 2.5 to 25.

Conners 3 (Parent, Teacher and Adolescent forms)

Purpose, use and age:

Teachers and counselors use the Revised Connors' Parent and Teacher Rating Scales (CPSR and CTRS-R; Conners, Sitarenios, Parker, & Epstein, 1998). The 2008 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. Pediatricians in their practice frequently use the Connor forms.

The purpose of the Conners 3 is to screen and assess behavior problems. It is a clinical tool for obtaining parental, teacher and adolescent reports of childhood behavior problems.

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 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.

Reynolds Adolescent Depression Scale (RADS-2)

Purpose, use and age:

The RAD-2 is a self-report screening tool for depressive symptoms in adolescents ages 11 to 20. It takes approximately 10 minutes to administer. The four factors that underlie the RADS-2 are dysphoric mood, anhedonia/negative affect, negative self-evaluation, and somatic complaints. The RADS-2 was ranked sixth in the meta-analysis of most widely-used depression inventories.

Center for Epidemiologic Studies Depression Scale (CES-D)

Purpose, use and age:

Radloff (1991) developed the CES-D, a 20-item assessment for individuals 14 years and older as a screening tool for depressive symptoms. The CES-D was ranked fifth in the meta-analysis of most widely-used depressive inventories.

Burk's Behavior Rating Scale (BHRS-Revised; Burk, 2008)

Purpose, use and age:

The purpose of the BHRS-2 is to diagnose children and adolescents (ages 4-18) with behavior problems. The BHRS scales include disruptive and emotional scales, social withdrawal, ability deficits, physical deficits, and weak self-confidence, and attention and self-control problems. Parent and teacher forms are available.

Hamilton Behavior Rating Scale for depression (HAM-D; Hamilton, 1960)

Purpose, use and age:

The HAM-D is designed to measure the severity of symptoms of individuals (primarily adults but can be used for all ages) who have already been diagnosed with depression. The results are based on the skill of the interviewer. The HAM-D has 21 questions. The Hamilton Rating Scale was ranked third in Erford's meta-analysis in most widely utilized depression scales (Hamilton, 1960).

Disorders (Selected)

Oppositional Defiant Disorder

Erford, Paul, Oncken, Kress, and Efrord (2014) identified and conducted a meta-analysis with 31 studies in which instruments were used to assess for oppositional defiant behavior to determine the most widely-used instruments for children. The three most widely used include: (1) The Child Behavior Checklist--58%, (2) Eyberg Child Behavior Inventory--35%, and (3) direct observations of oppositional symptoms--32%.

Substance Use Disorder

Juhnke, Vacc, Curtis, Coll, and Paredes (2003) surveyed 350 addiction counselors for the most widely-used and most important instruments for addiction. The instruments identified as the most widely used included (rank order): Substance Abuse Subtle Screening Inventory (SASSI), Michigan Alcohol Screening Test (MAST), Beck Depression Inventory (BDI), Minnesota Multiphasic Personality Inventory-2 (MMPI), and the Addiction Severity Index (ASI). The instruments considered to be of ranked importance included SASSI, BDI, MMPI-2, ASI, and MAST.

Posttraumatic Stress Disorder

Elhai, Gray Kashdan, and Franklin (2005) reviewed 102 inventories (81 adult, 21 child/adolescents) and reported that the Trauma Symptom Checklist for Children (TSCC) was most popular and commonly utilized for children (10%).

Differential Diagnosis

Psychiatrists and those trained to conduct a differential diagnosis (systematic method of diagnosing a disorder) utilize a decision tree or symptom tracking. Symptom gathering begins with clinical features such as those found in the presenting complaint and during the assessment interview. 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 "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, it 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) described 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 symptom diagnostic criteria found in the DSM-5. The counselor evaluates orientation, memory, 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

It is important 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.7.a). Informed procedures and client rights are central to the implementation of any treatment under the ACA Code of Ethics. Treatment questions are frequently 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). 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 the treatment and instrumentation section is a brief definition for different therapies and respective acronyms.

The ACA 2014 Code of Ethics makes reference to what the counselor is to do when using treatments that have scientific literature support and what to do when the treatment does not have literature support (ACA, 2014, C.7.a.).

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

Reference II identifies professional articles for select disorders regarding diagnosis, instruments, treatments, and monitoring.

Selected Classifications and Disorders Related to Comorbidity, Differential Diagnosis, Assessment, Treatment, Instrumentation, and Monitoring.

Disorders listed for comorbidity and differential diagnosis, respectively, are those page numbers specific to the DSM-5 (APA, 2013).

1. Neurodevelopmental Disorders

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).

Differential:

ADHD, depressive and bipolar disorders, anxiety disorders, autism spectrum, stereotypic movement, impulse-control, and major neurocognitive disorders.

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

Four disorders were combined in the DSM-5 to form autism spectrum (autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder). The three factors of qualitative impairments in communication, social interaction, and restrictive and stereotyped patterns of behavior (DSM-IV-TR) were combined into two factors, deficits in social communication and social interaction and restrictive repetitive behaviors (King, 2013b).

Comorbidity:

Specific learning difficulties, developmental coordination disorders, medical conditions to include epilepsy, sleep problems, constipation, avoidant-restrictive food intake disorders, intellectual impairment and structural language disorder (Ghaziuddin, Weidmer-Mikhall, & Ghaziuddin, 1983, pp. 58-59)

Differential Diagnosis:

Rett Syndrome, selective mutism, language disorders and social communication disorder, intellectual disability without autism spectrum disorder, stereotypic movement disorder, ADHD, schizophrenia (p. 58)

Treatment:

Intensive behavior treatment (IBT; Odom, Hume, Boyd, & Stabel, 2012), Snug Vest (Watkins & Sparling, 2014), behavioral (no single best behavioral treatment is currently found in the literature), floor technique, Pervasive Development Pivotal Response Training (PRI), response interruption and redirection (RIRD), differential reinforcement of other behavior (DRO; Ahearn et al., 2007).

Rogers and Vismara (2008) conducted an evidence-based review of autism treatments published during the years 1998-2006. Twenty-two randomized controlled design studies were classified according to Chambless et, al. (1996) and Nathan and Gorman (2002) efficacious criteria and definitions. The twenty-two studies consisted of four Type I, six Type 2, eleven Type 3 and one Type 6. According to criteria, efficacious treatment programs include:

Well-established

Lovaas model--Early Intensive behavioral intervention (EIBI; Lovaas, 1981, 1987, 2002). The Lovaas therapy program was approved by the United States General Surgeon's office in 1999. The therapy intervention is applied behavioral analysis (ABA).

Possibly efficacious

None

Probable efficacious

Focused Parent Training (FPT): Caregiver-based intervention. Special child care worker assigned, 15 hour classes over 12 week communication development. The focus is compliance, mutual enjoyment, joint attention and language (Jocelyn, Casiro, Beattie, Cox, & Kneisz, 1998).

Relationship Development Intervention (RDI): Parent-training intervention (PTI): Home-based, parent-delivered developmental social communication intervention; Drew, Baird, Baron-Cohen, Cox, Solonims, Wheelwright et al., 2002)

Parent-implemented Training (PIT): Social communication intervention (community care, speech and social skills training, manualized, parent-delivered program language intervention; Aldred, Green, & Adams, 2004)

Tellegen and Sanders (2014) conducted a single randomized control trial efficacy treatment study. They reported efficacious outcomes for Primary Care Stepping Stones' Triple P. Triple P is four brief sessions devoted to reducing child problems and improving parent styles, parenting satisfaction, and parental adjustment.

Other treatments include: Intensive behavior treatment (IBT; Odom, Hume, Boyd, & Stabel, 2012), Snug Vest (Watkins & Sparling, 2014), behavioral (no single best behavioral treatment is currently found in the literature), floor technique, Pervasive Development Pivotal Response Training (PRI), response interruption and redirection (RIRD), differential reinforcement of other behavior (DRO; Ahearn et al., 2007).

Instrumentation:

Childhood Autism Rating Scale (CARS; Schopler, Reichler, DeVellis, & Daly, 1988, 1991) is the most widely used. Pervasive Developmental Disorders Screening Test II (PDDST-II, ages 12 to 48 months), Siegel (2004), Autism Diagnostic Interview (ADI; Lord, Rutter, & LeCouter, 1994), Autism Observation Schedule (ADOS; Lord et al., 2000), The Vineland Adaptive Behavior Scales (Sparrow, Balia, & Cicchetti, 1984), The MacArthur Communicative Developmental Inventory (Fenson et al., 1993), Individual Education Plan (IEP). The Social Communication Questionnaire, Taylor and Jasper's Social Skills Inventory (Maurice, Green, & Foxx, 1996). Specific training includes making eye contact, taking turns, initiating greetings, answering social questions, employing empathy, asking questions, and relating to peers. Montgomery-Asberg Scale (Montgomery & Asberg, 1979).

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 (ACA, 2013, p. 65).

Adult ADHD--Intermittent explosive disorder, substance use disorder, antisocial personality disorder, obsessive-compulsive disorder, tic disorders, and autism spectrum (APA, 2005). Spencer, Biederman and Wilens (2004) cited antisocial disorder, substance abuse problems, learning disabilities, and mood and anxiety disorders for adults.

Differential Diagnosis:

Oppositional defiant disorder, intermittent explosive disorder, other neurodevelopment disorder, specific learning disorders, autism spectrum disorder, reactive attachment disorder, anxiety disorders, depressive disorders, bipolar disorder, disruptive mood dysregulation disorder

Treatment:

Pelham and Fabiano (2013) conducted an evidence-based systematized evaluation with randomization control therapies (RCT) for ADHD published during 1997-2006. They reported that behavioral parent training (BPT) and behavioral classroom management (BCM) met criteria for well-established.

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

Betchen (2003) recommended for adult ADHD treatment to include education, attention management training, behavioral management training, social skills training, anger management training, and problem-solving training.

Pelham and Fabiano (2008) conducted an evidence-based systematized evaluation with randomized control therapies (RCT) for ADHD published during the years 1997 to 2006. They reported that behavioral parent training (BPT) and behavioral classroom management (BCM) met criteria for well-established.

Instrumentation:

Achenbach Child Behavior Checklist is most commonly used, as well as the Behavior Assessment System for Children, 2nd edition, Conners Rating Scale-Revised (1989) and Conners Teacher Rating Scales-Revised.

Disorder: Tic Disorder

Assessment:

Function-based assessment for tics (FBAT) is recommended for variations of tics (motor and vocal)

Comorbidity:

Medical and psychiatric conditions, ADHD, OCD

Differential Diagnosis:

Obsessive-Compulsive Disorder (OCD)

Treatment:

Comprehensive behavioral intervention for tics (CBIT; Himle et al., 2014).

Instrumentation:

The Yale Global Tic Severity Scale (YGTSS; Leckman et al., 1989), Schizophrenia Spectrum and other Psychotic Disorders

2. Schizophrenia Spectrum and Other Psychotic Disorders

Disorder: Schizophrenia

Comorbidity:

Substance-related disorders, tobacco use, anxiety disorders, and panic disorder

Differential Diagnosis:

Major depressive or bipolar disorder with psychotic features, schizoaffective disorder, delusional disorder, schizotypal personality disorder, OCD, body dysmorphic disorder, PTSD

Treatment:

Holden, Link McQuaid, and Jeste (2013) reported that cognitive behavioral and social skills training are effective treatments for schizophrenia. Psychiatric management, antipsychotic medication, social skills training, family therapy, individual counseling

Instrumentation:

Independent Living Skills Survey (ILSS; Wallace & Liberman, 1985; Wallace, Liberman, Tauber, & Wallace, 2000), Maryland Assessment of Social Competence (MASC; Bellack & Meuser, 1993), Positive and Negative Syndrome Scale (PANSS; Kay, Feizbein, & Opler, 1987), Structured Interview for Psychotic Symptoms (SIPS; Miller, et al., 1999)

Disorder: Schizoaffective

Comorbidity:

Substance use disorders, anxiety disorders

Differential Diagnosis:

Psychotic disorder due to medical condition, schizophrenia, bipolar, depressive disorders, bipolar disorder with psychotic features

Treatment:

Psychoeducation and medication management; therapy is to be concrete and supportive, building social skills; family-focused therapy (Miklowitz, 2004). Turlington (2006) recommended cognitive-behavioral therapy for treatment. Group therapy is not recommended because of lack of social skills. Antipsychotics appear to be effective for schizophrenia, schizoaffective disorder and mood disorders with psychotic features. The atypical agents have a reduced risk for neurologic side effects and it has been noted better patient compliance (Bender, 2008).

3. Bipolar and Relater Disorders

Disorder: Bipolar I

Comorbidity:

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

Differential Diagnosis:

Major depressive disorder, other bipolar disorders, generalized anxiety disorder, panic disorder, posttraumatic stress disorder, substance/medication-induced bipolar disorder, ADHD

Treatment:

CBT, interpersonal therapy, interpersonal and social rhythm therapy with medication, combination family focused and CBT, psychoeducation, medication first line, rhythm therapy, group therapy during recovery, other treatment recommended—DBT has some support

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:

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), 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 disorder, ADHD, and sleep disorders (children-ADHD; p. 141)

Differential Diagnosis:

Bipolar and related disorder due to medical condition, depressive disorder, substance/medication-induced, bipolar disorder I, disorder with rapid cycling, bipolar II with rapid cycling

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 (Angst et al., 2005).

4. Depressive Disroders

Disorder: Adjustment Disorder (6 types)

Comorbidity:

Most mental disorders and medical disorders (p. 289)

Differential Diagnosis:

Major depressive disorder, PTSD, personality disorders

Treatment:

Individual outcome studies recommended brief therapies--solution-focused (de Shazer, 1991), miracle question, DBT, parent management training (when children are the clients), crisis-intervention model--relieving acute symptoms, brief psychodynamic psychotherapy, problem-solving

Instrumentation:

No specific instruments for assessment other than the SCID (First, Spitzer, Gibbon, & Williams, 2002)

Disorder: Disruptive Mood Dysregulation

Comorbidity:

Mood symptoms, oppositional defiant disorder, and ADHD. If children meet symptoms for oppositional defiant disorder or intermittent explosive disorder and disruptive mood dysregulation, only the disorder of disruptive mood dysregulation is to be assigned (p. 160)

Differential:

Bipolar disorder, oppositional defiant disorder, ADHD, major depressive disorder, anxiety disorders, autism spectrum disorder

Treatment:

This disorder is new; however, medication and psychotherapy are recommended until treatment research is available.

Instrumentation:

Disruptive Mood Dysregulation Disorder; Child Behavior Checklist Dysregulation profile (CBCL-DP (Achenbach, 1991a)

Disorder: Major Depressive Disorder

Comorbidity:

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

Differential Diagnosis:

Manic episodes with irritable mood or mixed episodes, substance/medication-induced depressive or bipolar disorder, ADHD, adjustment disorder with depressed mood

Treatment:

CBT, emotion-focused therapy* (three randomized effectiveness control studies; Greenberg, 2010), low level of social functioning, clients perform best with interpersonal psychotherapy (Seligman & Reichman, 2012). Newer therapies include behavioral activation therapy (BAT; Martell, Dimidjian, & Herman-Dunn, 2010), CBT-I (I-insomnia), mindfulness, exercise, and vagus nerve therapy

A promising treatment for major depressive disorder is emotion regulation skills and a skills-based mode of adaptive coping with emotions (ACE) that has been found to be an effective way of coping with negative emotions. For more information see major depressive treatment in Unit 2.

Treatment (Children and Adolescents):

David-Ferdon and Kaslow (2008) conducted a review of empirical studies for depression efficacious. Studies represented the time period of 1988 to 2006. The efficacious evaluation was composed of 28 randomized controlled trial design studies. Two age groups were addressed, 12 and under (10 studies) and 18 adolescent studies (13 and older). The studies for the 12 and under group represented Type 2 efficacy. The adolescent group had 10 Type 1 and 18 Type 2 efficacious ratings.

Well-established: Child group only and child group parent met criteria for well-established.

Probably efficacious: CBT Penn state program, self-control therapy, coping with depressant adolescent, and interpersonal therapy-adolescent met probably efficacious.

Experimental (interventions): Individual video self-monitoring (one study), parent-child (one study), primary and secondary control enhancement training (one study), Stress-Busters (one study), family systems (one study), child group plus parent intervention (one study), systems integrative family therapy (one study), group, child only, relaxation training (one study), child group plus parent/ teacher consultation, social skills training (one study)

Instrumentation:

Beck Depression Inventory, Hamilton Rating Scale, SCID

Instrumentation: Children

Muller and Erford (2012) researched and identified the six most frequently and widely utilized depression inventories for children.

1. Children's Depression Inventory (Kovacs, 2003)--40%
2. Beck Depression Inventory-II (Beck, et al., 1996)--31%
3. Hamilton Rating Scale for Children (Hamilton, 1960)--29%
4. Child Behavior Checklist Internalizing Scale and Anxious/Depressed subscale--24%
5. Center for Epidemiologic Studies Depression Scale--19%
6. Reynolds Adolescent Depression Scale-Second Edition--12%

Disorder: Persistent Depressive Disorder

Comorbidity:

Anxiety disorders and substance use disorders (p. 171)

Differential Diagnosis:

Major depressive disorder, psychotic disorder, depressive or bipolar related disorder due to medical condition, substance/medication-induced depressive or bipolar disorder, personality disorders

Treatment

Cognitive-behavioral therapy, interpersonal therapy, social skills, assertiveness and decision-making

Instrumentation:

Beck Depression Inventory, Steen Happiness Index

5. Anxiety Disorders

Disorder: Separation Anxiety (SAD)

Comorbidity:

GAD, PTSD, panic disorder, generalized anxiety disorder, social anxiety disorder, agoraphobia, OCD, and personality disorders (p. 195)

Differential Diagnosis:

Generalized anxiety disorder, panic disorder, agoraphobia, conduct disorder, social anxiety disorder, PTSD, illness anxiety disorder, bereavement, depressive and bipolar disorder, ODD, psychotic disorder

Treatment:

Children: Individual cognitive behavior therapy (ICBT), group cognitive behavior therapy (GCBT), GCBT with parents, GCBT for social phobia (SOP), and SET-C for SOP (probably efficacious using criteria for efficacious designs and protocols for Types I-V); (Silverman, Pina, & Viswesvaran, 2008).

Individual published evidence-based articles suggest exposure therapy highly effective, cognitive-behavioral most effective, Coping Cat model (manual design)

Instrumentation:

Child's Depression Inventory (ages 7 to 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: Generalized Anxiety Disorder (GAD)

Comorbidity:

Anxiety disorder, unipolar disorder (APA, 2000)

Differential Diagnosis:

Unspecified anxiety disorder, anxiety disorder due to another medical disorder, substance/ medication-induced anxiety disorder

Treatment:

Cognitive-behavioral therapy (cognitive restructuring) is frequently used, behavior therapy, acceptance-based behavior therapy** (ABBT; Roemer, Orsillo, & Salters-Pedneault, 2008)

Instrumentation:

GAD-7 (Spitzer, Kroenke, Williams, & Lower, 2006; screener), GAD-Q-IV (Newman et al., 2002), the Penn State Worry Questionnaire (PSWQ, PSWQ-A; Wuthrich, Johnco, & Knight, 2014). The PSWQ is a 16-item questionnaire designed to address severe worry and the PSWQ-A for adults is an 8-item measure. Beck Anxiety Inventory, Anxiety Disorders Interview Schedule (Brown et al., 1994)

Disorder: Social Anxiety Disorder (Social Phobia)

Comorbidity:

Other anxiety disorders, major depressive disorder, substance use disorders (APA, 2013, p. 208)

Differential Diagnosis:

Shyness, agoraphobia, panic disorder, generalized anxiety disorder, separation anxiety disorder, specific phobias, major depressive disorder

Treatment:

GCBT for social phobia (SOP). CBT is an empirically supported treatment for social anxiety; however, if the client remains symptomatic an alternative treatment based on a randomized clinical trial study ACT is recommended (Craske, Niles, Burklund, et al., 2014). Clark Ehlers, Hackmann, et al. (2006) recommended applied relaxation and cognitive therapy as treatment for social phobia.

Instrumentation:

Social Phobia Weekly Summer Scale (SPWSS: Clark, Ehlers, McManus, et al., 2003), Social Cognitions Questionnaire (SCQ; cited in Wells, Stopa, & Clark, 1993)

Disorder: Panic Disorder

Comorbidity:

Anxiety disorders, major depressive disorder, bipolar disorder, mild alcohol use

Differential Diagnosis:

Unspecified anxiety disorder, specified anxiety disorder, substance/medication-induced anxiety disorder, specific phobia, separation anxiety disorder, social anxiety disorder, acute stress disorder, PTSD, major depressive disorder, other medical conditions

Treatment:

Cognitive-behavioral therapy treated in 8-12 sessions (Addis et al., 2006; Levitt, Emily, Hoffman, Grisham, & Barlow, 2001). Brief cognitive therapy (Clark, Salkovskis, Hackmann, et al., 1999)

Instrumentation:

Panic Disorder Severity Scale (Shear et al., 1997) social anxiety, depressive disorder, PTSD, alcohol use disorder

6. Obsessive-Compulsive and Related Disorders

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)

Differential:

Neurodevelopment disorders, psychotic disorder, another medical condition, substance-related disorder

Treatment:

Exposure and response prevention therapy is first choice (Simpson, Maher, Wang, et al., 2011). Should exposure and response prevention therapy be rejected by the client (25% do reject; Woo & Keatinge, 2008), cognitive behavioral therapy specifically targeting errors in thinking may be employed, as well as reframing. ACT has been used; however, is lacking research effectiveness.

Children: Exposure-based ICBT (probably efficacious), family-focused ICBT and family-focused GCBT (possibly efficacious)--21 studies evaluated by Barrett et al. (2008) using criteria for efficacious designs and protocols (Types I-VI).

Instrumentation:

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

Disorder: Body Dysmorphic

Comorbidity:

Major depressive disorder, social anxiety disorder, OCD, substance-induced related disorders

Differential Diagnosis:

Eating disorders, OCD, illness anxiety disorder, major depressive disorder, anxiety disorders, psychotic disorders

Treatment:

CBT, Cognitive therapy (CT), reflective therapy, and group therapy

Instrument:

The Brown Assessment of Beliefs Scale (Eisen et al., 1998)

Disorder: Trichotillomania (TTM; Hair-Pulling)

Comorbidity:

Major depressive disorder, excoriation disorder, mood disorders, anxiety disorders, substance use disorders, eating disorders, personality disorders in adults, disruptive behavior in youth.

Differential Diagnosis:

OCD-related disorders, neurodevelopment disorders, psychotic disorder, another medical condition, substance-related disorders

Treatment:

Treatment should be individually tailored to the client with an established baseline and to begin at the start of the response chain. Response interruption is another strategy to eliminate the hair pulling.

Habit reversal is an empirically supported behavioral approach (Enos & Plante, 2001). The client is encouraged to self-monitor through record keeping of urges and emotions experienced. Cognitive therapy (Diefenbach, Reitman, & Williams, 2000; Gluhoski, 1995; Stein et al., 1995), group therapy (Diefenbach et al., 2000),

Instrument:

Harrison and Franklin (2012) list the following instruments for assessment: Trichotillomania Diagnostic Interview, NIMH Trichotillomania Questionnaire, Trichotillomania Scale for Children (TSC-C, TSC-P, child and parent), Milwaukee Inventory of Subtypes of Trichotillomania (MIST-A and MIST-C for adult and child), and Massachusetts General Hospital Hairpulling Symptom Severity Scale (MGH-HS), The Premonitory Urge for Tics Scale (PUTS)

7. Trauma-and-Stressor-Related Disorders

Disorder: Posttraumatic Stress Disorder (PTSD)

Comorbidity:

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

Differential Diagnosis:

Adjustment disorder, acute stress disorder, anxiety disorder, OCD, major depressive disorder, personality disorder, dissociative disorder, conversion disorder

Treatment:

CBT, evidence-based prolonged exposure therapy (Bryant, et., 2006; Foa, et al., 2005; Shnurr et al., 2007; Foa, Keane, Friedman, & Cohen, 2009), emotion focused cognitive-behavioral, trauma focused CBT (sexually abused children), although prolonged exposure therapy is considered the best treatment of choice (Foa, Keane, & Friedman, 2000). EMDR evidence-based meta-analysis (Bisson et al., 2007; Bradley, Greene, Russ et al., 2005; Lee 2008), Cognitive processing therapy (CPT) is recommended for survivors of sexual assault and traumatic brain injury and for PTSD. It has also been used for anxiety management training. Other treatments for PTSD include group, family therapy, and stress inoculation training.

Evidence-based Treatment (Child and Adolescents)

Evidence-based treatment for children and adolescents exposed to trauma was evaluated by Silverman et al. (2008) for effectiveness. The study covered the years 1992 to 2006. The authors analyzed 23 peer-reviewed studies regarding sexual abuse (eleven studies), physical abuse (three), community violence (one), major hurricane (one), marital violence (one), and vehicle accident (one). Seven of the studies were classified as Type 2 and 16 Type 1.

Well-established (WE): Trauma-focused behavioral therapy (TF-CBT)

Probably efficacious: School-based group cognitive-behavioral, cognitive-behavioral intervention in schools

Possibly efficacious: Resilient Peer Treatment (RPT), Family Therapy (FT), Client-Centered Therapy (CCT) Cognitive-Processing Therapy, Child-Parent Psychotherapy (CPP), Cognitive-Behavioral Therapy for PTSD, Eye Movement Desensitization and Reprocessing (EMDR)

Instrumentation:

Posttraumatic Checklist (PCL). The PCL is cited as the most widely used instrument for PTSD (Grubaugh, Elhai, Cusach, Wells, & Freuh, 2007). Trauma Symptom Checklist for Children, Beck Anxiety Inventory (neurophysiological, subjective, panic related and autonomic), the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995), the PTSD Checklist (Blanchard et al., 1996).

Elhai, Gray, Kashdan, and Franklin (2005) conducted a survey to determine the most commonly used instruments to measure event exposure and effects for PTSD. The survey was comprised of 41 inventories (10 clinically administered, 31 self-administered). The most popular instruments for adults in clinical use include: Clinician Administered PTSD Scale (CAPS), Trauma symptom Inventory (TSI), PTSD Checklist (PCL), PDS, Keane PTSD Scale, Impact of Event Scale, and revised version (IES-R), and Checklist 90-R's PTSD Subscales

Elhai et al. (2005) found the most popular for children was the Trauma Checklist for Children (TSCC). For children: K-SADS PTSD section, Child Behavior Checklist (Achenbach, 1991), Childhood Trauma Questionnaire (Bernstein et al., 1998), Psychometric Evaluation of the Children's Impact of Traumatic Events Scale-Revised (Chaffin & Shultz, 2001)

8. Dissociative Dissorders

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)

Differential Diagnosis:

Major depressive disorder, bipolar disorder, PTSD, psychotic disorders

Treatment:

Long-term individual psychotherapy has been found to be effective but is rarely used because of the time limitations that prevail at this time. Brand et al. (2009) recommended individual therapy and medication (antidepressants and anxiolytic medications).

Instrumentation

Sue, Sue, and Sue (2006) indicated that diagnosis with instruments has been difficult with psychological and physiological tests (EEG, galvanic skin response and cerebral blood flow). Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID), Dissociative Disorder Interest Scale (DDIS), Dissociative Experience (DES; Bernstein & Putnam, 1986), Cambridge Depersonalization Scale (Sierra & Berrios, 2000). Includes social role, gender identification, sexuality and body. Structured Clinical Interview for Depersonalization and Derealization Spectrum

9. Somatic Symptom and Related Disorders

Disorder: Somatic Symptom Disorder (Briquet's syndrome)

Comorbidity:

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

Differential Diagnosis:

Panic disorder, GAD, panic disorder, depressive disorders, illness anxiety disorder, conversion disorder, delusional disorder, body dysmorphic disorder, OCD

Treatment:

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

Instrumentation:

Anxiety Disorders Interview Schedule (ADIS-IV-L; DiNardo, Brown, & Barlow, 1994)

Disorder: Factitious Disorder

Comorbidity:

None in the DSM-5

Differential Diagnosis:

Somatic symptom disorder, malingering, conversion disorder, borderline personality disorders (p. 326)

Assessment:

Factitious symptoms include: dramatic but inconsistent medical history; unclear symptoms that are not controllable, become more severe, or change once treatment has begun; predictable relapses following improvement; extensive knowledge of hospitals and/or medical terminology; presence of many surgical scars; appearance of new or additional symptoms following negative results; presence of symptoms only when the client is alone or other procedures, willingness or eagerness to have medical tests or operations; history of seeking treatment at many hospitals, clinics and doctors; and reluctance to allow health care workers to meet with or talk to family members or prior health workers (Health Hub, 2013).

Treatment:

Stress management is helpful, although there is a lack of reported and identified therapies known to be effective

Instrumentation:

Clinical interview. Carter (2013) recommended instruments for malingering to include: Test of Memory Malingering (TOMM), Word Memory Test, Computerized Assessment of Response Bias,

Portland Digit Validity Test, Victoria Symptom Validity Test, MMPI-2 (most scales), and Structured Interview Report Symptoms (SIRS)

10. Feeding and Eating Disorders

Comorbidity

Social phobia, OCD, generalized anxiety disorder (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004) and PTSD and schizophrenia (Blinder, Cumella, & Sanathara, 2006).

Treatment:

Emotion-focused therapy, 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), Development of the Body Checking Questionnaire (Reas, Whisenhunt, Netemeyer, & Williams, 2002)

Disorder: Anorexia Nervosa

Comorbidity:

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

Differential Diagnosis:

Medical conditions, major depressive disorder, schizophrenia, substance use disorders, social anxiety, OCD, body dysmorphic disorder, bulimia nervosa, and avoidant/restrictive food intake disorder

Treatment:

Maudsley family-based, multidisciplinary approach, cognitive-behavioral therapy, DBT, group therapy, transdiagnostic approach, interpersonal psychotherapy and family therapy.

Treatment (child and adolescent)

Keel and Haedt (2008) conducted an efficacious study for eating disorders and identified Type 1 and Type 2 treatments.

Well established (WE): Family therapy

Probably efficacious: None

Possibly efficacious: Psychoanalytic therapy, Cash's Body Image Therapy, Family therapy for BN, CBT Guided Self-Care for Binge Eating in BN.

Instrumentation:

Questionnaire on Eating and Weight Patterns-Revised (QEWP-R), Development of the Body Checking Questionnaire (Reas, Whisenhunt, Netemeyer, & Williams, 2002)

Disorder: Bulimia Nervosa

Comorbidity:

Depressive symptoms, bipolar nervosa, depressive (p. 349)

Differential Diagnosis:

Anorexia nervosa, binge eating disorder, Kleine-Levin syndrome, major depressive disorder with atypical features, borderline personality disorder

Treatment:

Manualized-based CBT treatment is preferred and DBT for BED, IPT, CBT (greater decreases in vomiting and restraint), medication (fluoxetine-restraint, weight concern, food preoccupation improvement in nutritional management, decreases in binge eating and vomiting, abstinence from binge eating and medication) (fluoxetine-restraint, weight concern, food preoccupation improvements; Shapiro et al., 2007), trazodone decreases in frequency of binge eating, vomiting, and in fear of eating, and anticonvulsants--greater reduction in number of binge/purge days and in body dissatisfaction, drive for thinness

DBT, CBT, focus on therapeutic alliance, reducing negative affect, modifying eating behaviors, and identifying situations that trigger behavior (Maine, Davis, & Shure 2009)

Instrumentation

Eating Disorder Inventory (EDI; Garner & Garfinkel, 1979; Garner, et al., 1982; Garner, Olmstead, & Polivy, 1983)

Disorder: Binge Eating

Comorbidity:

Bipolar disorders, depressive disorders, anxiety disorders, substance use disorders (p. 353)

Differential Diagnosis:

Bulimia nervosa, obesity, bipolar and depressive disorders

Treatment:

Cognitive behavior therapy (Fairburn, 2008), interpersonal therapy (Wilson et al., 2007), DBT (Wilson et al., 2007).

Instruments:

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).

11. Sleep-Wake Disorders

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-occurring:

Depressive and anxiety disorders. King (2014h) listed other co-existing conditions including 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, together with sleep and circadian disorder.

Treatment:

Psychopharmacologies, CBT, bright light therapy, sleep education, sleep hygiene, and sleep restriction, stimulus control, cognitive restriction, paradoxical intension, relaxation and relaxation therapy (Riemann, Fischer, Mayer, & Peters, 2003).

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, and 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/practice/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, Reilly, & Midkiff, 1989), Sleep timing Questionnaire (Monk et al., 2003), Sleep History Questionnaire (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.

Disorder: Insomnia

Comorbidity:

Medical conditions (diabetes, heart disease, chronic pulmonary disease, arthritis, fibromyalgia

Differential Diagnosis:

Normal sleep variations, acute insomnia, delayed sleep, restless leg syndrome, breathing-related sleep disorders, narcolepsy, and parasomnias

Treatment:

CBT-I (stimulus control, sleep restriction, and common sense). Milner and Belicki (2010) reported that treatment for insomnia includes physical and psychological approaches. Physical approaches included pharmacology and bright light therapy. Psychological approaches include CBT (most effective), bibliotherapy, sleep education, sleep hygiene, sleep restriction, cognitive restructuring, paradoxical intention, and relaxation therapy (common technique). Pharmacological treatment using hypnotic and antidepressant medications are also common (trazodone and amitriptyline). There is no clinical evidence that relaxation therapy is effective (Edinger, Wohlemuth, Radthke, Marsh, & Quillian, 2001).

Instrumentation:

Duke Structured Interview for Sleep Disorders (DSISD), Structured Interview for Psychiatric Disorders, Patient Version (SCID-P), Insomnia Symptom Questionnaire (ISQ; Spielman, Saskin, & Thorpy, 1987)

12. Sexual Dysfunctions

Disorder: Female Sexual Interest/Arousal Disorder

Comorbidity:

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

Differential Diagnosis:

Nonsexual mental disorders (depressive disorders), substance/medication use, another medical condition, interpersonal factors, other sexual dysfunctions, absent sexual stimuli

Treatment:

Education, Eros clitoral therapy device (increases blood flow), emotion-focused therapy, couples and group therapy can be appropriate, relational therapy, 12-Step program modeled after Alcoholics Anonymous, Sex Addicts Anonymous, Sexual Compulsives Anonymous and Sex and Love Addicts

Instrumentation:

Brief Sexual Checklist, the Sexual Interest and Desire Inventory-Female (SIDI-F), the Sexual Opinion Survey (SOS; White, Fisher, Byrne, & Kingma, 1977), Sexual Dysfunction Scale (McCabe, 1998), Sexual Desire Inventory (Spector, Carey & Steinberg, 1996) and the Early Sexual Experiences Checklist (Miller, Johnson, & Johnson, 1991) used to detect unwanted sexual experiences before age 16. Interview for Sexual Functioning (DISF; DeRogatis, 1994, 1997) in five domains (sexual fantasy and cognition, sexual behavior and experiences, orgasm, sexual drive, and sexual arousal).

13. Disruptive Impulse-Control and Conduct Disorders

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. 475).

Differential Diagnosis:

Oppositional defiant disorder, ADHD, depressive disorders, bipolar disorder, intermittent explosive disorder, adjustment disorder

Treatment:

Problem-solving skill training (PSST), dysregulation, impulsivity social skills, anger management, and parent management.

Treatment (children & adolescents): Evidence-based efficacious treatments include:

Well-established efficacious: Parent management training Oregon mode (PMTO).

Probably efficacious: Anger control training, group assertive training, helping the noncompliant child (HNC), incredible years parent training (IY-PT), Incredible years child training (IY-CT), incredible years (IY), multidimensional treatment foster care (MTFC), multisystemic therapy (MST), parent-child interaction therapy (PCIT), positive parenting program, Triple Penhance treatment, problem-solving skills training (PSST), PSST + practice, PSST + parent (PSST + PMT), rational-emotive mental health program (REMH)

Other studies report problem-solving skill training (PSST), dysregulation, impulsivity social skills, anger management, and parent management

Instrumentation:

Achenbach Child Behavior Checklist is most widely 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, and substance use disorder (p. 466)

Differential Diagnosis:

Conduct disorder, ADHD, depressive disorder, bipolar disorder, disruptive mood dysregulation, intermittent explosive disorder, intellectual ability disorder, and social anxiety disorder

Treatment:

Evidence-based efficacious studies include:

Well-established efficacious: Parent Management Training Oregon mode (PMTO).

Probably efficacious: Anger control training, group assertive training, helping the noncompliant child (HNC), incredible years parent training (IY-PT), Incredible years child training (IY-CT), incredible years (IY), multidimensional treatment foster care (MTFC), multisystemic therapy (MST), parent-child interaction therapy (PCIT), positive parenting program, Triple P enhance treatment, problem-solving skills training (PSST), PSST + practice, PSST + parent (PSST + PMT), rational-emotive mental health program (REMH)

Individual studies with empirical support include family intervention.

Family intervention (Lonigan, Ebert, & Johnson, 1998), group counseling (Nitkowski, Petermann, Buttner, Krause-Leipoldt, & Peterman, 2009), problem-solving skills training (PSST), cognitive, behavioral (Owens, Richerdson, Bellsteikn, et al., 2005), individual therapy

Instrumentation:

Erford, Paul, Oncken, Kress, and Erford (2014) researched and conducted a meta-analysis with 31 articles and reported that the Child Behavior Checklist was used in 58% of the assessments and Eyberg Child Behavior Inventory in 35% of the assessments. Achenbach Child Behavior Checklist is widely used, as well as the Behavior Assessment System for Children, 2nd edition, Conners Teacher Rating Scales-Revised (Achenbach, 1991c).

14. Substance-Related and Addictive Disorders

Disorder: Alcohol Use Disorder

Comorbidity:

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

Differential Diagnosis:

Nonpathological use of alcohol, sedative, hypnotic or anxiolytic use disorder, conduct disorder in childhood and adult antisocial personality disorder

Treatment:

Evidence-based treatment for adolescent substance abuse was evaluated by Waldron and Turner (2008) for effectiveness. The authors analyzed 17 peer-reviewed empirical studies published during the years 1998 to 2006. From the 17 studies representing 46 interventions, 14 were classified as well-established (Type 1) and three probably efficacious. Interventions included individual CBT (seven replication studies), group CBT (thirteen replications), family therapy (seventeen replications), and nine minimal control condition studies. The results included:

Well-established (WE): Multidimensional family (MDFT), functional family therapy (FFT), group CBT

Probably efficacious: Multisystematic therapy (MST), brief strategic family therapy (BSFT), Behavior family therapy (BFT)

Individual published researchers recommended combined behavior interventions-motivation enhancement, cognitive therapy, social skills training, cognitive restructuring, relaxation training, stress management, 12-Step, and 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)

15. Neurocognitive Disorders

Disorder: Delirium

Comorbidity:

None provided in the DSM-5

Differential Diagnosis:

Psychotic disorders, bipolar and depressive disorders, acute stress disorder, diagnosis includes acute stress disorder, malingering and factitious disorder, other neurocognitive disorders (p. 601)

Treatment:

Logsdon, McCurry, and Teri (2007) reviewed fifty-seven randomized clinical trials, of which fourteen recommended environmental interventions (bright light, music or white noise therapy), pet therapy, aromatherapy, and educational intervention (direct care nursing-dressing or bathing). Medical and neurological assessment, psychotherapy and medication (slow the process), eliminate causal factors; medications causing side effects, metabolic disorders, etc.

Instrumentation:

None provided, Mental Status Examination and neurology referral

Disorder: Major or minor neurocognitive disorder (Dementia)

Comorbidity:

Age related diseases and delirium (p. 610)

Differential Diagnosis:

Normal cognition, delirium, major depressive disorder

Treatment:

Medication to slow the progression, support for caregivers

Instrumentation:

Comprehensive medical and neurological assessment, Geriatric Depression Scale (GDS; Yesavage, Brink, Rose, et al., 1983)

16. Personality Disorders

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

Treatment:

Psychodynamic, cognitive-behavioral, DBT, mindfulness, metallization-focused, schema therapy (Young, 1999; Young, Klosko, & Weishaar, 2003). Friedel (2004) indicated the following treatments for borderline personality disorders: (a) support therapy, (b) supportive psychotherapy, (c) cognitive-behavioral therapy, (d) dialectical behavior therapy, (e) interpersonal psychotherapy, (f) systems training for emotionally predictability and problem solving (STEPPS), (g) psychodynamic psychotherapy, (h) integrated psychotherapy, (i) mentalization-based therapy (MBT), and (j) group therapy.

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview, Level 2 DSM-5 Personality

Cluster A: Appear Odd or Eccentric

Disorder: Paranoid Personality Disorder

Treatment:

Minimal effectiveness studies available, individual treatment preferred, cognitive therapy, group therapy rarely recommended

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder: Schizoid Personality Disorder

Treatment:

Schema therapy (Young, 1999; Young, Klosko et al., 2003), behavioral techniques such as social and communication skills

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder: Schizotypal Personality Disorder

Treatment:

Supportive therapy, 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 Personality Disorder

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, metallization-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 Personality Disorder

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, especially schema-focused therapy (SFT) group (Farrell, Shaw, & Webber, 2009), and psychodynamic psychotherapy has one study equal to DBT

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder: Histrionic Personality Disorder

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-2, Structured Clinical Interview

Disorder: Narcissistic Personality Disorder

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 Personality Disorder

Treatment:

Randomized and control trials effective for psychodynamic psychotherapy (Gottdiener, 2006). Behavioral interventions, schema-focused therapy, group therapy, and family therapy may be helpful.

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder: Dependent Personality Disorder

Treatment:

Psychodynamic, cognitive-behavioral therapy, and schema therapy can be helpful

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder: Obsessive-Compulsive Personality Disorder

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, and Structured Clinical Interview

Reality Impairment

Disorder: Brief Psychotic

Comorbidity:

Schizophreniform and brief psychotic disorder share many symptoms and may resemble schizophrenia and delusional disorder. Brief psychotic disorder is considered rare; however, usually begins in adolescence (Sadock & Sadock, 2007).

Differential:

Substance-related disorders, depressive and bipolar disorders, other psychotic disorders

Treatment:

Schizophrenia, schizophreniform, delusional, and schizoaffective--randomized and control trials indicate behavior and psychosocial therapies are preferred for schizophrenia (Gottdiener, 2006), along with antipsychotic medications. Crisis intervention is helpful, as these clients are often in crises. Clients diagnosed with schizophrenia and psychotic symptoms treated with medication should also be

treated with CBT (Dixon et al., 2010; Kuipers et al., 2006) and ACT (Bach, Hayes, & Gallop, 2012) to reduce the severity of symptoms.

Instrumentation:

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

Disorder: Schizophrenia

Comorbidity:

Tobacco use disorder, anxiety disorders (OCD, panic disorder), schizotypal

Differential Diagnosis:

Major depressive or bipolar disorder, schizoaffective disorder, schizophreniform disorder and brief psychotic disorder, delusional disorder, schizotypal personality disorder (p. 104)

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, Fiszbein, & Opler, 1987), Structured Interview for Psychotic Symptoms (SIPP; Miller et al., 1999)

Disorder: Schizoaffective

Comorbidity:

Substance-use disorders, anxiety disorders, medical conditions (APA, 2013, p. 110)

Differential:

Psychotic disorder due to another medical condition, schizophrenia, bipolar, and depressive disorders, (APA, 2013, p. 109)

Treatment:

Psychotherapy (concrete, supportive, build social skills), family-focused therapy where appropriate family systems exist, psychoeducation, medication management

Treatment: Couples

Emotion-focused therapy, relational (clinical attention):

Treatment Definition

Acceptance Commitment Therapy (ACT):

ACT's principles and techniques involve interoceptive exposure, mindfulness meditation, DBT, and ACT. These therapies target thoughts and combine acceptance, compassion, and commitments to

achieve goals. ACT teaches acceptance of thoughts, choosing goals that honor 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 (1985) used a five-stage AWARE process (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 leading to 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 (1993). 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.

Copying Cat

A manualized approach that prescribes 16 to 20 sessions, the first half of which focuses on psychoeducation, emotional awareness, relaxation and cognitive restructuring, while the latter half focuses on facing fears through exposures (Kendall, 2000). Child behavior therapy program ("copying cat") was designed to target anxiety disorders in general among children but especially SAD (Flannery-Schroeder & Kendall, 2000). Strategies or techniques for the treatment include psychoeducation, exposure to feared stimuli or situations, developing plans for anxiety coping skills, and homework assignments. Social reinforcement is used by the therapist during the recommended 16 sessions. Eight of the sessions are training sessions and in the final eight sessions the child practices new skills in imagery and real-life situations.

Dialectical Behavior Therapy (DBT)

Marsha Linehan indicated DBT theory development started with her research and interest in suicide and eventually 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. The goal for DBT is to develop a balance in tensions existing between dependency versus independency and emotional control versus emotional tolerance, and trust versus suspicion. Behavior targets or goals include: decreasing suicidal behaviors, decreasing behaviors that interfere with therapy and a quality of life, increasing behavioral skills, and decreasing behaviors related to post traumatic stress (Freidel, 2004).

Emotion-Focused Therapy for Depression (EFT)

Greenberg and Goldman (2008) developed a person-centered therapy approach including gestalt principles involving narrative and emotional expressions through the use of lived stories that can be re-evoked and reconstructed through recollection and memory. Three interrelated pathways are developed with emotion and narrative processes with the goal that the client is able to access and articulate a meaningful understanding of emotional processes evoked from personal stories. The three guiding principles are emotion awareness, emotion regulation and emotion transformation (Greenberg, 2004, 2010). Emotion-focused therapy is a dialectical-constructivist model with focused attention on personal meaning that is built on the concept of self-organization and one's own emotional experience involving reason and emotion.

A fundamental understanding is that emotional schemes are composed of responses and experiences that are stored in memory and become a part of the lived experiences of clients. Some emotions are maladaptive and may be rooted in attachment responses where a client was met with criticism or rejection. Criticism or rejection may be experienced later in life, resurfacing earlier emotions of fear or shame (Greenberg, 2004). The client, in re-experiencing this story that is heavily laden with emotions, attempts to make sense by symbolizing it into a story. The counselor often hears these stories repeatedly during therapy. Singer and Blagov (2004) suggested that these expressions of stories of past events are the pathway through which is revealed the client's identity, emotion, behavior, and personality for a change process. The story is revealed as a bodily-felt, expressed feeling. Key terms in EFT include:

1. Emotion assessment: Different types of emotions
    a. Primary emotions: most fundamental direct initial reactions to a situation
    b. Secondary emotions: responses to prior thoughts and to other, more primary internal processes and may be defenses against feelings (hopeless when angry; Greenberg, 2004, p. 7).
    c. Maladaptive emotions: old familiar feelings that occur repeatedly and do not change
2. Goals for EMFT
    a. Increasing awareness of emotions (primary emotion and primary adaptive response), feeling the feeling
    b. Enhancing emotion regulation (overcoming avoidance of emotional arousal and the promotion of emotional processing)
    c. Transforming emotion
3. Emotion Regulation: the emotions to be regulated are secondary emotions and those primary emotions that are maladaptive. The goal is to teach clients to tolerate and to self-soothe by allowing the feelings to come and go with regulating breathing.
4. Emotion Transformation: changing emotion with emotion, which is undoing a maladaptive emotion, which helps to transform it. Another method is to shift attention, as the emotion may be present non-verbally in tone of voice or manner of expression.

Client stories tend to be the same old story: empty stories, broken stories, untold stories, unexpected outcome stories and healing stories.

Eye Movement Desensitization Response (EMDR)

F. Shapiro is the founder of eye-movement desensitization and reprocessing (EMDR). EMDR is a technique that combines imaginal exposure with eye movement and has been researched as a treatment for trauma-related anxiety. EMDR pairs visual stimulation, kinesthetic stimulation, and auditory stimulation with a focus on the traumatic memories. EMDR's approach to trauma is to focus on distancing and free association. This approach differs from exposure therapies that focus on exposure to reliving crucial aspects of the trauma. EMDR places a greater emphasis on distancing (duo focus in which the client maintains focus on the trauma material and also is present with the therapist in the room and the trauma memory is to be observed not relived. The process is to desensitize (Lee, 2008).

Habit Reversal Training

The therapist assists the client in identifying situations, stresses and other factors that trigger habits such as skin picking or nail biting. The task is to find other activities to do instead of the habit, such as squeezing a rubber ball. This will help ease and occupy the hands. The therapist will attempt to alter or change the environment to help curb the behavior.

Maudsley Family-based therapy

The main thrust of this therapy is that parents take control of the adolescent's anorexic behaviors. The therapy approach is a combination of structural, strategic, Milan's systemic, and narrative therapies (Lock & Grange, 2005). A fundamental belief is that the child is not in control; rather, the illness is in control. The client is separated from the problem and rather than the person is the problem, the problem is the problem. The therapist does not attempt to find the reasons or causes of the behavior but rather the solution, much like solution-focused therapies. The counselor is not an expert but assists in finding solutions. The technique used by the counselor is questioning. A three-phase treatment that usually takes 20-24 sessions (Hurst, Read, & Wallis, 2012).

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.

Meditation

Three forms of meditation are focused attention, mindfulness, and compassion. Focused attention is to concentrate on the in-and-out cycles of breathing. The mind tends to wander so focused attention is to regain the focus. Mindfulness (open-monitoring) is observing sights, sounds, and other sensations, including internal bodily sensations and thoughts. Compassion is feelings of benevolence toward other people, whether friend or enemy (Ricard, Lutz, & Davidson, 2014a). The goal of mediation is to achieve a clear mind, emotional balance, a sense of mindfulness, and compassionate caring.

Neuroscientists believe that mediation can rewire the brain circuits and aims to tame and center the mind. It is also believed that the brain can experience growth.

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 others' mental states, faulty thinking about relationship problems which triggers abandonment fears and reduce impulsivity, self-harming and suicidal behaviors (Bateman & Fonagy, 2006a, 2008). The four elements of MBT include: (1) focusing on the client's current thoughts, feelings, wishes, and desires; (2) avoiding discussions that are not connected to a subjectively felt reality, a more conscious awareness mentalization; (3) developing a climate whereby thoughts and feelings are available to be considered; and (4) an enhanced or enlightened understanding of the feelings and thoughts prior to an engagement of behaviors in the future.

Mindfulness-based Therapies

These therapies are based on the present moment, meditation and relaxation techniques. Mindfulness-based 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 learn to accept them without judgment. The client becomes capable of thoughts in the moment and lets them pass.

Mindfulness-Based Stress Reduction (MBSR)

MBSR, developed by Jon Kabat-Zinn, is a technique or strategy that, when combined with meditation, teaches (instructs) clients 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 believed the mind can be rewired to allow the client to pause and reset. MBSR has been recommended for anxiety issues. The typical program is once a week for eight weeks, meeting two-and-half hours. The concept is based on the fact that the mind can adapt and be rewired (neuroplasticity). The strategy is to de-stress through meditation and mindfulness practice. Research tends to support that mindfulness practice does lower cortisol levels and blood pressure and increase the immune response.

Neuroscience

Heinrich, Gevensleben, and Strehl (2007) define neuroscience and neurofeedback as monitoring and changing brain wave patterns that lead to other changes in behavior, a sense of and ability to self-regulate. The function of neuroscience feedback is to allow clients to monitor and make changes with brain wave patterns that assist in self-regulation and symptom reduction. Neuroception is a term Porges described as the nervous system's continuous evaluation of risk to determine whether the environment is safe or requires a defensive response (fight/flight). Within his polyvagal theory the vagus nerve is this pathway for self-regulation. Chapin (2014) stated bridging the brain and behavior for strategies is for self-regulation and learning the physiological basis of behavior. He offered 10 strategies for self-regulation. Neurobiological behavior is defined as "the relationship among brain

anatomy, function, biochemistry, learning, and behavior" (CACRP, 2009, p. 60). The goal of this form of feedback is to recognize, monitor, and train clients to self-regulate brain waves to improve health and happiness, and to understand the mind-body connections (Heinrich, Gevensleben, & Strehl, 2007; Ross, Homan, & Buck, 1994). Heilman, Bowers, and Valenstein (1985) refer to neuroscience feedback as the relationship between the right brain and primary emotions. The smart vagus nerve is associated with the active processes of attention, motion, emotion, and communication (Porges, 2011).

Panic Control Theory (PCT)

A cognitive behavioral approach that focuses on 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). A similar approach in working with parents is Floor Time (Greenspan, 1999).

Polyvagal Theory: Vagus Nerve Therapy (VNS)

A device is implanted in the chest that sends electrical impulses to the vagus nerve to activate the brain, leading to improvement 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 creating more control, and talk during the therapy regarding the trauma. Several evidenced based outcome studies exist (Brant, Moulds, Guthrie, et al., 2003; Bryant, et al., 2006; McLean & Foa, 2013; Shnurr, et al., 2007)

Psychodynamic Psychotherapy

The focus of psychodynamic psychotherapy treatment is to explore underlying thoughts, feelings, and motivations. As a treatment it is less intense than psychoanalysis but does require the therapist to be able to recognize the client's problem, assist the client to control self-destructive behaviors, encourage the client to commit to and adhere to the terms of the therapy, and to understand the efforts to change come with setbacks.

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, which is an improved quality of life. The idea is to overcome the intrusive, sensorimotor elements of the trauma and 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 while telling the story as if it happened to another person.

Schema Therapy

Schema therapy is a combination of psychodynamic, supportive, and cognitive behavioral therapies. Treatment focuses on organized patterns of behavior, cognition, and feelings that were most commonly, but not necessarily, established during childhood. The schemas include abandonment, anger/impulsivity, primitive parent, and detached protector (patterns in childhood). Other examples of schema beliefs are: "I'm unlovable, I'm a failure, people don't care about me, something bad will always happen, and I will never be good enough". 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, Bernstein, & Young, 2011). Schemas are categorized into five modules and include: (1) abandoned and confused child, (2) angry and impulsive child, (3) detached protector, 4) punitive parent, and (5) healthy adult. The elements of change include: (1) limiting re-parenting, (2) emotion-focused work involving the use of imagery and dialogues, (3) cognitive restricting and education, and (4) behavioral pattern breaking (Friedel, 2004)

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.

Social-effectiveness therapy (SET-C)

SET-C is designed for children and adolescents experiencing social anxiety disorder and is administered in 24 sessions, twice a week over a 12-week period of time. Each week one session is devoted to exposure and the second session to social skills training. The program is designed to decrease social anxiety, improve interpersonal skills, improve social performance, and increase participation in social activities (Turner, Beidel, Cooley, Woody, & Messer, 1994).

Supportive Therapy

Supportive therapy is probably the most common form of psychotherapy and often is not practiced or performed in similar ways. Supportive therapy is designed to develop a working relationship with clients in order to collaborate in the treatment phase of the identified problem.

Supportive Psychoanalytic Psychotherapy (SPP)

SPP was developed by Applebaum (2006, 2008) and Carsky (2013) with an emphasis on psychoanalytic concepts, less the therapists' interpretations of the relationship between the client and the therapist. The therapist assists the client in attending to his or her emotional reactions and the relationship is the change agent for a safe place to learn and experiment with change. According to Applebaum SPP does not use homework, systematic teaching, or group therapy methods.

Social Effectiveness Training

Social effectiveness training is designed to decrease social anxiety, improve interpersonal skills, improve social performance, and increase participation in social activities (Turner, Beidel, Cooley, Woody, & Messer, 1994).

Transference-focused Therapy

This therapy utilizes the development and understanding of transference to address common symptoms such as anger, emotional dysregulation, and impulsivity associated with eating disorders, alcohol misuse, substance use disorders, and dysfunctional behaviors. The trained therapist who understands this can make transference interpretations during the therapeutic process to integrate destructive expressions of unintegrated anger and move toward a goal of establishing meaningful interactions comprised of whole objects rather than split-off positive or negative part-object relationships.

Referral and Monitoring

Monitoring is the process of observing changes in thoughts, feelings and behaviors of clients 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.

A client may be experiencing difficulties in expressing him/herself socially in the form of 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 behavior change monitored is dependent upon the treatment goals. For someone experiencing agoraphobia, improvement behaviors may be attending a social function, going shopping, mailing a letter, or any behavior whereby the client comes into contact and interacts 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. The cross-cutting symptom measures, if administered during the initial contact, can be effective for monitoring on a pre-post measure. A person experiencing an alcohol use disorder might count the days of sobriety, attending AA meetings, meeting with a sponsor and meeting specific objectives of the 12-Step program. Relapse is another way to measure improvement and in this case 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 may 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 again 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. Axis V can be used at the time an assessment is determined and later at the time of hospital or treatment discharge.

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. 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. Individuals experiencing chest pain and palpitations or 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, MRI's, 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.

Medication

Be alert to medication issues such as positive and negative psychiatric effects of antiepileptic drugs especially for clients with seizure disorders (Ketter, Post, & Theodore, 1999). 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. Noncompliance 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 begin a process of gathering information, including: 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 can be either individual and/or group that includes 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) defined 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 ongoing and comprised of 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), monitoring the quality of professional services offered to the clients being evaluated and/or treated and serving 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's 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 scenario may place an examinee in the role of the supervisor or as 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 online 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 (Section E), and AMHCA in order to become aware of dilemmas often encountered in counseling and processed in supervision. Also, 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 codes--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 insofar 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; evaluation 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). Supervision contracts are essential when beginning counselors conduct a search for post-graduation supervisors.

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 a supervisee to practice outside the 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, 2003, p. 190).

Models (Selected)

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' (2000) guidance approach and the Holloway Systems Approach Supervision (SAS; Holloway, 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 styles, 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 may 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 lunch to discuss particulars about the situation.

Answers: a, b

Question

A supervisor is describing a supervision contract to a supervisee. According to the supervision standards the contract is to include the following (Select as many as you consider appropriate):

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 four to eight 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, breadth 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 for the supervisor to be aware of the advantages and disadvantages of homogeneity versus heterogeneity of supervisees' levels of experience and group composition.

Question

The counselor has recently left a counseling agency where individual supervision was the agency policy and accepted a position with an agency that utilized group supervision. The counselor learned that this agency has group supervision and in consultation with the group supervisor the counselor asked what might be the advantages of group supervision compared to individual supervision. (Select as many as you consider appropriate).

a. Confidentiality
b. Economics of time, costs, and expertise
c. Vicarious learning
d. Breadth of client exposure
e. Group phenomena issues
f. Isomorphic
g. Feedback of greater quality

Answers: b, c, d, f, 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 supervisees present case conceptualizations, techniques utilized and issues related to ethics.

d. Yes. Broader ranges of clients are present during group supervision thus providing a breadth of client exposure.

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

f. Yes. A supervisor and supervisee can set up a group format that mirrors the treatment being supervised (isomorphism or parallel process).

g. Yes. Supervisors with expertise and knowledge based on their own therapy experiences and providing supervision become experts in providing succinct responses during case presentations. The quality of experiences may also be enhanced by the presentations of challenging cases by fellow supervisees.

Question

The counselor during individual supervision informed 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 and review critical points in 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 (f is a possibility; however, the complexity of the case is not provided)

Question

During individual supervision and prior to the client's termination the supervisor asked the counselor how he/she evaluated his/her effectiveness in responding and receiving supervision. The counselor responded that he/she did not know and would appreciate suggestions. What methods might the supervisor utilize to provide client statistics as a form of feedback for the counselor? The counselor could benefit from: (Select the best answer)

a. a bug in the ear (BITE)

b. asking the client

c. in vivo exercise

d. phone ins

e. client relapse

f. employing an empirical study

Answer: f. An empirical study using a single subject design, quasi-experimental or experimental design dependent upon the research method meeting specific design requirements.

Question

For eight weeks the counselor provided a client diagnosed with delirium treatment consistent with psychoeducation and supportive therapy. During the seventh week of a 14 week therapy commitment the client informed the counselor that he/she didn't think he was getting better or had benefited from the counselor's efforts to help. During supervision the counselor requested what he might recommend to the client (Select as many as you consider helpful)

a. Provide the client the truth that there is no treatment for dementia
b. Seek consultation from a hypnotherapist
c. Try CBT
d. Continue psychoeducation and supportive therapy
e. Ask the client for specific suggestions that would be helpful
f. Survey the literature for treatments that are helpful for specific aspects of dementia

Answer: e, f

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? (Select as many as you consider appropriate).

a. Supervisor's clinical 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: a, e

Explanations:

a. This would be helpful.
b. This might 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 supervision knowledge and exposure to different supervision models, elements for a 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 (specific) behaviors should be addressed during 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: The supervisor may want to gauge the counselor's developmental progress by reversing a normal procedure in which the supervisor identifies or teaches target goals for social phobia. The counselor's ability to identify goals might reflect the counselor's preparation in identifying symptoms and in treating a client suffering from social phobia.

The counselor might set up a treatment protocol that started with steps for immediate relief. Signs of improvement will encourage client collaboration for the treatment that will require modifications in behaviors.

a. Yes. It can be helpful to provide anxiety-disordered clients with 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 clients diagnosed with a specific social phobia to use 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 it would be appropriate for the counselor to seek supervisory assistance to understand the process and appropriate therapeutic techniques.

c. No. This is a form of pro-active teaching and treatment and not a target behavior requiring change. However, during treatment it would be helpful to teach clients how to recognize and accept the physiological symptom of blushing caused by increased blood flow in the face.

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 they may be contributing to the child's failure to speak by doing such things as 'enabling' by finishing their child's sentences and creating over-

dependence. Rather, they should do such positive things as empowering initiative to speak, avoiding pleading or forcing speech, attentive listening, and learning to be patient.

e. Yes, this concern is 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 mediated anxiety 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. Negative self-talk, which reflects the presence of an internal self-criticism script, can be an area where the counselor can address the cognitive component of the phobia. It would be important to determine if the client deliberately and consciously initiates avoidance and perfectionistic behaviors.

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 toward 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 that 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, mainly excessive amounts, 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 2014 Code of Ethics to become aware of different tasks, duties, and relationships of a supervisor and counselor. Specifically review Sections F.2., F.3., F.4., and F.5.: Counselor Supervision Competence, Supervisory Relationships, Supervisor Responsibilities and Counseling Supervision Evaluation, Remediation and Endorsement. In addition, see consultation services provisions in 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, 2014):

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, 2014).
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.c.): 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.7.a.): Use techniques and procedures grounded in theory and have empirical support. Those techniques and procedures that have been defined as unproven should be subjected to ethical consideration and acknowledged as having a potential risk.
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 2014 Ethical Code (ACA, 2014). Specific focus and attention should be devoted to ethical terms and counselor and supervisor tasks involving consultation, supervision, and administrative tasks. Care should be exercised in the use of DSM-5 labels when the validity of the data is lacking or scant for making an assessment. 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) evidence-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, and 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 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: 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 health personnel use proper forms.

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 & Herlihy, 2010). The client must 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 for 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 (45.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, to comply 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, 2015).

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 & Herlihy, 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 a correct diagnosis 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 disorder is likely to be best treated with the addition of 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. There are many instruments listed throughout the supplement and many of those instruments will likely not be on the NCHMCE. One approach for preparing for instruments is

to be aware of those instruments widely or frequently used. found in the literature and noted in the supplement.

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 the data-gathering questions that requests medical information. In those cases, the test taker should consider the possibility that a medical concern might surface from other questions later in the scenario. 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 or medical 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 a rule in/out question 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 not take place until after the provisional 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 or biological or environmental markers. These include mood disorders, bipolar disorder, schizophrenia, anxiety disorders, ADHD, eating disorders, tics, alcoholism, and substance use.
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 2014 ACA Code of Ethics Section C.7.a. Scientific Bases for Treatment Modalities regarding obligations to the client.

2. DSM-5 CLASSIFICATION

The DSM-5 contains 20 categories of disorders. The disorders are arranged sequentially in each unit according to a life span developmental approach, from disorders first experienced in childhood to disorders experienced in older adults. The diagnosis of posttraumatic stress disorder is covered for children under age 6. Temper dysregulation disorder with dysphoria was changed to disruptive mood dysregulation disorder. Learning disabilities is a diagnosis that combined three disorders into one.

For the purpose of the NCMHCE supplement, a number of disorders will be selected based on a frequency of occurrence in the population.

In terms of children, the following disorders are to be found within neurodevelopment disorders.

1. Intellectual Disabilities
2. Specific Learning Disorders
3. Communication Disorders (Learning Disorders, Speech Sound Disorders, Childhood 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 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 small 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) 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 subaverage 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 intelligence quotient (IQ) scores. 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 (APA, 2013, 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, namely 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 rationale that mental retardation was an injurious and outdated term (King, 2014l).

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, and 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. Term, adaptive functioning, and intelligence range code the amount of impairment in intellectual functioning. 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 at 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 are the age level, 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 with and observations regarding the individual being assessed. In most cases, children with intellectual disabilities should 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 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 intellectually disabled children.

Incidence:

It is estimated that approximately 1% of the population has an 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 for 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 subaverage 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 age 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 include:

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 a specific environment. The first set involves personal skill development, which includes 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 include:

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 (APA, 2013, p. 59). Criterion A specifies that 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 be 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 task, to establish and maintain a task (goal establishment), and to complete a task. Common to inattention is the inability to ignore irrelevant stimuli and to refrain from becoming distracted from the task. From the menu provided in the DSM-5, a frequent difficulty is developing and maintaining organizational skills and focusing attention. 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, 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 neurologically-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 including 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) suggested 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 those individuals with ADHD, conduct disorder (CD), and oppositional defiant disorder (ODD) have a poorer prognosis when these disorders occur 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 as 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 on a menu list in which 12 of 18 symptoms must be present for a diagnosis of the combined type (specifier), and six of nine 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 seeming inability to listen, and difficulty organizing tasks. Hyperactivity criteria 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 assessing reports from others.

Although structured and semistructured clinical interviews are available, Brown (2000) pointed out 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 on behavior, rating scales such as the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992), the Connors Rating Scales (1997), and the Child Behavior Checklist (Achenbach, 1991a, b) are effective scales to assess for the problem and for adaptive behaviors. A detailed developmental history is also recommended. This history taking will shed light on 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 for social, occupational or academic issues and who are later diagnosed with adult ADHD may not have been previously treated for this disorder, although having ADHD symptoms has 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 can also occur, as the adult may have another disorder at the time of the interview. Borland and Heckman (1976) found a high rate of antisocial personality, anxiety, and depressive disorders in their adult studies when compared with 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) indicated that at least 50% of children with ADHD might develop mood disorders, particularly bipolar spectrum disorders (Pavuluri, Henry, Nadimpalli, et al., 2006). Hudziak et al. (1998) reported 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) reported 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 disorders are most often diagnosed as symptoms of ADHD. Typically, beginning prior to age 7, symptoms appear more often in boys than girls and cause disruption in school and at 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 scored lower than did 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. Social desirability, halo effects, parent exasperation, and leniency errors affect accuracy. A number of rating scales, frequently parent and teacher forms, are available to assess ADHD. Some of these include:

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, 1989)

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 because 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. (1995, 2001) reported that Tourette's syndrome and tic disorders are found in conjunction with ADHD.

Treatment:

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) recommended 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).

In the treatment of ADHD, recent studies have reported success with electroencephalographic (EEG) biofeedback (neurofeedback). These studies have reported improvement in attention and behavioral control and gains on tests of intelligence and academic achievement (Monastra et al., 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 (1996) recommended 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)--available in both short acting and extended release forms--has been the pharmacologic intervention used most frequently in the past with amphetamine-dextroamphetamine (Adderal) and extended release methylphenidate (Concerta). Also, these stimulant medications are becoming more commonly prescribed (Michelson et al., 2000), with a response rate of 70% for children and adolescent ADHD (Sinzig et al., 2007; Spencer, Biederman, Wilens, & Faraone, 1996, 1998). Improvements in children have been recorded with both ADHD and tics using methylphenidate and clonidine (Johnson & Safranek, 2005).

Occasionally physicians may prescribe certain medications, including atomoxetine (Strattera), modafani (Provigil), guanfacine (Intuniv), and bupropion (Wellbutrin), rather than stimulants to treat for ADHD but find that patients with significant symptoms do not experience as much improvement.

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 twofold 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, 2004; 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 and includes:

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 have also 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:

Faraone (2004) and 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 were children and adolescents. Mattes, Boswell, and Oliver (1984) found the response rate for adults to be 25%. Occasionally physicians may prescribe certain medications, including atomoxetine (Strattera), modafani (Provigil), guanfacine (Intuniv), and bupropion (Wellbutrin), rather than stimulants to treat for ADHD but find that patients with significant symptoms do not experience as much improvement. Stimulants such as methylphenidate (Ritalin), including the long acting form of Ritalin (Concerta) and the combination of dextroamphetamine and racemic amphetamine salts (Adderal), lisdexamfetamine (Vyvanse), are the most commonly prescribed medications for adults and children (Michelson et al., 2003).

When medications are prescribed and taken, the counselor should monitor for any adverse effects such as insomnia, headache, edginess, and bipolar mania for amphetamine compounds. For Atomoxetine (strattera), adverse effects may be gastrointestinal discomfort, increased difficulty sleeping, sexual dysfunction in men (Michelson et al., 2003), and mild increase in heart rate and blood pressure (Spencer et al., 2004).

Group counseling is recommended to encourage participants to share coping strategies and enhance socialization, thus reducing the stigma and isolation sometimes associated with ADHD.

Monitoring:

Self-reports and observations of overt behaviors are recommended. Betchen (2003) and Jackson and Farrugia (1997) provided a few examples, suggesting that there be a reduction in the following observations:

1. Lengthy pauses in a speech pattern (inattentive)

2. Abrupt stops in speaking in the middle of a sentence
3. Client forgetting what he or she said
4. Wandering into places and forgetting the reason for going to that place
5. Clients requesting repeats of what was said to them or requested of them
6. Staring into space rather than focusing 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, Linkugel, and Bevins (2007) reported that individuals diagnosed with ADHD are at increased risk to start smoking and will have much difficulty quitting.

Treatment:

Pelham and Fabiano (2008) conducted an evidence-based ADHD study using published empirical randomized controlled studies published during the years 1997 to 2006. The authors reported that behavioral parent training (BPT) and behavioral classroom management (BCM) met well-established criteria. Of the studies under review, 22 were BPT (mainly group based treatments), 22 were BCM studies that utilized contingency management procedures, and 22 were peer interventions and relationships (BPI). Behavioral peer interventions (BPI) focused on peer interactions and relationships such as social skills training, group-based, and office-based approaches had minimal effects. In summary, the results of this efficacious evaluation included:

Well-established:

Behavioral Parent Training (BPT)

Behavioral Classroom Management (BCM)

Intensive program-based peer interventions (BPI)

In summary, Pelham and Fabiano reported different guideline recommendations for psychopharmacological intervention (stimulants). The AMA indicated 'may include' pharmacotherapy, AAP 'should' recommend medication, and AACAP treatment 'may consist' of pharmacological intervention.

Motor or Tic Disorder

All tic disorders (Tourette's, persistent motor or vocal tic, and provisional) are characterized in the DSM-5 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 twelve months;

3. Tourette's 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. Tic disorder assessment may include a function-based assessment for tics (FBAT; Himel et al., 2014). Assessment focuses on the frequency, antecedents and consequences of the severity of the tics. The comprehensive integrated model (CI) targets environmental and contextual cues (precede the tic, e.g., mood states, anxiety, excitement, thoughts, and premonitory urges). External environmental settings include classrooms, public places, and the home (Woods, Piacentini, & Walkup, 2007).

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., 1989)

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, Woods, Walkup, et al., 2010). CBIT is based on habit reversal training that includes two concepts: tic awareness and competing-response training (Piacentini, & Chang, 2006). Tic awareness training teaches the individuals 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 single 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's 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) provided 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's clients may have multiple tic types. This syndrome can be associated with other disorders (Albin & Mink, 2006). For example, a child with Tourette's syndrome may have also been diagnosed with ADHD by age 4 and OCD by age 7.

Treatment

The goal for treatment is to improve social functioning and self-esteem and to reduce tics (Kenney, Juo, & Jimenez-Shahed, 2008).

Behavioral therapies found to be effective for 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 et al., 2008). Symptoms unresponsive to behavioral interventions may require pharmacological and even surgical procedures.

Adults with Tourette's syndrome, compared with children, require a greater focus on cognitive deficiencies than overt behavior symptoms displayed by children (Weiss & Weiss, 2004). Woods, Lovejoy and Ball (2002) suggested 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) are helpful to assess sustained attention and response control.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia spectrum is defined by abnormalities including 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 nonbizarre 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 (p. 99). Characteristic symptoms of schizophrenia are included within the group of the five listed below and should include one of the first three symptoms (delusions, hallucinations, disorganized speech) during a one-month period (APA, 2013). In the DSM-5, Criterion A for schizophrenia regarding psychosis, the client can no longer meet the criterion with a single bizarre delusion but now requires two or more symptoms from the list below, at least one of which must be delusions, hallucinations, or disorganized thinking (King, 2014a).

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (i.e., affective flattening, alogia, or avolition).

Clients diagnosed 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) described 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 nonbizarre 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, and so on, 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 negative symptoms persist for a period of at least six months and one of the months in which prodromal or residual symptoms exists and there are signs of disturbance in either manifesting only negative symptoms or by at least two 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).

Distortions in consciousness are a core feature of schizophrenia and contribute to a lack of a sense of self. A lack of a sense of self is when the client reports extended or running hallucinations that involve a voice. If the client reports the voice as external rather than internal (sense of self), the result is diminished self-affection. Symptoms and phenomena of schizophrenia are a result of abnormalities in the organization of consciousness (ipseity disturbance model). According to the ipseity disturbance model, the thought process is composed of two interrelated distortions, hyperreflexivity and diminished self-affection (Moe & Docherty, 2014).

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, & Weisman, 1984), with a worldwide prevalence of 1% (Andreasen, 1999; Keith, 1997). The APA (2013) reported 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:

Bach, Hayes, and Gallop (2012) conducted a study with hospitalized clients diagnosed with psychotic and mood disorder with psychotic features and found that brief acceptance and commitment therapy with four sessions was associated with reduced hospitalization at one year post-discharge.

Schneider (1999) viewed schizophrenia as a cognitive impairment requiring treatment in an environment that 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. Turlington, et al. (2006) recommended cognitive-behavioral therapy.

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 is generally considered the most important element of treatment for 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 are 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 antipsychotic drug dating back to the 1970s, that blocks dopamine neurotransmitter activity in the brain and is often accompanied by very uncomfortable motor movement side effects. Chlorpromazine is rarely prescribed now but Haloperidol is still prescribed for some clients to control symptoms (i.e., hallucinations), particularly when cost is a factor. In most cases, however, psychotic symptoms are being treated with newer and more effective agents that act upon a broader group of 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--Quetiapine (Seroquel), and three more recently approved antipsychotics: asenapine (Saphris), iloperidone (Fanapt), and lurasidone (Latuda). Their antipsychotic characteristics allow for control of positive symptoms such as hallucinations and delusions as well as negative symptoms like anhedonia, depression, and detached emotional responsivity, whereas 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, & Biondi, 2007; Mortimer, Joyce, Balasurbramaniam, Choudry, & Saleem, 2007); however, the presence of excessive weight gain and Type II diabetes mellitus as potential serious side effects often precluded their usage. It is of interest that Clozapine still remains the most effective of the antipsychotics and for that reason is primarily used to treat chronic schizophrenia and/or bipolar clients only when all other antipsychotics were tried and found to be ineffective.

Schizophrenic clients who are acutely agitated are generally treated with rapid-acting antipsychotic medications. These include Haloperidol injections, often prescribed in conjunction with lorazapam (Ativan); ziprasidone (Geodon) intramuscular, olanzapine (Zyprexa Zydis)--a rapidly disintegrating oral antipsychotic; olanzapine (Zyprexa) intramuscular (Centorrino 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 responsively and generally have fewer side effects when prescribed and monitored judiciously (Keith, 1997; Schneider, 1999).

Recent clinical trial studies with quetiapine have proven it effective for long-term usage in providing relief across all symptomatic domains. One of the most commonly prescribed atypical antipsychotics is quetiapine (Seroquel). Clinical trials found Seroquel to be effective for individuals with chronic psychotic symptoms and bipolar disorders. Clinical relief is noted in four domains--positive, negative, cognitive, and mood--as well as in preventing relapse, somatic concerns, anxiety, guilt feelings, depressions, and compliance to treatment (Kasper, 2004). Priebe, Roeder-Wanner, and Kaiser (2000) reported treatment compliance regarding schizophrenic clients' quality of life, changes in anxiety, and depression. Quetiapine is quite unique in that it is prescribed within a broad dosage range, from 25 mg to 1000 mg. A high dose (500 mg and above) appears to be frequently necessary to achieve antipsychotic effects, while a lower dose has been used for off-label purposes as a nighttime sedative for individuals with severe insomnia when traditional sedatives aren't effective.

Although most schizophrenic clients will hopefully take prescribed medications as directed, many fail to do so. As a result, these less-responsible clients who discontinue medications will most likely suffer a relapse of psychotic symptoms. Thus, it is vitally important that a less-responsible client has the assistance of family members and professionals to monitor the appropriate usage of the medications and ensure that he or she does not stop taking them.

For clients who request or are compliant with oral medications, long-acting antipsychotic drugs are available in injectable form. Haloperidol (Haldol) and fluphenazine (Prolixin) are both older antipsychotics that are still being prescribed by injection every two or four weeks and have proven to be quite useful for maintenance therapy. 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. Other newer long-acting injectable antipsychotics are olanzapine (Zyprexa Pamoate)--30-day duration; paliperidone (Invega Sustenna)--28-day duration; and aripiprazole (Abilify Maintena)--28-day duration.

The following injectable antipsychotics are now used for maintenance therapy: fluphenazine (Prolixin Decanoate)--14-day duration; haloperidol (Haldol Decanoate)--21-day duration; and risperidone (Risperdal Constanta)--14-day duration.

Brief Psychotic Disorder

Psychosis includes delusions, hallucinations, and loss of ego boundaries, disorganized speech, and impairment in reality testing (Kaplan & Sadock, 1998). The most common psychotic disorders or syndromes are schizophrenia, schizophreniform disorder, schizoaffective, delusional disorder, and brief psychotic disorder (King, 2014e).

During assessment when psychotic symptoms are noted the interviewer should include as one of the possible etiologies sexual or physical trauma. Putts (2014) reported that assessors might fail to request trauma history when psychosis is a first episode. Mueser, Lu, Rosenberg, and Wolfe (2010) reported that 21% of clients were exposed to sexual and physical assaults and 26% of those were assaulted by individuals related to them and 29% (sexual) and 45% (physical) were assaulted by someone not related to them (cited in Putts, 2014).

Other disorders associated with psychosis include major depressive disorder with psychotic features, schizophreniform disorder with brief psychotic features, psychotic disorder due to another medical condition, primary psychotic disorder, brief psychotic disorder, and delusional disorder.

Delusional disorders include subtypes such as erotomanic, grandiose, jealous, persecutory, somatic, and mixed. Criterion A requires at least one or more of delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior (p. 94). Criterion B specifies duration of at least one day but less than one month. Criterion C indicates the disturbance is not attributable to a major depressive disorder or bipolar disorder with psychotic features, schizophrenia or catatonia.

Catatonia Associated With another Mental Disorder (Catatonia Specifier)

Definition

The APA (2013) reclassified catatonia from a subtype to a separate specifier that can occur with other disorders. The assessment includes twelve 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 the APA (2000, 2013), the distinguishing features of catatonic specifiers 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 positioned away from the body by another person and continue to remain in that position (Bootzin & Acocella, 1988). Many catatonics alternate between periods of immobility and heightened motor activity (Bootzin & Acocella). Catatonia specifier diagnostic criteria include the predominance of at least three of the following twelve (APA, 2013, p. 119):

1. Motoric immobility as evidenced by stupor (1) or by catalepsy (2)

2. Excessive motor activity (3)—purposeless
3. Mutism (4), extreme negativism (5) - motiveless resistance to all instruction
4. Peculiarities of voluntary movement, posturing (6), prominent mannerisms (7), stereotyped movements (8), or grimacing (9)
5. Echolalia (10)--senseless, parrot-like repetition of a word or phrase spoken by another person, or echopraxia (11), imitation of movements of another person (12) (p. 119).

Schizophrenia and Other Disorders Associated with Psychotic Features or Symptoms:

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 are visual, tactile, or olfactory hallucinations. 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), otherwise known as fixed false beliefs. 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 (also found in other mental states such as dementia or delirium) or paranoid disorder, delusional disorder specifiers consist of delusions of grandiosity, eroticism, jealousy, somatic, mixed type, and unspecified types that 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 compared to those commonly found in schizophrenic patients (i.e., being followed by the FBI or being controlled by extraterrestrials). These individuals also lack other schizophrenic symptoms, such as hallucinations, flat affect, and other aspects of thought disorder.

The cause of delusional disorder is not known and its existence is much rarer than is 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. These clients typically use denial to avoid awareness of painful reality and may project their own feelings of anger and hostility 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 with 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, being stalked, being deceived, being erotically desired, being jealous, and being a victim of physical illness).

There are a number of specifiers for delusional disorder, but 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), 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:

Incidence 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). The 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 should include a medical evaluation to rule out medical-related causes and a neurological assessment, and to rule out central nervous system pathology causing the disorder.

Medication may be helpful if delusional clients are willing to take it. Supportive counseling or therapy is the mainstay and will be most effective when the clinician can develop a trusting relationship. During assessment of the delusions, the clinician should 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; King, 2014e).

Bipolar Disorder

Definition and Assessment:

Bipolar and related disorders and depressive disorders are now separate categories. A recent change for assessment 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, but 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 and is prescribed an antidepressant medication, but then experiences anxiety, rapid onset of energy, difficulty sleeping, and possibly a clear-cut manic episode. Such a response to antidepressant treatment indicates the presence of bipolar disorder, mixed type. A proper assessment is to investigate for a history of cyclic mood swings and evaluate the activity and energy level of the client's mood, including the presence of depression, heightened and elevated mood symptoms, or mixed states that could be experienced as anxiety.

It most often starts with depression, followed by mania. Most individuals suffer both depressive and manic episodes, but 10% to 20% experience only manic ones. Most commonly, manic episodes have a rapid onset but sometimes 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 antipsychotic medications or both in combination. Untreated, a manic episode can last three months.

Manic episodes may reach psychotic proportions in a client with bipolar I disorder and be misdiagnosed as schizophrenia, whereas 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:

The APA (2013) reported a prevalence rate for a 12-month period, as cited 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. Sixty percent 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. Bipolar I clients may experience more severe manic and depressed swings, whereas 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; King, 2014e). There are 10 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 and family discord. Criterion A for bipolar I diagnosis accounts for the state of the individual and is summarized by the following (APA, 2013, p. 126):

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

Currency of a hypomanic episode (less severe than a 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 three symptoms of another episode that does not overlap with the primary mood episode.

Criterion B addresses the history of previous types of episodes or whether the manic episode is not better accounted for by psychotic-type disorders such as psychotic 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 rules 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, Russel, Newman, et al., 1994), substance abuse (Kessler et al., 1994), eating disorders (Angst, 1998), paraphilia (Nelson, 2001), attention-deficit/hyperactivity disorder (Hudson et al., 2003), impulse-control disorders such as gambling (Pallanti, Quercioli, Sood, & Hollander, 2002), conduct disorders (Boyd, 1984), autism, Tourette's syndrome, migraines (Merikangas, Angst, & Isler, 1990; McCracken et al., 2002), diabetes

(Regenold, Thapar, Marano, Gavirneni, & Kondapavuluru, 2003), and obesity (Hirschfeld, Young, & McElroy, 2003; McElroy et al., 2002).

Treatment

Frank (2007) reported two large efficacy studies for bipolar I and depression when interpersonal and social rhythm therapy are combined with medication were reported as effective treatment. These studies compared the three well-known treatments for bipolar illness (family-focused therapy, IPSRT, and cognitive-behavioral therapy). All three therapies place an emphasis on sleep hygiene and sleep-wake cycles.

Bipolar II Disorder

Bipolar disorder, type II, is characterized by at least one episode of hypomania (never a full manic episode), at least one or more major depressive episodes and at least one hypomanic episode. The APA (2013) reports a 12-month prevalence rate of 0.8% for the United States. Bipolar II disorder clients have a history of lifetime 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 pointed 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) recommended 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 to precipitate 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 (which may include a general physician, physician's assistant, or advanced practice nurse without specialized training in psychiatry to consider prescribing antidepressant medication).

The diagnostic criteria for a bipolar II disorder are a recurring mood episode consisting of one or more major depressive episodes (lasting two weeks) and at least one hypomanic episode (lasting at least four consecutive days). The mood episodes require that five or more symptoms for Criterion A 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 (Markowitz & 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 shown promising results in relapse prevention in combination with pharmacotherapy (Goodwin & Jamison, 1990).

Fountoulakis et al. (2005) conducted a critical review of bipolar treatments that 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 (Carney, 2013, Carney & Edinger, 2013). Sleep psychology is of interest for the American Psychological Association's research and study of sleep disorders. 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 steps that include stimulus control (limiting stimulation before bedtime); sleep hygiene (controlling the environment and behaviors before sleep); sleep restriction (controlling time in bed); and sleep (diary, common-sense advice). The client addresses these steps with a standard questionnaire to be completed with "agree" or "disagree". Frank (2007) reported two large efficacy studies for bipolar I and depression when interpersonal and social rhythm therapy combined with medication were introduced as treatment. These studies compared the three well-known treatments for bipolar illness (family-focused therapy, IPSRT, and cognitive-behavioral therapy). All three therapies place an emphasis on sleep hygiene or sleep-wake cycles.

Pharmacotherapy:

Pharmacotherapy is considered to be the most effective treatment to control and stabilize bipolar symptoms (Markowitz & Klerman, 1991). The first medication approved by the FDA for the treatment of bipolar disorder was lithium (Fountoulakis et al., 2008; Goodwin & Viea, 2005), which is still widely prescribed primarily as a maintenance medication to prevent recurring bipolar symptoms and bipolar depression and has been demonstrated to reduce the risk of suicide. Lithium has not proven 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 overdose or renal failure.

During the past decade and a half, 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.

Several anticonvulsive drugs, particularly valproate, carbamazepine, and oxcarbaepine, have been commonly prescribed for mood stabilizing purposes. Carbamazepine, which was a popular treatment option for bipolar in the late 1980s and early 1990s, effectively treats manic episodes and rapid-cycling bipolar disorder but is less effective in preventing relapse than lithium or valproate. Carbamazepine is not currently prescribed as often as valproate, which is particularly effective in treating manic episodes. Lamotrigine, a less frequently prescribed anticonvulsant mood stabilizer, is somewhat effective in treating bipolar depression and has some benefit in preventing further depressive episodes but is of little benefit in controlling mania or rapid cycling disorder. Depending on the severity of the case, anticonvulsants may be used in combination with lithium or on their own. Antipsychotic medications are effective for short-term treatment of bipolar manic episodes and appear to be superior to lithium and anticonvulsants for this purpose. Manic clients suffering from

psychotic symptoms and acute agitation may respond more quickly to selected antipsychotic and/or anticonvulsants, particularly olanzapine and/or valproate (Centrorrino et al., 2007). Atypical antipsychotics that have been used to treat bipolar disorders include clozaril, aripiprazole, alanzapine, quetiapine, risperideone, ziprasidone, asenapine, and lurasidone. Specifically for bipolar depression, the antipsychotics lurasideone and quetiapine, the combination of fluoxetine and olanzapine, and the anticonvulsant lamotrigine have all been prescribed and found helpful, with lurasideone becoming increasingly predominant for the most severe bipolar depression. Fountoulakis, Grunze, Molar, Grunze, and Broich (2007) cited research findings that indicated that antidepressants should be avoided in bipolar clients because antidepressants might trigger manic episodes, rapid cycling, anxiety attacks, or agitation.

Manic patients suffering from psychotic symptoms and acute agitation may respond more quickly to selected antipsychotics and/or anticonvulsants, particularly olanzapine and/or valproate (Centorrino et al., 2007). Fountoulakis, Grunze, Molar, Grunze, and Broich (2007) cited research findings that indicated the nonuse of antidepressants should be avoided in bipolar clients because antidepressants 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, 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 indicates 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 antipsychotic medications), and thrombocytopenia (Carbamazepine).

Monitoring is also important because of the high incidence of relapse, most often caused by noncompliance 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 five years.

Psychotherapy supports the use of family-focused (Rea et al., 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, 2007). 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 to recognize

subtle mood changes and symptoms, trigger recognition, detect warning signs for acute episodes, and monitor treatment protocol overall (APA, 2002).

Cyclothymic Disorder

Cyclothymic disorder has a lifetime 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 sudden onset 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 can occur at any time in life but usually begin during the 20s 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 twelve 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. Electroconvulsive 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 that is administered only in specific centers is transcranial magnetic stimulation (TMS), a noninvasive method to treat depression causing depolarization or hyperpolarization in brain neurons.

When treating bipolar disorders, psychopharmacological approaches are essential. Manic episodes are treated with antipsychotics and/or mood-stabilizing medications, whereas mixed bipolar symptoms are treated with mood stabilizers that are most often specific anti-convulsant medications. A depressed individual with undiagnosed bipolar disorder must be properly assessed before medication 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 that include, along with depressed mood, an inability to carry out normal activities, frequent absenteeism from work, and 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 do those with chronic physical conditions, such as hypertension, diabetes, and arthritis. These researchers have also reported that 40% of those who frequently seek medical care suffer from depression. A study of 13 years researching first on-set for depression in a sample of 3481 adults household residents including 92 first lifetime onset of major depression reported that female participants showed higher risk of onset of a depression disorder, longer duration of episodes, and a nonsignificant tendency for higher risk of recurrence (Eaton, Shao, Nestadt, …et al., 2008).

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.

Although 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 includes 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, 1994, 2013):

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 symptoms 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 (Blehar & Lewy, 1990).

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 persons (APA, 1994). This is unfortunate, according to Keller (1994), because the recovery rates for individuals within the first and second year of depression when treated properly are 70% and 81%, respectively.

Incidence:

Depression rates for clients of diversity 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 that are lower (3.3%) compared with Mexicans Americans born in the United States. Slone et al. (2006), in a study of depression in four cities in Mexico, found that the lifetime prevalence rate in Oaxaca, Guadalajara, Hermosillo, and Merida was 12.8% and was lower than was the prevalence rate for the United States (17.1%). A factor contributing to the lower rate is the intact family structures that appear to offer resistance to depression symptoms (Vega et al., 1998). Diminished ability to think, sleep disturbances, and weight and appetite symptoms were the most prevalent symptoms for those with lifetime experiences with depression (Slone et al., 2006).

Instruments:

McHugh and Behar (2009) reported on the readability of self-report measures for depression. The instruments selected include:

1. Assessment of Depression Inventory (Mogge & LePage, 2004)
2. Beck Depression Inventory II (Beck et al., 1996a,b)
3. Carroll Depression Scales Revised (Carroll, 1981, 1998)
4. Center for Epidemiological Studies-Depression Scale (Radloff, 1977)
5. Depression Questionnaire (Bertolotti et al., 1990)

6. Diagnostic Inventory for Depression (Zimmerman, Sheeran, & Young, 2004)
7. Hamilton Depression Inventory (Reynolds & Kobak, 1995)
8. Hopelessness Depression Symptom Questionnaire (Metalsky & Joiner, 1997)
9. Inventory Depressive Symptomatology (Rush et al., 1996; Rush et al., 2000)
10. MMPI-2 Depression Screener (Burnam et al., 1989): The current Scale 2 (D) consists of 57 items.
11. MOS-Item Depression Screener (Burnam et al., 1988)
12. Patient Health Questionnaire-9 (Kroenke, Spitzer, & Williams, 2001, 2003)
13. Revised Hamilton Rating Scale for Depression-Self Report (Warren, 1994)
14. Zung Depression Self-Rating Depression Scales (Zung, 1965)
15. Structured Interview Guide for the Hamilton Depression Rating Scale (Williams, Link, Rosenthal, et al., 1988)
16. Mood Disorder Questionnaire (MDQ; Hirschfeld, Holzer, Calabrese, et al., 2003)

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 noncompliance, prescription costs, and potential side effects. These findings should be interpreted with caution with regard to individuals suffering from more severe depression, symptoms which, in general, require pharmacotherapy to control (Matheny, Brack, McCarthy, & Penick, 1996; Wexler & Cicchetti, 1992). When medications are prescribed for severe depression Bender (1999) reported the importance of maintaining medication because there can be both positive and negative side effects. 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.

Williams, Teasdale, Segal, and Kabat-Zinn (2007) encourage the use of mindfulness-based stress reduction (MBSR) for depression. This self-care approach is a program of eight weeks during which the client learns how to focus on awareness of the moment and not on tangential matters. Gilliam and Cottone (2005) supported couple's therapy when one of the partners is diagnosed with a major depression and there is evidence of marital distress. They suggested that outcome effectiveness is better with couple therapy than with individual therapy. The clinician may consider the "matching hypothesis" (Beach & O'Leary, 1992) that marital discord is a predictor of a poorer outcome for depression and that cognitive dysfunction predicts a poorer outcome for couple's therapy to treat depression. The authors did suggest that additional research is needed concerning couple's therapy for depression.

Radkovsky, Ardle, Bockling, and Berking (2014) advocate training clients to apply emotion regulation (ER) skills. Emotion regulation refers to extrinsic and intrinsic processes responsible for monitoring, evaluation, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals (Thompson, 1994, pp. 27-28). ER skills are coping skills for negative emotions. A skill-based model of adaptive coping with emotions (ACE) includes ER. ACE is a situation-dependent interaction between different regulation skills.

These regulation skills include the ability to: (a) be consciously aware of emotions, (b) identify and (c) correctly label emotions, (d) identify what has caused and maintains one's present emotions, (e)

actively modify emotions in an adaptive manner, (f) accept, (g) tolerate undesired emotions when they cannot be changed, (h) approach and confront situations likely to trigger negative emotions if this is necessary to attain personally relevant goals, and (i) provide compassionate self-support when working to cope with challenging emotions (Thompson, p. 249).

Treatment

Treatment (Children and Adolescents: David-Ferdon and Kaslow (2008) conducted a review of randomized controlled depression studies published during the years 1988 to 2007. The efficacious evaluation was composed of 18 adolescent studies (13 and older) and 10 child studies (12 and younger). Adolescent treatment classified as well-established consisted of adolescent only group and IPT individual. Probably efficacious treatment for children included CBT adolescent group plus parent component, CBT individual, and CBT individual plus parent/family component.

Child treatment:

Well-efficacious: Child group only and child group plus parent (CBT)

Probably efficacious: CBT adolescent group plus parent component, CBT individual, and CBT individual plus parent/family component.

Adolescent treatment:

Well-efficacious: CBT adolescent only group and IPT individual.

Probably efficacious: CBT adolescent group plus parent component, CBT individual, and CBT individual plus parent/family component.

Treatments:

Well-efficacious: None

Probably efficacious: CBT Pen Prevention Program, Self-Control Therapy, Coping with Depression-Adolescent, interpersonal therapy (IPT)

Persistent Depressive Disorder (PDD)

Dysthymic disorder was renamed persistent depressive disorder in the DSM-5 (APA, 2013). Persistent depressive disorder includes seven specifiers and the diagnostician specifies if the disorder is early onset (before age 21) or late onset (after age 21).

PDD is a consolidation of major depressive disorder and dysthymic disorder symptoms. 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, sadness or being 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 coexists 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 (2013), the essential difference between major depressive disorder and PDD is that major depressive disorder is more discrete and severe, whereas 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 a persistent depressive disorder from a major depressive disorder, whereas symptom-free episodes occurring longer than two months would rule out the diagnosis of dysthymic disorder.

Diagnostic features for persistent depressive disorder for Criterion A are 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 symptoms 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 it is two to three times more likely to occur in women than men. In children, gender prevalence rates seem to be equal (APA, 2000, pp. 378-379). The APA (2013) reported 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, whereas Markowit and Klerman (1991) noted cognitive therapy to be an effective treatment approach. With the advent of effective antidepressant 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, Anisman, Merali, 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 antidepressant medication have shown that psychological interventions, particularly cognitive–behavioral therapy, are at least as effective as medication is in the treatment of depression when the outcome is assessed with client-rated measures and a long-term follow-up is considered (Antonuccio, Danton, & DeNelsky, 1995). A study of the effectiveness of psychotherapy combined with the antidepressant 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, McCullough, Klein, et al., 2000 a, b). Nefazedone is now rarely prescribed since several cases of irreversible liver toxicity were reported in 2003.

Antidepressants from different classes, modulated by one or more of the following neurotransmitters: serotonin, dopamine, or noradrenalin, have been shown to have effective antidepressive activity in an average of 65% of cases (Brunello et al., 1999). The antidepressant medications include several groups. The tricyclics, which act on the 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. Because of their somewhat adverse side effects and potential lethality if taken in overdose, they are rarely prescribed any longer. MAO inhibitors (MAOIs) Emsam (selegiline), Marplan (isocarboxazid), Nardil (phenelzine), and Parnate (tranylcypromine), which act by inhibiting the activity of monoamine oxidase, may cause potentially serious side effects under certain conditions. The biological effect of MAOIs is to prevent the breakdown of monoamine neurotransmitters (serotonin, melatonin, epinephrine, norepinephrine, and dopamine), which provide the antidepressant effect. But it can also cause a risk for individuals who consume foods containing tyramine (found in cheese) or foods containing tryptophan, or certain red wines, and who could suffer a hypertensive crisis caused by excessive amounts of norepinephrine suddenly flooding circulation. However, the recently introduced Selegiline transdermal system introduces an 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 antidepressants have not worked but they cannot be prescribed if an individual is also taking SSRI or antidepressants, amphetamines, chlorpheniramine, cocaine, cyclobenzaprine, dextromethorphan, phencyclidine (PCP), pheniramine, and over-the-counter food supplements such as St. John's Wort, because the combination might cause a potentially fatal hypertensive crisis.

Before making a switch between an MAOI and another antidepressant, 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 1987, when fluoxetine (Prozac) was approved by the FDA and became a widely successful antidepressant. After that time other SSRIs entered the market, including sertraline (Zoloft), paroxetine (Paxil), Fluvoxamine (Luvox), citalopram (Celexa) and escitalopram (Lexapro). The most recent is vilazodone (Viibryd). Selective serotonin reuptake inhibitors act only by increasing levels of the neurotransmitter serotonin. Other antidepressants that work somewhat differently from the SSRIs, MAOIs, and tricyclics include nefazedone (Serzone, which is no longer available), bupropion (Wellbutrin), mirtazapiinne (Remeron), trazodone (Deseryl), escitalopram (Lexapro), sertraline (Zoloft), paroxetine (Paxil), Fluvoxamine (Luvox), and citalopram (Celexa). Selective serotonin reuptake inhibitors act only on the neurotransmitter serotonin. Other antidepressants that work somewhat differently from the SSRIs, MAOIs, and tricylics include nefazedone (Serzone), bupropion (Wellbutrin),

mirtazapine (Remeron), trazodone (Deseryl), Venlafaxine (Effexor) and duloxetine (Cymbalta). The latter two are serotonin and norepinephrine reuptake inhibitors (SNRIs), which are more effective when compared with the SSRI antidepressants in some clients and also appear to help control pain (primarily duloxetine). The availability of effective antidepressant medications is a promising development because social and characterologic disturbances, so pervasive in dysthymic symptoms, often recede with continued pharmacotherapy.

Extended Bereavement Exclusion

The DSM-5 considers the possibility that when symptoms of depression occur after a significant loss, 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; King, 2014h). A significant loss may be bereavement, financial ruin, and 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 have also 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.

Persistent Complex Bereavement Disorder and 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 six to twelve 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 circumstance and 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 posttraumatic 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 attacks with and without agoraphobia are unlinked and are separate disorders, panic attack and agoraphobia (King, 2014f).

Fear and anxiety are predominant emotions and autonomic responses. Assessment for anxiety disorder tends to differentiate 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 thirteen 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., 1993, 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 (posttraumatic 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).

Assessing Anxiety Disorders:

When conducting a diagnostic interview, the interviewer should assess the duration, frequency, onset, antecedents, and consequences of the specific symptom (Beidel, 1994; Fong & Silien, 1999; King, 2014f) and use a step-by-step interviewing format for assessing anxiety disorders that include:

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. Frances, First and Pincus (1995) and APA (1994) differentiated 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 are 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.

Assessing anxiety for children, it is important to secure information on ways the anxiety might be interfering in daily activities. To secure this information it is important to validate this information from parent or school personnel. Lyneham et al. (2013) reported cited literature that frequent client answers to interference for children include: (a) peer relationship problems, (b) school absenteeism (c) decreased concentration, (d) poorer school performance, (e) quality of interactions between members of the family, and (f) restricts or limits the type of activities the family participates in. (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 that measures cognitive and somatic components of anxiety.
4. Clinical Anxiety Scale (CAS; Westhuis & Thyer, 1986). The CAS is a scale that measures the amount, degree or severity of clinical anxiety.
5. Beck Anxiety Inventory

Instrumentation (Children and Parent)

Lyneham, Sburlati, Abbott, Rapee, Hudson, Tolin, and Carlson (2013) identified widely-used instruments for parent and child data gathering. Although not ranked, they include:

1. Child Anxiety Life Interference Scale (Calis)
2. The Anxiety Disorders Interview Schedule for Children for DSM-IV (ADIS-C/P; Silverman & Albano, 1996)
3. The Spence Children's Anxiety Scale (SCAS; Spence, Barrett, & Turner, 2003; Nauta et al., 2004)
4. The Strengths and Difficulties Questionnaire-Parent Version (SDQ-P; Goodman, 2001)
5. The Child Behavior Check List Competence Scales (CBCL-Comp; Achenbach & Rescoria, 2001)
6. The Children's Global Assessment Scale (CGAS; Shaffer et al., 1983)
7. Multidimensional Anxiety Scale for Children (MASC; March et al., 1997)
8. The Sheehan Disability Scale-Revised (SDS-R; Leon, Olfson, Portera, Farber, & Sheehan, 1997)

Another widely used instrument for children is The Revised Child Anxiety and Depression Scale (RCADS; Chorpita, Moffitt, & Gray, 2005). The RCADS questionnaire subscales include: separation anxiety disorder (SAD), social phobia (SP), generalized anxiety disorder (GAD), panic disorder (PD), obsessive compulsive disorder (OCD), and major depressive disorder (MDD).

Treatment (Children and Adolescents)

Evidence-based analysis regarding anxiety treatment for children and adolescents was conducted by Silverman, Pina, and Viswesvaran (2008). Thirty-two peer-reviewed anxiety studies were analyzed to determine if efficacious criteria were met for one of the six efficacy types (well-established, probably efficacious, possibly efficacious, and experimental). Most of the 32 studies were classified Type 1. Eight studies met Type II and three studies Type 3. Findings indicated that none of the 32 studies met criteria for well-established. Individual cognitive behavior therapy (ICBT), group cognitive behavior therapy (GCBT), GCBT with parents, GCBT for social phobia (SOP), and SET-C for SOP met probably efficacious (Silverman, Pina, & Viswesvaran, 2008).

Well-established: None

Possibly efficacious: Individual cognitive behavior therapy (ICBT), group cognitive behavior therapy (GCBT), GCBT with parents, GCBT for social phobia (SOP)

Probably efficacious: SET-C for SOP met probably efficacious

Compton, Walkup, Albano, …et al. (2010) conducted a randomized placebo-controlled trial comparing four treatment groups that included (separation anxiety disorder (SAD), sertraline (SRT), and their combination (COMB) against pill placebo (PBO),, generalized anxiety, (GAD), and social phobia (S.P). The outcome for this six-year study involving 488 children and adolescents has yet to publish results. Timing and duration of treatment are issues for counselors and clients. Gryczkowski, Tiede, Dammann, …et al. (2013) reported shorter treatment duration for exposure therapies when compared to efficacy trial.

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 about how animals seek protection when frightened (survival pattern). He translated this idea to humans and further conjectured that this concept could be applied to how individuals, particularly children, seek protection and closeness with a protective person. From these observations he developed two principles; the quality of early interactions with caretakers (mainly parental figures) that shapes the quality of and 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, this leads to 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). Jane Ainsworth developed the 'strange situation' procedure which created separation anxiety between the infant and caregiver. The observer evaluated how the infant reacted to the reunion and determined that there were different attachments. The patterns she found were measured behaviorally according to a child's emotional response to separation. During this procedure the child was brought into a room to play for 20 minutes and then observed while caregivers and strangers first entered and then left the room. The child's responses, including changes in anxiety related to separation and reunion, were observed and found to be comprised of the following attachment patterns: secure, anxious, avoidant, ambivalent/ resistant, and disorganized.

The reunion is what determined the patterns, which were classified as securely attached, anxiously attached, avoidantly attached, anxiously 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 securely attached child seeks or is active in initiating renewed engagement. The anxiously attached infant actively avoids the caregiver upon reunion or failure to be comforted by the caregiver. The avoidantly attached experiences routine rebuffs when the infant needs tender care. During the field experiments, these avoidantly-attached children were held as much but not when they needed it and the anxiously/resistant attached child failed to be comforted (passive or angry) upon reunion.

Bowlby and Ainsworth believed that the relationship between the caregiver and infant determined the 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 normal development, yet some infants were constrained by either path taken. The basis of these ideas promoted an interpretation that if a child had an anxiously/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 those corrective pathways or patterns were forthcoming.

The APA (2013) defined 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 experiencing 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 (pp. 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 ages 6 to 12 is approximately 4% and for adults 0.9% to 1.9%.

Treatment:

Most treatment programs that are family oriented recommend parent training. There is literature to support the fact that the mother, who may have had exposure as a child to certain aspects of separation issues, 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 fifty-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 rationale 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 fifty-minute sessions (Schneider et al., 2013).

The Copying Cat Model as reported by Podell, Martin, and Kendall (2008) and Podell et al. (2010) is an evidence-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 panic response. 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. Crome and Baillie (2014) reviewed four epidemiological surveys that identified the most fears and the severity of those fears through the use of face-to-face interviews. The DSM-5 specifier for social anxiety is performance only such as public speaking. Using item theory the findings suggested that lower ranking fears included public speaking, participating in meetings and classes, and being the center of attention. Moderate severity rankings included talking to people in authority, being assertive, talking to unfamiliar people, and attending public parties. Severe rankings included entering a room when others are present, working in small groups, writing, eating or drinking in public, and using bathrooms. Typical characteristics of social phobia include fearfulness, shyness, anxiousness, self-consciousness, submissiveness, anger, and experience of being shamed (Hofmann & Barlow, 2002; Hofmann, Heinrichs, & Muscovitch, 2004). Otto and Gould (1996) illustrate three maladaptive conditions associated with cognitive functioning. These are: 1) underestimating his or her ability to cope in social situations; 2) exaggerating the perceived consequences of performing inadequately in social situations; and 3) 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. Individuals with SAD experience intense fears of negative evaluation and being subjected to embarrassment. Children with SAD have few friends, few extracurricular activities, underachieve, have more instances of school refusal or in-attendance, selective mutism, and comorbidity with anxiety, depressive, somatoform, and substance use disorders (Essau, Conradt, & Petermann, 1999).

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, pp. 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 (Juster & Heimberg, 1995). Age of onset is 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 (instruments 1-5 are widely used).

1. Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovex, 1990)
2. Penn State Worry Questionnaire—Adults (PSWQ-A; Hopko, 2003), a screener
3. Beck anxiety Inventory (BAI; Beck & Steer, 1990a,b)
4. Social Phobia and Anxiety Inventory (SPAI; Turner, Stanley, Beidel, & Bond, 1989)
5. Social Phobia and Anxiety Inventory (SPAI-18; deVente, Majdandzic, Voncken, Beidel, & Bogels, 2014)
6. Diagnostic Interview Schedule for Children (Costello et al., 1984)
7. Schedule for Affective Disorders and Schizophrenia for Children (Puig-Antich & Chambers, 1978)
8. The Anxiety Disorders Interview Schedule for Children (Albano & Silverman, 1996)
9. Social Anxiety Scale for Children-Revised (LaGreca & Stone, 1993)
10. Social Phobia and Anxiety Inventory for Children (SPAI; Beidel, Turner, & Cooley, 1993; Beidel, Turner, & Morris, 1995, 1999)
11. Social Phobic Scale and Social Interaction Scale (SIAS; Mattick & Clark, 1989, 1998)*
12. Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990)*
13. Penn State Worry Questionnaire–Adults (PSWQ-A; Hopko, 2003)-screener
14. Beck Anxiety Inventory (BAI; Beck & Steer, 1990)*
15. Social Phobia and Anxiety Inventory (SPAI; Turner, Stanley, Beidel, & Bond, 1989)
16. Social Phobia and Anxiety Inventory (SPAI-18; deVente, Majdandzic, Voncken, Beidel, & Bogels, 2014)

17. The Social Avoidance and Distress (SAD) and Fear of Negative Evaluation (FNE; Watson & Friend, 1969)
18. The Interaction Anxiousness Scale (IAS; Leary, 1983)
19. Brief Social Phobic Scale (BSPS; Davidson et al., 1991)
20. 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 lifestyles 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, Spitzer, & Liebowitz, 1993), although subtypes are not listed in the DSM-5. The duration of the disturbance is at least six months (APA, 2013).

Adults and children suffering from SAD express fears of speaking, reading and eating in public, of going to parties, of speaking to authority figures and of informal social interactions. Reported physical symptoms include choking, flushes or chills, palpitations, fainting, shaking, fear of dying, and headaches (Beidel, Turner, & Morris, 1999). The interviewer should consider genetic transmission as family studies reveal that first-degree relatives of clients with SAD manifest higher rates of SAD than normal controls (Fyer, Manuzza, Chapman, Liebowitz, & Klein, 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. Craske, Niles, Burklund, et al. (2014) reported that CBT is the empirically supported treatment for social phobia; however, some clients remain symptomatic. Their efficacy study regarding ACT and CBT for social phobia resulted in ACT specifically targeted anxiety symptoms (avoidance, negative evaluation). Key features of CBT and ACT are that CBT emphasizes symptom reduction while ACT focuses on psychological flexibility. The outcome indicated that CBT and ACT performed equally. Their randomized clinical study compared ACT with a wait list. 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. Social skills training as a treatment intervention when compared with social effectiveness therapy (SET) was efficacious. SET provided additional benefit specifically for social distress and social behavior (Beidel, Alfano, Kofler, Rao, Scharfstein, & Sarver, 2014)

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 thirteen 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 to 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 reported a prevalence rate of 0.2% to 0.3% for adults and adolescents (APA, 2013). Bradley, Wachsmuth, Swinson, and Hnatko (1990) and Sargent (1990) estimated 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, posttraumatic stress disorder, and generalized anxiety disorder are not uncommon. The comorbidity 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 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 a duration of 12 to 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 at risk to cause dependency problems, with alprazolam being the most risky 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 has been separated or unlinked to be separate disorders, panic disorder and agoraphobia disorder, although the symptoms for each remain the same. If a client meets full criteria for both disorders, both are recorded.

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) suggested that the strongest predictor of agoraphobia is gender. Women tend to experience panic disorder with agoraphobia more often 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 described 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 that 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 et al., 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). Kessler, Berglund, Demler, Jin, and Walters (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) indicated 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 used by the assessment expert may be:

1. GAD-7 (Spitzer, Kroenke, Williams, & Lower, 2006)
2. GAD-Q-IV (Newman, et al., 2002)
3. Trait Anxiety Inventory-Child Scale (Spielberger, 1973)
4. Child Depression Inventory (CDI; Saylor, Finch, Spirito, & Bennett, 1984)
5. Child Assessment Schedule (Hodges, Kline, Fitch, McKnew, & Cytryn, 1981)
6. Anxiety Disorders Interview Schedule for Children (Albano & Silverman, 1986)
7. Beck Anxiety Inventory (BAI; Beck & Steer, 1990)
8. Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990)
9. Penn State Worry Questionnaire-A (PSWQ-A; Hopko, et al., 2003), 8 item screener

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 SSRIs, buspirone, and the SNRI-venlafaxine (Ellison, 1996).

Psychotherapies which have been most helpful include cognitive-behavioral therapy (Evans 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 were combined. Overholser and Nasser (2000) indicated 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" (APA, 2013, p. 150). Evidence-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 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). OCD was previously within the DSM-IV-TR category of anxiety, body dysmorphic disorder was previously within the somatoform category, and trichotillomania was previously within the other impulse control disorders.

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, Schotte, Denys, van Megen, & Westenberg, 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, 1996). Rasmussen and Tsuang (1986) indicated 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. Assessing for OCD requires evaluating both obsessions and compulsions (King, 2014j). 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.). Obsessions are the presence of recurrent or persistent thoughts that the individual tends to ignore or suppress. Compulsions are repetitive behaviors and mental acts meant to prevent or reduce the anxiety.

Cognitive models emphasize six domains of dysfunctional beliefs or thoughts. These include: (1) over-importance of thoughts, (2) need to control these thoughts, (3) perfectionism, (4) intolerance of uncertainty, (5) inflated personal responsibility, and (6) overestimation of threat (Alonso et al., 2013;

OCCWG-Obsessive Compulsive Cognitions Working Group, 2005). Assessing for OCD requires evaluating both obsessions and compulsions (King, 2014j). 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). Anxiety is prominent in that it is a result of behavioral activation, a building of tension. Client behavioral avoidance is the clue to this restlessness. Criterion A.1. specifies that thoughts, urges, or images are intrusive and unwanted. Criterion A.4. specifies that the client recognize that his/her thoughts and urges are a product of his/her own mind and in Criterion B the client recognizes that these thoughts and urges are unreasonable and excessive (APA, 2013). Criterion B includes that the amount of time for obsessions or compulsions is more than one hour per day. The assessor is to specify if the OCD assessment is with good or fair insight, with poor insight, or with absent insight/delusional beliefs. 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. Craske, Niles, Burklund, et al. (2014) reported that CBT is the empirically supported treatment for social phobia; however, some clients remain symptomatic. Their efficacy study regarding ACT and CBT for social phobia resulted in ACT specifically targeted anxiety symptoms (avoidance, negative evaluation). Key features of CBT and ACT are that CBT emphasizes symptom reduction while ACT focuses on psychological flexibility. The outcome indicated that CBT and ACT performed equally. Their randomized clinical study compared ACT with a wait list. 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. Social skills training as a treatment intervention when compared with social effectiveness therapy (SET) was efficacious. SET provided additional benefit specifically for social distress and social behavior (Beidel, Alfano, Kofler, Rao, Scharfstein, & Sarver, 2014)

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 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 one-year rate of 0.5% to 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 disorders, mood disorders, learning disorders, somatoform disorders, psychoses, eating disorders, and substance disorders (Albano, March, & Piacentini, 1999). The DSM-5 Level 2-Repetitive Thoughts and Level 1 Cross-Cutting Symptom Measure are recommended for data gathering,

monitoring, and treatment planning for children ages 6 to 17 (King, 2014f). 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, 1989a)--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, 1988a,b)
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 et al., 1989; 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) provided a comprehensive table of such programs that include Kraepelin'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. The use of computer-assisted software packages for assessment and treatment of OCD appear to be useful but there have been a limited number (eight) of outcome studies contained in the literature thus far.

Treatment:

Karno and Golding (1991) found that clients reported they had OCD symptoms at least seven years before seeking treatment. After seeking help they are likely to receive medication, nonmedical approaches such as psychotherapy or CBT, or combined treatments. Kobak, Greist, Jefferson, Katzelnick, and Henk (1998) and Greist and Jefferson (2007) pointed 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, indicated that behavioral treatment is the most effective. The interventions were systematic desensitization, modeling, muscle relaxation, exposure, and response prevention (McLeod, 1997). Combined treatments 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. Techniques for CBT are based on learning theory and combine 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, provided 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 Wiebe (1992) recommended a less intense form of exposure therapy for children, as well as relaxation and breathing training. Marks (1981) indicated that for adults combining exposure therapy with response prevention is a treatment of choice. Karasu (1989) found support for supportive psychotherapy.

Acceptance and commitment therapy (ACT) has demonstrated promise in treating OCD. ACT's objective is to increase flexibility regarding the belief system held by many OCD clients. Six core processes are the treatment goals that include: acceptance, defusion, self as context, present moment awareness, values, and committed action (Hayes, Strosahl, & Wilson, 2011).

Cognitive models emphasize six domains of dysfunctional beliefs or thoughts. These include: (1) over-importance of thoughts, (2) need to control these thoughts, (3) perfectionism, (4) intolerance of uncertainty, (5) inflated personal responsibility, and (6) overestimation of threat (Alonso et al., 2013; OCCW-Obsessive Compulsive Cognitions Working Group, 2005). Assessing for OCD requires evaluating both obsessions and compulsions (King, 2014j).

Treatment Efficacious

Barrett et al. (2008) analyzed 50 peer-reviewed randomized controlled treatment studies regarding child and adolescent OCD. Twenty-one (50 total) studies met criteria for Type I, four met criteria for Type II, and the remaining were classified as uncontrolled studies Type III. Findings indicated that none of the 21 studies met criteria for well-established, probably efficacious was met by exposure-based ICBT and possibly efficacious met by family focused GCBT and family-focused individual (ICBT).

Well-established (WE): None

Probably efficacious: Individual exposure-based CBT

Possibly efficacious: Family-focused individual ICBT and family-focused GCBT.

Cognitive models emphasize six domains of dysfunctional beliefs or thoughts. These include (1) over-importance of thoughts, (2) need to control these thoughts, (3) perfectionism, (4) intolerance of

uncertainty, (5) inflated personal responsibility, and (6) overestimation of threat (Alonso, et al., 2013; OCCW-Obsessive Compulsive Cognitions Working Group, 2005).

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 tricyclic antidepressants--except for the tricyclic Clomipramine (Anafranil)--are ineffective for significantly reducing OCD (Mavissakalian & Prien, 1996). However, in addition to Clomipramine (Thoren, Asberg, Cronholm, Jornestedt, & Traskman, 1980; Turner, Jacob, Beidel, & Himmelhoch, 1985), selected SSRI antidepressants, particularly Fluoxetine and Luvoxamine, have proven to be effective. Wilhelm et al. (2008) in a recent study found that D-cycloserine enhanced the effectiveness of behavior therapy with OCD clients.

Hollander, Alterman, and Dell'Osso (2006) suggested 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 computer-assisted assessment and treatment has been recently developed to treat OCD and consists of three types of specific technology include virtual reality, hand-held computers, and software programs (Lack & Storch, 2008). Greist 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 it 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 classified as a disorder within the obsessive-compulsive and related disorders in the DSM-5 (Knoblock, 2013). In earlier versions of the DSM it was classified as a somatoform disorder and even a psychotic disorder. Body dysmorphic disorder is a preoccupation (often a secret) with one or more perceived defects or flaws (imagined defect in appearance) and often-repetitive behaviors to avoid the appearance (APA, 2013). The average age of onset is 15 and typically lasts 18 years. Others do not notice the flaws or concerned defects but often the client compares oneself to others. The concern can be that one's body is too small or too large. Phillips, McElroy, Keck, Pope and Hudson (1993, 2006) reported in 30 cases of imagined ugliness that men (17) and women (13) reported defects with an average of four preoccupations such as hair, nose, and skin. There is preoccupation with delusional or nondelusional defects and the behavior of an individual with this disorder is characterized by mirroring, checking, camouflaging or attempting to hide the flaw, avoiding social gatherings, and even making suicide attempts. Frequently an individual with this

disorder will also suffer from another disorder such as major depressive disorder or a psychotic disorder.

Assessment and Instrumentation:

Added to the DSM-5 symptom list is client awareness to performing repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or a mental act of comparing. The Brown Assessment of Beliefs Scale (Eisen et al., 1998; Knoblock, 2013) is a useful instrument because it is a brief 7-item scale assessing for beliefs in the past week for insight and provides a cut score for nondelusional beliefs. It would be important to assess for depression when the client expresses beliefs of ugliness. The Hamilton Rating Scale for Depression can be useful to determine if there is an accompanying mood disorder (Hamilton, 1960).

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 comprises 5% of the client population in outpatient clinics and up to 50% in hospitals or psychiatric consultations (APA, 2013). Field data reported that 10% of psychiatric diagnoses are adjustment disorders. This diagnosis 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, and 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 for adjustment disorder include:

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, 2013). 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 include:

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:

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

Incidence:

The APA (2013) reported 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 do women and girls.

Diagnostic Considerations:

The diagnosis of adjustment disorder is less serious than posttraumatic 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 posttraumatic 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 client 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 clients 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, and cognitive disputation, and 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 may need 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 and adolescents):

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 that include:

Cognitive problem-solving skills training (PSST) consist 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 but 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 fourteen symptoms in Criterion B.

The four types of exposures are:

1. Directly experiencing
2. Witnessing, in person, the event 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 (APA, 2013, p. 280).

The 14 Criterion B symptoms include 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 posttraumatic 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 have 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, antisocial 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% to 33% (APA, 2000). The DSM-5 indicated 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).

Posttraumatic 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 6 or younger (APA, 2013). Posttraumatic 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 anxiety disorders, although has some similar symptoms with 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, but does not apply to media exposure unless it is work related as exemplified by 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, and physiological or psychological reactions from trauma reminders. Avoidance is to avoid situations that elicit the memories or external reminders (requirement of one). Alterations in cognition and mood are 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 posttraumatic stress disorder or acute stress disorder 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 (King, 2013d; Resnick, 1997). If the client 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 (APA, 2013). Breslau, Kessler, and Peterson (1998) recommended using a structured interview during assessment. 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).

Caution is exercised when assessing for psychotic features or a psychotic disorder because the assessor may fail to identify a trauma or trauma history and as a result does not assign PTSD as the diagnosis.

Incidence:

The APA (2013) cited a 12-month prevalence rate of 3.5%. The APA (2000) cited a lifetime prevalence of posttraumatic 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, Schienger, Fairbank, 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 whom 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, van Kammen, 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) reported 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 noncombat soldiers had PTSD. Of interest is the incidence of comorbid 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) cited 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;

Grubaugh, Elhai, Cusach, Wells, and Freuh (2007) reported that the PTSD Checklist (PCL) is a widely used instrument for assessing PTSD. The PCL contains 17 items that are rated on a 1-5 scale for symptom frequency (Weathers et al., 1993). Other PTSD instruments include

1. The Revised Civilian Mississippi Scale for PTSD (Keane, Caddell, & Taylor, 1988; Norris & Perilla, 1996). Self-reported symptoms of posttraumatic stress in veteran populations.
2. Civilian Version of the Mississippi PTSD Scale (Norris & Perilla, 1996)
3. MMPI-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 Posttraumatic Stress Disorder (Breslau, Peterson, Kessler, & Schultz, 1999)
8. Short Screen Scale for DSM-IV PTSD (Breslau et al., 1999)
9. Harvard Trauma Questionnaire (Mollica et al., 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: (a) critical incident stress debriefing (CISD; Mitchell, 1988), (b) psychotherapy, (c) group therapy, (d pharmacotherapy, (e) cognitive-behavioral therapy, (f) art therapy, (g) hypnotherapy, (h) abreactive therapy, (i) flooding, (j) neurolinguistic programming, (k) eye movement desensitization, (l) restructuring (EMDR), and (m) trauma incident reduction therapy (TIR). Many of today's posttraumatic treatment modalities are based on variations of hypnosis (Brende, 1985) and 'reliving' techniques first used a century ago (hypnotic abreactive treatment) (Breuer & Freud, 1893) and abreaction (Jung, 1954). Drug induced abreaction was also used (Perry & Jacobs, 1982), as well as other nonchemical '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 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). Bradley, Green, Russ, Dutra, and Westen (2005) reported that a randomized trial study for patients exposed to psychotherapy with cognitive and eye movement and reprocessing desensitization improved and maintained that improvement.

Rape trauma victims with PTSD have benefited from stress management (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick & Schnicke, 1993; Resick, Gordon, Girelli, et al., 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 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 a trauma victim process and modify trauma-related beliefs than 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).

Treatment (Evidence-based Child and Adolescents)

Evidence-based treatment for children and adolescents exposed to trauma was evaluated by Silverman et al. (2008) for efficacy. The evaluation covered the years 1992 to 2006. The authors analyzed 23 peer-reviewed randomized controlled studies regarding sexual abuse (11 studies),

physical abuse (3), community violence (1), major hurricane (1), marital violence (1), and vehicle accident (1). Seven of the studies were classified as Type 2 and 16 Type 1.

Well-established (WE): Trauma-focused behavioral therapy (TF-CBT)

Probably efficacious: School-based group cognitive-behavioral, cognitive-behavioral intervention in schools

Possibly efficacious: Resilient Peer Treatment (RPT), Family Therapy (FT), Client-Centered Therapy (CCT) Cognitive-Processing Therapy, Child-Parent Psychotherapy (CPP), Cognitive- Behavioral Therapy for PTSD, Eye Movement Desensitization and Reprocessing (EMDR)

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 (King, 2014).

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 (2000, 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, 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. 292). 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) that are inconsistent with everyday memory. Recurrent memory gaps in everyday events, important personal information and trauma events that are independent of common forgetfulness are assessed (King, 2014g)
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) explained 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:

The APA (2013) reported 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 five 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 the 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) is a 28-item self-report scale that takes 7 to 20 minutes to take and score. 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). The DDIS is a 236-question structured interview that is 90% sensitive, and takes 75 to 90 minutes to administer.
2. Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1993 a, b).

Treatment:

Chu (1998) suggested that prior to embarking on treating a client 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 bipolar disorder, intermittent explosive disorder, borderline personality disorder, schizophrenia, and posttraumatic 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 client 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 psychological treatment is usually followed with medication (antidepressants and anxiolytic medication) and expressive therapies (Brand et al., 2009).

The initial goal in treating a client 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 referred 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) offered 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) recommended 13 guidelines in treatment, (although not included is the important step of controlling persecutory or destructive personalities) that include:

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) suggested 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), and 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 is not 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, 2000, 2013, p. 520). The prevalence rate is reported to be 1.8% over a 12-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 of depersonalization, derealization or both (Criterion A). The client's symptoms are characterized by a feeling of detachment from oneself (depersonalization) or surroundings (derealization). The individual may have the experience of feeling like an "automaton", "living in a dream or movie" 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 symptoms 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 maladaptive thoughts, feelings, and behaviors that define the condition (Carter, 2008; King, 2014f).

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, 2013j).

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 that represent emotional states, the mental health assessment must take this into account, and the interviewer's questions should be directed in ways that can determine the connection. Carter (2008) suggested the assessment protocol should include an evaluation for malingering. Clients with physical symptoms and/or somatization disorder may also 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 is to be met:

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 (APA, 2013, 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. The APA (2013) emphasized thoughts, feelings, and behaviors that accompany the symptoms and are persistent for six months. McKay and Bouman (2008) cautioned the clinician to be aware that individuals with somatization disorder often do not establish clear boundaries and may lack conviction about the nature of their illnesses. Taylor and Asmundson (2004) and McKay, Abramowitz, Taylor, and Asmundson (2009) provided guidelines for the clinician to clarify and identify the presence of a strong disease conviction. Other factors that differentiate from somatization disorder include: Clients with body dysmorphic disorder often report embarrassment and may also be obsessed with or even delusional about physical abnormalities. Clients with conversion disorder can be emotionally detached and lack appropriate concern about the seriousness of their physical disorder. Hypochondriacal clients often are excessively convinced about the seriousness or even potentially lethal nature of their physical symptoms and psychotic clients' symptoms include delusional beliefs and body sensations.

Incidence:

The APA (2013) reported no known prevalence rate at this time; however, it may be around 5% to 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 (Blazer, Kessler, McGonagle, & Swatz, 1994; Kessler, Somnega, Bromet, et al., 1995; 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 can also 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 the Twelve Theme Assessment of Post-Traumatic Symptoms (HSTE-12) is a validated instrument (Brende, Gfroerer, & Arthur, 1997) that assesses the prevalence of traumatic histories and the severity of posttraumatic 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 clients 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 the clients' socialization and coping skills (Corbin, Hanson, Hopp, & Whitley, 1988; Ford, 1984). Moreno, Gill et al. (2013) reported when 168 somatization diagnosed patients were compared using three treatments; treatment as usual (TAU), individual CBT, and group CBT that post-treatment screening results revealed that greater individual changes were achieved in the individual CBT patients. Smith describes a 7-step approach in leading such a group that includes:

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 dysmorphic disorder, conversion disorder, and somatization disorder. These interventions are composed of theories, attention training, distraction, hypnosis, social and environmental manipulation, and awareness of 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, and special sensory, and mixed symptoms. The assessor is to specify if acute episode is persistent and with psychological stressors or without psychological stressors (APA, 2013). A neurological examination is emphasized and the recognition of the importance of relevant psychological factors present at the time of diagnosis.

Treatment:

Treatment findings are scant, although 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. Motivational interviewing is recommended for patients suspected of psychotic and drug use disorders (Martino, Carroll, Charla, & Rounsaville, 2006) and as an adjunct to exposure therapy for anxiety disorders (Slagle & Gray, 2007). The malingerer 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 client 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 client 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. Parnell and Day (1998) provided eighteen guideline features and three categories: child-victim, mother-perpetrator, and family.

Incidence:

The APA (2013) reported the prevalence rate is unknown other than in 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 patients (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. Carter (2008) indicated that assessment procedures should include an observation for malingering or screening using an instrument. An assessment that includes instruments to validate suspected malingering might include the Minnesota Multiphasic Personality Inventory-2, Structured Interview of Reported Symptoms, Specialized Tests of Poor or Intentional Failure on Neuropsychological Assessments, Tests of Memory Malingering (TOMM), Word Memory Test, Computerized Assessment Response Bias, Portland Digit Recognition Test, and Victoria Symptom Validity Test. Because individuals with factitious disorder have physical symptoms that represent self-destructive or injurious behaviors that hide emotional pain, the mental health assessment must take this into account. 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 include:

Criterion A: imposed on self are falsifications of physical or psychological signs or symptoms 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 reward

Criterion D: behavior is not better explained by another mental disorder (pp. 324-325).

The mental health professional must differentiate between factitious 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 disorders.

A History and Severity of Traumatic Events and the 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 posttraumatic syndromes or somatization disorder, it also may be of some use in the client with a 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. The presence of 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, individuals with Munchausen by proxy often avoid or flee treatment.

Feeding and Eating Disorders

Flegal, Carroll, Odgen, and Cutin (2010) reported that two thirds of the adults in the United States are overweight (body mass index [BMI] > 25) or obese (BMI > 30). The DSM-5 disorders within the classification of feeding and eating disorders include: pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge eating disorder.

Abraham and Llewellyn-Jones (1997) postulated 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 (King, 2014d; Shekter-Wolfson). Shallcross (2013) indicates that gender is important because males and females use different language 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 Disorder

Definition:

The core concepts for anorexia nervosa are unchanged. The requirement for amenorrhea 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 their body. The criteria have been expanded to include persistent behavior that interferes with weight gain in addition to an overly expressed fear of gaining weight. Severity is based on BMI.

Assessment:

Palmer, Oppenheimer, Dignon, Chaloner, and Howells (1990) recommended 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).

Schwitzer (2012) considers a diagnostic and conceptual profile when diagnosing women for anorexia nervosa includes:

> Primary symptoms (duration/severity, associated cognitive features, associated behavioral features
>
> Co-occurring features (depressive mood symptoms, anxiety symptoms)
>
> Common psychological and development themes (low self-esteem, interpersonal dependency, perfectionism)
>
> Common psychosocial, environmental, and family features (family history and dynamics, school and academic pressures, psychosocial history)
>
> Help-seeking characteristics (multiple help-seeking attempts, initial presenting concerns, past counseling, and past adjunct supports (p. 282).

Berg, Peterson, and Frazier (2012) recommended specific questions to be used when assessing eating disordered symptoms. A few sample questions will be matched with type and include:

> Screening: Eating behaviors--"What is your general eating pattern?"
>
> Compensatory behaviors--"Have you ever done anything to compensate for what you have eaten, such as self-induced vomiting or taking laxatives?"
>
> Body esteem—"How do you feel about your shape and weight?"

Diagnostic fear of weight gain--"Have you ever been afraid of gaining weight?"

Overvaluation of shape/weight--"Does your shape/weight influence how you feel about yourself?"

Body image disturbance--"Do you still feel that your body or part of your body is too large?"

Seriousness of low body weight--"Has anyone told you that it could be dangerous to be as thin as you are?"

Binge eating--"Have you ever had a binge eating episode?"

Compensatory behavior--"Have you ever self-induced vomiting to control your shape or weight?"

Dietary restriction--"Have you ever tried to follow any dietary rules such as rules about how much you can eat, what types of foods you can eat, or what you can eat?" (p. 264)

The diagnosis is to specify one of two commonly identified subtypes of anorexia nervosa: restricting and binge-eating/purging within the last three months. 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 self-induced by purposeful vomiting or by misusing laxative agents (p. 339). 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., 1997). Binge eating/purging type clients engage in recurrent episodes of binge eating or purging behavior.

Incidence:

The prevalence for a 12-month period for anorexia 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 around .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, 1986; Mazzeo, 1999)
4. Eating Disorder Belief Questionnaire (EDBQ; Cooper, Cohen-Tovee, Todd, Wells, & Tovee, 1997)
5. Eating Disorder Thoughts Questionnaire (EDTQ; Cooper, Todd, Woolrich, Sommerville, & Wells, 2006)
6. Body Image Avoidance Questionnaire (BIAQ; Rosen, 1991)
7. Body Checking Questionnaire (BCQ; Reas, Whisenhunt, Netemeyer, & Williamson, 2002)

8. Satisfaction with Body Parts Scale (SBPS; Berscheid, Walster, & Bohrnstedt, 1973)
9. Eating Disorder Examination Interview (EDE-Q; Fairburn & Belgin, 1994)
10. Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Regier, Touyz, & Beumont, 2002)
11. Emetophobia Questionnaire (EmetQ-13; Boschen, Veale, Ellison, & Redell, 2013)

Treatment:

A lack of motivation for treatment to modify eating disordered thoughts and to adhere to suggested changes is often because the eating disordered client perceives the issue as ego-syntonic (Guarda, 2008; Vanderlinden, 2008). The strategy for acceptance and commitment therapy (ACT) is to teach the client to learn to accept the presence of distressing thoughts and feelings without using the urges as a guide for the negative and avoidance behaviors related to eating.

Research in two different trials revealed that ACT was more productive than CBT. ACT targets treatment motivation through clarifying goals and values in relation to eating episodes and body image (Herbert & Forman, 2012, Juarascio, Shaw, Forman, Timko, et al., 2013; Juarascio, Forman, & Herbert, 2010).

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 (2007) cited research 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. The overall goal for these psychotherapies is for symptom reduction and elimination and in reducing the risk for relapse (Lowe et al., 2001; Steinhausen, 2002). Psychoeducation is 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, Whittaker, Shoebridge & Campbell, 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 focus on improving mood disturbances, poor self-esteem and feelings of ineffectiveness (control), which comprise a large component of psychological concerns for 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, & Hilbert, 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) indicated 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) believed 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 and 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, 2007).

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 Disorder

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, p. 345) described the essential features as binge eating, inappropriate compensatory methods to prevent weight gain, and self-evaluation that is unduly influenced by body shape and weight.

Criterion C changed the minimum frequency of binge eating average from twice a week to once weekly for three months. 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 the ability to maintain self-control. Ironically, the loss of self-control is a significant part of both bingeing and purging. Criterion A requires that both A.1. and A.2. behaviors are met. A.1.stipulates that the eating occurs during a discrete period of time (any two-hour period an amount of food is eaten that is definitely larger than what most people would eat in that same time period). The A2. Requirement is that the client experiences a sense of a lack of control over the eating during the episode (APA, 2013, p. 345).

Criterion B refers to the compensatory behaviors such as self-induced vomiting, misuse of laxatives, diuretics, or other medications and fasting or excessive exercise.

Understanding the definition of 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% to 1.5%.

Treatment:

The treatments of choice for adults with 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). Cognitive behavioral treatment (CBT) is currently considered to be the most effective treatment for eating disorders, especially for bulimia (National Institute for Clinical Excellence; 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 that 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 other two treatments (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. The first step of treatment is to help normalize eating and then to address other issues associated with the eating

disorder. Normalization generally begins with a dietary consultation 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. CBT has an advantage, however, since it has been proven to be more cost-effective. Trials have shown that CBT brings positive results within 20 weeks, while IPT needs one year (Fairburn, Jones, & Peveler, 1991; Stolorow, Brandchaft, & Atwood, 1987).

Family therapy is also recommended by NICE (2004), although a recent comparison study by Schmidt, Lee, Beecham et al. (2007) with 85 bulimia nervosa clients reported that CBT was more effective at six months while at twelve months this difference disappeared. The conclusion was CBT had a slight advantage when it came to time (cost) but not necessarily improvement of symptoms.

Treatment: (children and adolescents)

1. Keel and Haedt (2008) conducted an eating problems and eating disorder efficacious study with published articles during the years 1985 to 2006. The randomized controlled design studies included Type I (2), Type II (10) for young adolescents (ages 11-20) and 49 empirical studies for adults aged 17-65. The majority of the studies related to bulimic nervosa (BN). In the adult studies CBT is the treatment of choice for older adolescents.
2. Well established (WE): Family therapy
3. Probably efficacious: None
4. Possibly efficacious: Psychoanalytic therapy, Cash's Body Image Therapy, Family therapy for BN, CBT Guided Self-Care for Binge Eating in BN.

Binge Eating Disorder (BED)

Definition:

Binge eating in the DSM-IV-TR was only referred to as a problem requiring clinical attention while in the DSM-5 binge eating is a category disorder. Binge eating disorder is recurrent binge eating, distinct distress about the binge eating, an absence of inappropriate weight compensatory behavior, eating unusually large amounts of food, eating in secret and alone, experiencing a loss of control, and being sensitive to negative emotions (Grilo & White, 2011). Epidemiological studies report lifetime prevalence estimates in the community of 3.5% among women and 2.0% among men (Hudson, Hiripi, Pope, & Kessler, 2007) while the DSM-5 (APA, 2013) reported 12-month prevalence rates of 1.6% (males) and 0.8% (females) for adults 18 and older.

Assessment:

Criterion A stipulates for recurrent episodes of binge eating during any two-hour period of time and includes a sense of a lack of control in eating. Assessing for binge eating consists of eating episodes associated with three (or more) of the following: (a) eating much more rapidly than normal, (b) eating until uncomfortably full, (c) eating large amounts of foods when not feeling physically

hungry, (d) eating alone because of being embarrassed by how much one is eating, and (e) feeling disgusted with oneself, depressed, or very guilty after overeating (APA, 2013, p. 350). In addition, Criterion C specifies that the binge eating does not include compensatory behavior.

Schwitzer (2012) outlined categories for assessment including diagnostic features, co-occurring features, common psychological and developmental themes, common psychosocial and family stressors, and help-seeking characteristics. Within each of these categories are specific questions such as cognitive features (rumination about body appearance, thinness, weight management), behavioral features (weight fluctuations, excessive exercise, secretive eating), low self-esteem (fragile or unstable self-esteem), perfectionism (difficulties with problematic perfectionism across different domains such as body image and academics), family history (likely to have a family member with an eating disorder), psychosocial history (possibility of past sexual victimization experiences), multiple help-seeking attempts, presenting concerns (appearance of adjustment disorder rather than feeding and eating disorder), and past counseling.

Berg, Peterson, and Frazier (2012) delineated specific questions to ascertain behavior symptoms for screening and for diagnosis. These questions assess for compensatory behaviors, body esteem, fear of weight gain, over-evaluation of shape/weight, body image disturbance, seriousness of low body weight, binge eating, and dietary restriction.

Treatment:

Prevention, intermediate, and psychotherapeutic approaches to treat eating disorders include recognizing potential clients susceptible to an eating disorder, those clients experiencing symptoms or characteristics of an eating disorder but not meeting full criteria for an eating disorder, and clients who do meet full criteria for a feeding and eating disorder.

Psychotherapeutic approaches found to be effective included cognitive behavior therapy (CBT), interpersonal therapy (ITP), and dialectical behavior therapy (DBT; Schwitzer, 2012). Presently CBT has been the gold standard, with cited efficacy studies in the literature (Wilson et al., 2007). Vanderlinden et al. (2012) reported using a manualized CBT approach with binge eating clients and the focus was to achieve a reduction in the number of binge eating episodes and to decrease the number of times losing control over the eating behavior. To achieve these goals the clients were encouraged to normalize their eating behaviors and to eat a minimum of three times a day and to stop dieting. Achieving these goals provided effective feedback in monitoring improvement.

Sleep-Wake Disorders

The classification for sleep-wake disorders includes 10 disorders or 3 groups of sleep disorders. The three groupings and disorders include:

1. Insomnia disorder, hypersomnolence disorder, narcolepsy
2. Breathing-related sleep disorders include obstructive sleep apnea hypopnea, central sleep apnea, sleep-related hypoventilation, circadian rhythm sleep-wake disorders (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: nonrapid eye movement (NREM) sleep arousal disorder, 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, 2014c).

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 two or more 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).

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 rate 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 mood disorders, pain, medical conditions, neurodegenerative disorders, medication effects, respiratory disorders, and congestive heart failure, all of which can cause sleep disturbances and should be questioned 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 individuals with serious sleep problems are encouraged by family members to see their physicians. For example, if the wife becomes aware and concerned that her husband 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. If there is a major problem with snoring he may be referred to an ENT (ear-nose-throat) specialist to diagnose for an airway obstruction.

Assessment:

It is important to understand the stages of sleep for daytime and eveningness. Eveningness is the preference of an individual who chooses later to bed and later to rise. Assessing evening sleep-wake patterns means checking on behavioral activities associated with sleepiness and alertness during 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 experiences behaviorally related sleep issues such as falling asleep while sitting and reading, in public places, as a passenger in a vehicle, talking to someone (drowsing off), after lunch, at a traffic light or after a workout (Johns, 1991).

The DSM-5 provided more focus and detail to comorbidity and to co-existing conditions. Time 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 disorder often involves talking and moving during the REM phase of sleep and has a prevalence rate of 0.38% to 0.5% (APA, 2013; King, 2014c). 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 online.

During the assessment for a specific sleep-wake disorder the interviewer is to be aware of neurobiological validators and genetic evidence before and during the data gathering. This is important because of the relationship that exists between sleep-wake disorders and mental and medical conditions. King (2014h) reviewed many of those relationships and found embedded sleep problems 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).

The assessment pointed out earlier can include inventories and questionnaires such as: (a) sleep diary, (b) Sleep Disturbance Questionnaire (Espie, Brooks, & Lindsey, 1989), (c) Sleep History Questionnaire (Edinger, 1987), (d) Sleep Impairment Index (Morin, 1993), (e) the Beliefs and Attitudes about Sleep Scale (Morin, 1993), (f) Pittsburgh Sleep Quality Index (Buysse, Reynolds, Monk, Berman, & Kupfer, 1989), and (g) 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 that often carry over into daytime disruptions in alertness. Along with these

issues may be found hyperarousal experiences contributing to daytime and nighttime disturbances for restful sleep.

A symptom checklist may highlight issues such as snoring, leg movements, and daytime fatigue and may alert the assessor to sleep-wake disorders such as sleep apnea, restless legs syndrome, narcolepsy, or 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, poorer sleep (stage 1) with a longer latency to sleep (stages 3 and 4), earlier morning awakenings, and reduced sleep efficiency. When an individual has insomnia marked by fragmented sleep there are different factors to analyze including age, times of broken sleep, length of sleep latency, early morning awakening and reduced sleep efficiency.

Treatment:

Treatment for sleep-wake disorders may vary depending upon the specific disorder. Pharmacotherapy includes anxiolytics, sedatives, certain low-dose antipsychotics and some antidepressant medications.

There is a strong correlation between sleep issues and mood or depressive disorders. Bright light therapy has some benefits for insomnia (Campbell, Dawson, & Anderson, 1993). Cognitive-behavioral therapy (CBT) has demonstrated helpfulness for insomnia, with improvement noted in two to six sessions.

Bibliotherapy in the form of homework has some positive effects in booklet form or as specific CBT strategies and exercises.

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 an excessive amount of time in bed (more wake time, less deep sleep and more light sleep-stage 1 (Morin, Hauri, Espie, Spielman, Buysse, & Bootzin, 1999; Riemann, Fischer, Mayer, & Peter, 2003).

Some specific psychological techniques have also shown positive gains, such as cognitive restructuring, paradoxical intention and relaxation therapy. Two new approaches to treat sleep-wake disorders are mindfulness and a treatment identified as CBT-I for insomnia (Edinger et al., 2009; Milner & Bilecki, 2010) although they lack effectiveness data in the literature.

Carney (2013) reported the American Psychological Association established sleep psychology as a specialty area and supported CBT-I as a standard treatment for sleep disorders. Brief data from four studies indicated that 40% to 50% of clients reported improvements above expectations. The treatment method included requesting that the client record bedtimes and each day upon awakening assign a rating, number or word representing the sleep quality and the number of night awakenings. The counselor should also use common sense advice like reducing caffeine and alcohol intake and making sure the bedroom is dark and quiet. Therapy is composed of three segments: stimulus control, restriction, and common sense.

Several surgical procedures are available for certain sleep disorders associated with obstructive breathing and sleep apnea but they will not be discussed in this supplement.

Insomnia Disorder

Insomnia is described as client dissatisfaction with initiating and maintaining sleep, and early morning awakenings. Criterion C (APA, 2013) defines insomnia as poor quality and quantity, insufficient, or nonrestorative sleep for a period of three nights per week and persisting for at least three months (APA, 2013; Buysse & Reynolds, 1990). The diagnosis of insomnia disorder is further defined as a sleep disturbance that causes clinically significant distress in a number of areas of daily functioning and is not caused by a substance. When insomnia goes untreated the client basically goes deprived of a pleasant quality of life. Voinescu, Szentagotai, and David (2012) reported that insomnia together with abnormal sleep circadian cycles are also associated with a worsening of overall satisfactory rest.

Incidence:

The prevalence rate for insomnia disorder is estimated to be a third of the general population and can be broken down into 10% to 15% experiencing daytime impairment and 6% to 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, 2003, 2005, 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 about 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 for insomnia disorder are one or more of the following: (a) 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, (b) and present for at least three months, (c), an impairment in functioning, (d) and not better explained by physiological effects or substance, and (e) or another sleep disorder. Edinger, et al. (2011) studied sleep patterns in women who were aged 50 and older and suffered from nonmestastic cancer. These researchers described diminished sleep quality (particularly when influenced by depression), as objective characteristic (broken sleep), insomnia symptom severity (nocturnal awakenings were excessive), and daytime sleepiness (onset was longer).

Treatment:

Milner and Belicki (2010) reported that treatment for insomnia should include physical and psychological approaches. Examples of physical approaches included pharmacology and bright light therapy. Psychological approaches include CBT-I (most effective), sleep education, sleep hygiene, sleep restriction, cognitive restructuring, paradoxical intention and relaxation therapy (common technique).

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 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 resulting in snoring (Rothenberg, 1997). When the obstruction is significant enough to block adequate breathing during the night, sleep apnea results. Individuals with sleep apnea associated with obstructive breathing are at risk for hypertension, pulmonary hypertension, and stroke. Interviewers should note symptoms of loud snoring, reports by others of apnea, and awakenings with choking, coughing, or gasping for breath (Stepanski, Rybarczk, Lopez, and Stevens, 2003). These individuals suffer from a reduced oxygen supply to the brain which, when occurring long periods of time, may cause changes in the neuron of the hypocampus and the right frontal cortex of the brain. Neuroimaging has revealed evidence of hyppocampal atrophy in more than 25% of individuals with obstructive sleep apnea (OSA), resulting in difficulties with nonverbal information, executive functions, and working memory. Because of the adverse effects on cognitive functioning they may also be observed to have difficulty with manual dexterity (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 indicated 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 combative. The combination of these activities is referred to as sleep inertia.

Incidence:

The prevalence rate is approximately 5% to 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 nine 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 nonrestorative sleep.

Criterion B indicates hypersomnolence occurs at least three times per week for at least three months.

Narcolepsy

Narcolepsy is distinguished as unique from hypersomnolence in the DSM-5. It is a disorder of the neural control mechanisms (sensorimotor, neurological) that regulate sleep and waking and is represented by a recurrence of irrepressible desires to sleep, lapsing into sleep, or napping occurring in the same day. Hypocretin is a neuropeptide neurotransmitter, secreted by the hypothalamus in the brain that plays an important role in the regulation of sleep cycles. Obtaining a small amount of cerebral spinal fluid via a spinal tap can do testing for the presence of hypocretin. The presence of a low or nonexistent hypocretin level may indicate a need for a sleep study to confirm a diagnosis of narcolepsy.

Specifically, Criterion A sleepiness occurs at a minimum three times a week for at least three months. One of the following must be 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 (the absence of 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 mid-day nap, and unexplained accidents during the day. The various causes for obstructed airways can be poor muscle tone in the throat and tongue, the hyperrelaxation effect of alcohol and or a sleeping pill, long soft palate and uvula narrows the passage, deformities, and obesity.

Assessment and treatment:

An interview should include identifying symptoms such as snoring or waking up from sleep times gasping for breath. A physician will, in most cases, refer the client to a neurologist or directly to a sleep laboratory for a polysomnography. A central sleep apnea is diagnosed when breathing cessation is longer than 10 seconds. 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 (C-PAP) 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).

Parasomnias

The term parasomnia refers to a wide range of behaviors associated with sleep. Individuals with these disorders all experience an activation of the physiological system (autonomic nervous, motor, or cognitive systems) at inappropriate times during the sleep-wake cycle (APA, 2000, 2013). This results in the activation of associated behaviors that can include sleep walking, sudden or partial awakenings from deep NREM sleep, night terrors (nightmare disorders), and confused awakenings (insomnia disorder). Parasomnia disorder is also characterized by rapid eye movement behavior disorder (RBD). The interviewer should be alert to reports of acting out during which the dreamer 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 nonrapid 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 generally are referred to as nightmares that scare individuals out of REM sleep into a state of full alertness. Nightmare disorder causes significant distress. In children ages 3 to 5, 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). The APA reported prevalence rates of 1.3% to 3.9% for preschool children, decreasing for both genders after age 29 and 1% to 2% for adults that experience, with 6% reporting frequent nightmares at least monthly (APA, 2013). 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 et al., 2001).

Interview and assessment:

The interviewer who assesses for nightmare disorder should ask about recurring frightening dreams that are hard to forget. When considering diagnostic features the interviewer is to listen for repeated dysphoric and well-remembered dreams. Furthermore, the interviewer should ask the client if he or she has symptoms related to any other disorder or has been using substances since nightmare disorder cannot be attributed to the physiological effects of a substance and or to other mental disorders. In relating the dreams the client frequently has an elaborate, lengthy, and story-like order in relating that seems real. The nightmare is typically emotionally laden and comprised of themes of victimization or escape from harm or danger about which he or she can remember every detail (APA, 2013). Nightmares usually occur in the middle of the night or early morning when REM sleep and dreaming are more common. Nightmares erupting from REM sleep during the early portion of the night are sometimes associated with sleep fragmentation, jet lag, and medication effect.

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. An assessment should include obtaining information from daily sleep diaries, if possible, and a referral for medical examination. It is important to ask about dreams and the presence or absence of detailed recall. Finally a sleep-disturbed individual should be referred for examination in a sleep laboratory where detailed all-night neurophysiological monitoring can be done.

Restless Leg Syndrome (RLS)

Restless leg syndrome is described as an uncontrollable urge to move the legs and is often associated with 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 as beginning or worsening during periods of rest or inactivity, as becoming 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, particularly in older adults, are uremia, iron deficiency anemia, and peripheral neuropathy (Stepanski, Rybarczk, Lopez, & Stevens, 2003).

Periodic limb movement in sleep (PLMS) is present with 90% of individuals 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 morning rise time also becomes earlier, 4 a.m., rather than 7 a.m. The cause(s) are unknown (Weitzman, Moline, Czeisler, & Zimmerman, 1982). RLS prevalence is reported in a range of 2% to 7.2% (APA, 2013).

Medical conditions associated with sleep disorders

The assessor should be mindful that if any of the following neurological diseases are recorded 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 and is prone to experience 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 heart failure and serious lung disease including advanced emphysema are at risk for sleep deprivation and sleep-breathing disorders
8. Chronic pain in synovial tissue, bones, joints, or muscle caused by arthritis, diabetic neuropathy, fibromyalgia, dermatomyositis, and bone or synovial disease.

Treatment:

Bootzin and Rider (1997) offered 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 is particularly helpful for insomniacs who go to bed early and spend 10 or more hours in fragmented sleep. It consists of limiting clients to spending time in bed only for the purpose of consolidating nighttime sleep. 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 can also 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), (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, 1997). For instance Shoham, Bootzin, Rohrbaugh, and Urry (1995) found paradoxical intention to be most effective with clients who are not able to fall asleep in spite of intense efforts to do so. An example of this approach is to encourage these insomniacs to try and stay awake for as long as possible in order to diminish their performance anxiety, thereby hopefully enabling him or her to fall asleep more easily. 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 (Baran & Richert, 2003; Harris, Glozier, Ratnavaclei, & Grunstein, 2009; Rosenberg & Doghramji, 2009), 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 evidence-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).

Hypopnea is a medical condition associated with obstructive sleep apnea wherein normal sleep is impaired by overly shallow breathing, a very low respiratory rate, or partial obstruction of the airway. Impaired air movement into the lungs causes the abnormally low oxygen blood level found in an individual with hypopnea. An individual suffering from this disorder should have a sleep study that, upon completion, is likely to result in a referral to an ENT specialist to confirm the diagnosis and make a treatment recommendation. When the condition is caused by airway obstruction, surgical intervention may be necessary to widen the airway.

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.

Nonsurgical remedies include instructing the client to avoid sleeping on his or her 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 also be caused by excessive weight or obesity, in which case 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 farther or reduce the advancement as necessary.

For many clients 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 other nonsurgical procedures including removing excess or obstructive tissue or hardening the soft palate by inserting small polyester rods. However, for most clients with this obstructive sleep apnea 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 at a high enough level according to the client's needs, at a level that will eliminate the sleep apnea and or hypopnea and subsequent sleep fragmentations 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 as specifiers for all sexual dysfunctions. Sexual dysfunctions have a minimum time frame of at least six months except for substance-and medication-induced sexual dysfunction (King, 2014a, b). 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 to several of the sexual dysfunction disorders such as lifelong acquired and generalized versus situational.

Sexual dysfunction has been defined by the APA (1994) as the inability to have or enjoy coitus. According to the APA (2013) sexual dysfunction is characterized by a disturbance in a person's ability to respond sexually or to experience sexual pleasure. The dysfunction is defined as impairment in sexual response or with pain associated with sexual intercourse. A sexual dysfunction must be experienced on most or all occasions (75% to 100%) of partnered sexual activity (APA, 2013, pp. 424, 426, 429). The DSM-5 factors that need to be considered during assessment are the partner, relationship, individual vulnerability, psychiatric comorbidity, stressors, cultural/religious factors, and medical factors (King, 2014a). 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 explained by sexual difficulties (King, 2014a).

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 (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) suggested 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 a particular 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 (King, 2014b). Frank, Mistretta, and Will (2008) charted Berman's (2005) causes, examples, and sexual symptoms. Berman 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 of 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 a 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 one of three symptoms in the range of 75% to 100% of the time for 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 meeting one or more of four difficulty areas for pain, during vaginal penetration, vulvovagional or pelvic pain during penetration or intercourse, 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 cited prevalence rates for delayed ejaculation, the least common male complaint (lack of definition), is less than 1% (p. 425), erectile disorder is unknown, female orgasmic disorder is 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 age range 18-34, 41% for age range of 66-74 (p. 442), premature ejaculation depending on definition is 20% to 30% of men from ages 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 to 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 for 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, including 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 of 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 intervention followed by counseling for the client's individual issues that will

likely include the partner. These issues for females 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: 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 include:

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 that 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) contended 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) suggested integrating the treatment of posttraumatic symptoms and sexual dysfunctions. 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 bodies are incongruent with their manifest genders, as opposed to having psychological confusion regarding their gender identifications" (King, 2014b, p. 13). 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 sex identified at birth.

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 criterion is separate for children and for adolescents and adults. The assessment criteria for children is to observe aversive attitudes, aversive behaviors, mental fixation, and strong desires (King, 2014d). The emphasis in the diagnosis is to determine if there is a strong desire to be the other gender or gender incongruence versus cross-gender identification. The criteria includes make-believe play or fantasy play, desire for playmates of the other gender, strong rejection of masculine toys (boys), feminine toys (girls), dislike of one's sexual anatomy, and desire for primary and/or secondary sex characteristics that match one's experienced gender (A, 1-8).

Adolescents and adult criteria symptoms are to be manifested at least six months and meet at least two of the six symptoms. 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).

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 dysphoria 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 for adolescents and adults indicated that two of six symptoms must be met in order to apply the term GID. The first component of the DSM-5 classification is incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration. Criterion B is a significant distress in social, occupational, or other important areas of functioning (APA, 2013, p. 453).

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 indicated 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 1998 Standards of Care of the International Harry Benjamin Gender Dysphoria Association, listed below.

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. 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-5 criteria. Several factors must be considered for Criteria 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 children, although it is more extensive and time-consuming than for adolescents and 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) indicated 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) estimated prevalence range for natal adult males is from 0.005% to 0.014% and females from 0.002% to 0.003%. In children there is 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) estimated 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 (1993) 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 6 and more so between the ages of 2 and 4. Money and Lehne (1999) indicated that this disorder in children is rare. The Harry Benjamin International Gender Dysphoria Association (1998) estimated an undocumented 3,000 to 6,000, as of

1979, had undergone hormonal and surgical 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 sexual reassignment surgery (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 nonrewarding 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 (APA, 2000, 2013) described 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 (pp. 469, 93). Fifteen specific criteria are unchanged and divided into four categories: (1) aggression to people and animals, (2) destruction of property, (3) deceitfulness or theft, and (4) serious violation of rules (APA, 2013, pp. 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 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 (King, 2014i).

New in the DSM-5 are examples for the severity specifiers (mild, moderate, moderate-severe, severe). Examples of mild are lying, truancy, staying out after dark without permission and other rule breaking. Examples of moderate are stealing without confronting the victim and vandalism, and severity, i. e., forced sex, physical cruelty, use of a weapon, stealing while confronting the victim, and breaking and entering (p. 471). At least 3 of the 15 criteria must be met within a 12-month time period and at least one criterion in the last 6 months. It should be noted that oppositional defiant disorder is closely related but less severe than conduct disorder. Conduct disorder overlaps and includes many symptoms of ADHD, suggesting a need for the clinician to assess the presence of attention difficulty 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 should specify if one of the following five subsets: limited prosocial emotions, lack of remorse or guilt, callousness (lack of empathy), unconcerned about performance, or with shallow or deficient affect.

Criterion C indicates that if the individual is 18 or older and criteria are not met for antisocial personality disorder, the assessor should also designate an additional specification for childhood onset, adolescent onset, or unspecified onset as well as specifying the presence of one of the following: 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 incongruent 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) stipulated that comorbidity is commonly found with the following conduct disorders:

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 et al., 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 of or reaction to socio/cultural context or gender differences (APA, 1994). Sommers-Flanagan and Sommers-Flanagan (1998) suggested 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 disorder 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 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. This type of interview allows for observation of the client's emotional responsiveness and the manner in which he or she relates to the examiner. Its reliability can be determined later when compared to information obtained from other sources.

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 he or she is disrespectful of the interviewer. Second, assess his or her ability to form attachments by asking an open-ended question such as, "If you were asked to choose someone to eat a meal with, who would you choose? Your mother, father, brother, sister, friend, other adult, or would you prefer to eat by yourself?" This allows the child to hypothesize, in a given situation, the person he or she would choose to be with. 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 have probably contributed to increasing amounts of cultural clashes within American cities. Shaffer and Steiner (2006) pointed 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 a less constrained and morally declining American culture may engage in a moral 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 culture they think of as foreign. 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), an intervention for helping a family struggling with intercultural conflict.

Incidence:

The DSM-5 prevalence rate estimated for one year was in the range from 2% to more than 10% (APS, 2013, p. 464), while the DSM-IV-TR (APA, 2000) had previously indicated that conduct disorders

were much higher in males than females and prevalent in the general population from less than 1% to more than 10% (p. 97).

Treatment:

While developing a treatment plan, the clinician will want to keep in mind that individuals with a history of behavior problems 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. If these individuals have a second DSM-5 disorder such as ADHD and anxiety disorder they are more likely to experience improvements with treatment than if they have conduct disorder as the only diagnosis (Bernstein, 1996; Biederman, Baldessarini, Wright, Keenan, & Faraone; 1993; Frances & Ross, 1996). Some youth with conduct disorder can be successfully treated on an outpatient basis if firm behavioral controls are maintained at home. It is also very helpful if they have other positive attributes such as 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 treatment using 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. Last, functional family therapy using behavioral, structural, strategic, and communication techniques is recommended for the entire family. Generally speaking, the earlier and more aggressive the interventions the better the prognosis.

Treatment (efficacious-children and adolescent)

Eyberg, Nelson, and Boggs (2008) conducted an evidence-based study for published randomized controlled design studies during the years 1996 to 2007 regarding psychosocial treatment for children and adolescents with disruptive behavior (conduct and oppositional defiant disorders). The review consisted 20 Type I studies and 14 Type II studies and included specific information regarding sample type, child race, sex, and age.

1. Well-established efficacious: Parent management training Oregon mode (PMTO).
2. Probably efficacious: Anger control training, group assertive training, helping the noncompliant child (HNC), incredible years parent training (IY-PT), Incredible years child training (IY-CT), incredible years (IY), multidimensional treatment foster care (MTFC), multisystemic therapy (MST), parent-child interaction therapy (PCIT), positive parenting program, Triple P enhance treatment, problem-solving skills training (PSST), PSST + practice, PSST + parent (PSST + PMT), rational-emotive mental health program (REMH)
3. Possibly efficacious: Nine other treatments were classified as possibly efficacious.

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, 1991)

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 combined with at least four symptoms from criteria A" (APA, 2013). An assessment will reveal a pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures in the last six months. The eight symptoms are clustered to reflect both emotional and behavioral symptomatology. This list is divided into three segments: angry/irritable, argumentative/defiant behavior and vindictiveness. The descriptors include negativistic, defiant, loses temper, and annoys others, touchy, disobedient and hostile behavior toward authority figures that persists for at least six months (APA, 2013, p. 462). The angry/irritable mood symptoms are: (1) often loses temper, (2) is often touchy or easily annoyed, and (3) is often angry and resentful. The word "by others" was removed. In addition, the frequency and severity of violations are different for children younger than five years of age (most days for six months) than 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; added "with authority figures", (3) actively defying or refusing to comply with the requests or rules of adults; added "with authority figures", (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 client is to be spiteful or vindictive at least twice within the past six months.

Criterion A indicates that the client has to exhibit the symptoms with at least one individual who is not a sibling (p. 462). The purpose of this addition is to be sure that the behavior in terms of persistence, frequency, and intensity should be used to differentiate normative expressions from symptoms that are uncharacteristic for the individual's developmental level, gender, and culture (King, 2014 k, p. 12).

Criterion stipulates that for children younger than five years of age, the behavior must occur on most days for six months while older than five years of age the behavior must occur at least once per week for six months.

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).

Three ratings for severity are based on pervasiveness: 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.

Oppositional defiant 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)

Treatment (efficacious-child and adolescent)

Eyberg, Nelson, and Boggs (2008) conducted an evidence-based study for published randomized controlled design studies during the years 1996 to 2007, regarding psychosocial treatment for children and adolescents with disruptive behavior (conduct and oppositional defiant disorders). The review consisted 20 Type I studies and 14 Type II studies and included specific information regarding sample type, child race, sex, and age.

1. Well-established efficacious: Parent management training Oregon mode (PMTO).
2. Probably efficacious: Anger control training, group assertive training, helping the noncompliant child (HNC), incredible years parent training (IY-PT), Incredible years child training (IY-CT), incredible years (IY), multidimensional treatment foster care (MTFC), multisystemic therapy (MST), parent-child interaction therapy (PCIT), positive parenting

program, Triple P enhance treatment, problem-solving skills training (PSST), PSST + practice, PSST + parent (PSST + PMT), rational-emotive mental health program (REMH)

3. Possibly efficacious: Nine other treatments were classified as possibly efficacious.

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 (King, 2014k).

The new classifications found in the DSM-5 are as follows. 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 were combined into a single use disorder with a continuum from mild, moderate, or severe use; legal consequences were removed and craving was added as a symptom.

These disorders pertain to symptoms caused by the abuse of alcohol, inhalants, chemicals, toxic substances and unknown substances. Abuse and dependence are presently on a continuum rather than separate features of the previous disorder of alcohol use and abuse. Two of eleven symptoms are to be met for alcohol use disorder. Examples of the criterion symptoms include the drug is taken in larger amounts over a long period of time, is in continuous use, taken with increased amounts with a persistent desire to cut down or control, spending time seeking out the drug, craving, and recurrent excessive or continuous use. Alcohol-related disorders include alcohol use disorder, alcohol intoxication, alcohol withdrawal, other alcohol-induced disorders, and unspecified alcohol-related disorder.

Definition and Interview:

Substance induced disorders cause symptoms which 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 has 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. While it is of significant clinical interest to understand the differences between abuse and dependence, these two are combined into one diagnostic category--use disorder--in the DSM-5 for coding purposes.

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, as that 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 recommended 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 the client 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 that presume the use of a substance until more evidence is acquired.

Step 2: Have a thorough knowledge of the 10 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, including prescription medications that 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 that 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. Labiality of mood
    5. Impaired attention
    6. Impaired judgment
    7. Interference with personal functioning

A. 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, now referred to as alcohol use disorder in the DSM-5™, has been defined for many years either as alcohol abuse or alcohol dependence on a continuum, 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 alcoholics forge upon themselves are as serious as the physical costs. While the percentages of health care resources used up by alcoholics' inpatient and outpatient clinical visits comprise more than 50% and 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 rates of successful interventions are a dismal 5% to 10% (Clement, 1986). Although health care providers have tended to avoid asking probing questions or intervening with clients about possible drinking problems (Burge et al., 1997), 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).

Alcohol Use Disorder

Interview and Definition:

Alcohol use disorder in the DSM-5 includes the following types of alcohol problems: 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 use combines substance abuse and dependence although legal problem was removed from the criteria. Abuse is a behavioral pattern that is recurrent and with significant adverse consequences with repeated use of substances. Criteria five, six, and seven are characteristic of this pattern (APA, 2013). Consistent with the description of this maladaptive pattern, alcohol users (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 use disorder (abuse), individuals must have these problems repeatedly in the same 12-month period and suffer from the development of tolerance, withdrawal, and 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 2 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, pp. 490-491).

Assessing tolerance or withdrawal can indicate dependence on alcohol. 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 (DTs), 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 associated with alcohol intoxication: slurred speech, incoordination, unsteady gait, nystagmus, impairment in attention or memory, and stupor or coma (APA, 2013, p. 497).

Alcohol Withdrawal

Alcohol withdrawal occurs after the cessation of heavy and prolonged alcohol use and at least 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 is 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 Mac Andrew 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). E. W. Ewing and B. A. Rouse developed the CAGE to assess alcohol abuse (Ewing, 1984). The CAGE is a four-item interview schedule and the letters stand for 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)
9. Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT was developed from a World Health Organization project for the identification and treatment of alcohol use. The participants for the data gathering were individuals with hazardous drinking histories (Daeppen, Yersin, Landry, Pecoud, & Decrey, 2000).

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 (McLellan, Loborsky, Woody, & O'Brien, 1980). 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. Lengthier treatments result in better outcomes. 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 (pp. 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 another diagnosis (i.e., alcohol use disorder, 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).

Teaching ways to cope with cravings and the relapse process should be a component of the treatment program for addictive disorders. Relapse studies exist not only for substances but also for nonaddictive 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) described 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 and became the combined disorder of substance use. In reviewing the DSM-5, symptoms 1-3 and 8-10 refer to the term dependence and symptoms 5-7 to abuse. Adolescent substance use (abuse) has significantly increased over the last several years (Jaffe, 1998). It is, therefore, important for practitioners to have an understanding of the importance of an effective interview process with this group. Jaffe recommended a number of factors to consider in the interview as well as specific questions to ask that should 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 indicated an alcohol problem (Jaffe, 1998, p. 72). Additional questions were offered by Bergman, Smith, and Hoffman (1995): (a) Do you prefer to go to places where alcohol is available? (b) Do you ever drink more than you planned?, and (c) 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 use (abuse), a comorbid factor that has often been overlooked (Karacostas & Fisher, 1993; Yu, Buka, Fitzmaruce, & McCormick, 2006).

Treatment (efficacious-adolescents)

Evidence-based treatment for adolescent substance abuse was evaluated by Waldron and Turner (2008) for effectiveness. The authors analyzed 17 peer-reviewed empirical studies using randomized controlled design and were published during 1998 to 2006. Seventeen studies representing 46 interventions were analyzed for efficacious outcome. Fourteen of the studies were classified as well-established (Type 1) and three probably efficacious. Interventions included individual CBT (7 replication studies), group CBT (13 replications), family therapy (17 replications), and 9 minimal control condition studies. The results included:

Well-established (WE): Multidimensional family (MDFT), functional family therapy (FFT), group CBT

Probably efficacious: Multisystematic therapy (MST), brief strategic family therapy (BSFT), Behavior family therapy (BFT)

Non-Substance-Related Disorders

Gambling Disorder

Gambling is a new category that was listed within impulse-control disorders and is now a new behavioral addiction (King, 2014,q, i). 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 (SAMPSA, 2014). The person risks something of value for a greater value. The gambling addiction can result in a number of destructive behaviors including: deception about the extent of losses caused by gambling, family and job dysfunction, theft, repeated high risk gambling, and repeated futile attempts to recover losses while gambling (APA, 1994, 2013). Illegal acts are no longer a symptom for a gambling disorder.

Interview and Assessment:

The assessment interview for a gambling disorder should consider four or more symptoms of nine during a twelve-month period of time (Criterion A). These symptoms include gambling with increasing amounts, restlessness or irritability when attempting to stop gambling, repeated unsuccessful efforts to control it, preoccupation with gambling, gambling when feeling distressed, the emotional sequelae from losing money gambling, compulsive behavior such as returning another day to get even or to make up for the loss, engaging in deception to conceal gambling losses, significant job or relationship loss, and imposing on others to provide money (APA, 2013, p. 585). Specifying severity is a number of criteria met such as: mild (4-5), moderate (6-7), and severe (8-9).

Dixon and Johnson (2007) developed the Gambling Functional Assessment (GFA), 20 items grouped into four contingencies that maintain gambling behavior. These contingencies include the tangible rewards (i.e., money), sensory experience (i.e., the internal reward sensations that accompany gambling), social attention (i.e., social aspects of gambling), and escape (i.e., engaging in gambling as a means of dealing with an aversive event or situation in one's life).

Incidence:

The APA (2013) cited a prevalence rate of 0.2% to 0.3% while incidence reported by the APA (1994) revealed a prevalence rate of 1% to 2%.

Instrument:

Gambling Functional Assessment-Revised (GFA; Weatherly, Miller, & Terrell, 2011)

Treatment

Gamblers Anonymous, with its 12-step program, has been a popular source of help for compulsive gamblers and is quite helpful when the client remains with the program (Petry, 2003; Petry 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 six months post-treatment (based on a subsample of 1,568), 50% were in control at one year post treatment (based on a subsample of 225), and 27% were in control at two years post treatment (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 et al., 2996; Toneatto & Ladouceur, 2003). SAMSHA (2014) listed behavioral, cognitive therapy, and cognitive-behavioral therapy as most effective treatments.

Neurocognitive Disorders

Neurocognitive disorders (NCD) replace the DSM-IV-TR category of delirium, dementia, amnestic and other geriatric cognitive disorders (King, 2013f). A primary deficit in cognition and disorders associated with a cognition deficit are what distinguish them from a neurodevelopment 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 dementia and other mental disorders that can cause cognitive dysfunction (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 labiality of mood (i.e., crying or irritability). 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 typically evidence that dementia 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 one 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 prescribed medications or combinations of medications are not uncommon sources of delirium in the elderly.

Gintner (1995) described four steps to follow or questions to ask during a differential interview for delirium. Step 1 is to determine if the psychological symptoms are accompanied by any metabolic or infectious problem, such as uremia caused by kidney failure, fluctuating blood sugars found in poorly managed or previously undiagnosed diabetes, or an acute urinary tract infection. 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% to 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 rate indicated that in the general population is low, 0.4%; however, this increases with age and by 55 years of age is 1.1% (APA, 2013).

Typical delirium symptoms resolve within 10 to 12 days, yet for some disorders such as prolonged renal failure, may last up to 6 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 by treating the underlying medical condition and controlling any agitation that may accompany the client'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, supported by familiar people 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):

1. Delirium Symptom Interview (DSI)
2. Confusion Assessment Method (CAM)
3. Delirium Scale (D scale)
4. Global Accessibility Rating Scale (GARS)
5. Saskatoon Delirium Checklist (SDC)

Major or Mild Neurocognitive Disorder (Alzheimer's)

Definition and Interview:

Major or mild neurological disorders (MND) include Alzheimer's, Frontotemporal lobar degeneration, Lewy body disease, vascular disease, Traumatic brain injury, Substance/medication use, HIV infection, Prion disease, Parkinson's disease, Huntington's disease, another medical condition, and multiple etiologies, Unspecified (p. 603). Major or mild neurocognitive disorders are 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-motor, or social cognition (APA, 2013, Criterion A, p. 602).

Decline is associated with the concern of the individual and close family members, becoming aware of substantial impairment in cognitive performance 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 are 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)" (APA, 2013, pp. 627, 632). A clinical description of major or minor neurological disorder included 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 frequently accompany psychosis, paranoia and other delusions (disorganized speech and disorganized behavior are not characteristic of psychosis), mood disturbances, depression, anxiety and elation. Additional symptoms can be agitation, confusion, frustration, sleep disturbances, apathy, wandering, disinhibition, hyperplasia, and hoarding (King, 2013e).

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 phase involves diagnostic testing. During the fourth phase 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, although long-term memory is eventually affected along with agnosia, apraxia, and loss of executive functioning (Benson & Cummings, 1986; Cummings & Benson, 1983). Because memory disturbance is the most common initial symptom, Alzheimer's 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 in advancing Alzheimer's: aphasia (language disturbance), apraxia (sequential motor activities), agnosia (familiar objects), and disturbances in executive functioning (i.e., abstract thinking, organizing; APA, 2000, p. 148).

Diagnosing for major or mild neurocognitive disorder due to Alzheimer's disease should involve assessing for symptoms that meet criteria either for possible, probable, mild, or major neurocognitive disorder. There is insidious onset and gradual progression or impairment in one or more cognitive domains. Possible Alzheimer's disease can be diagnosed if either one of the following are present: (a) evidence of a causative factors such as Alzheimer's disease mutation from family history or genetic testing, or (b) all three of the following elements are present: clear evidence of decline in memory, steadily progressive gradual decline in cognition, and no evidence of mixed etiology such as other causative factors causing cognitive decline (APA, 2013).

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 types of neurocognitive disorders (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 that may also cause depression and/or dementia (Cummings, 1992).

Incidence:

Reviewing data from the APA 2013 and 2000 reports indicated that the data varies. APA (2013) cited prevalence rate by etiological type and estimates are only available for older populations. The data cited by APA is for dementia to be 1% to 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 et al. (2002) indicated 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 Neurological Disorder (Dementia)

Logsdon, McCurry, and Teri (2007) conducted a review of evidence-based treatments for disruptive behaviors. This 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 lead to any significant change in the incidence of disruptive behaviors. It was 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 programs 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 adjust or modify the environment (developing a schedule and contributing to interpersonal interaction).

The Peaceful Mind Manual is an evidence-based cognitive-behavioral intervention workbook (Stanley, Wilson, Novy, et al., 2009) used by a collateral and the client to reduce anxiety-accompanying dementia and to reduce distress of the caregiver. The approach is designed to teach skills of

awareness, breathing, calming self-statements, coping self-statements, increasing activity, and sleep management. The emphasis is a behavioral rather than cognitive intervention, slowing the pace, limiting the material to be learned, and increasing repetition and practice, using cues to stimulate memory (Paukert et al., 2013).

Finally, the individual suffering from a progressive dementia eventually loses all capacity for daily living and becomes so impaired that hospitalization or direct personal care is required. However, this slow demise does not occur when individuals suffer from rapid onset cognitive impairment caused by 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 may observe "silent" strokes or mini-strokes not easily recognized by the individuals affected. Finally, a high percentage of persons suffering from dementia also suffer from depression, psychosis, or delirium, which can complicate their diagnoses.

Assessment:

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). Depression should be assessed when diagnosing for dementia. The Geriatric Depression Scale (long form-30 questions and short form-15 questions) is used extensively with the older population.

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 as well as 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 acety cholinesterase inhibitors. These medications delay the breakdown of acetylcholine in the brain, a key neurotransmitter that is important for memory. The acetylcholinesterase inhibiting group of medications is most commonly prescribed in early stages of Alzheimer's dementia. Another type of medication, memantine (Namenda), commonly used to treat moderate to severe forms of dementia, shields the brain from a neurotransmitter called glutamate which ordinarily takes on a stimulating function to improve learning and form memories. In individuals with Alzheimer's glutamate becomes an 'exitotoxin' which contributes to the death of brain cells. Clients with Alzheimer's disease may be prescribed an acetylcholinesterase 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 polytheism 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 are 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 that is likely to have started during adolescence or early adult years. The behavior is not the result of a substance or a medical condition (APA, 2013, p. 648).

Turkat (1990) estimated 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 occurs in social, occupational, and other important areas of life (APA, 2013, p. 646). 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 (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 disorder clients will repetitively utilize the same maladaptive coping skills.

Fong (1995) stated 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 with a personality disorder is likely to 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 to have traits or symptoms of more than one personality disorder at the same time, while not meeting criteria for any one of them. That may result in a diagnosis of unspecified personality disorder or other specified personality disorder and the traits are listed out.

Cognitive features, affective features, interpersonal features, and capacity for impulse control can also define each of the 10 personality disorders.

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 typified by glib and sometimes persuasive speech. Researchers have found neurophysiologic findings that confirm the presence of deficiencies involving the prefrontal cortex associated with stimulation seeking, bad decision-making, rule breaking, and irresponsible behavior (Raine 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 inappropriate or constricted affect, 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) pathologies 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. Last, 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 characterized by behaviors reflecting 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 that 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. Individuals with OCPD, APD, and BLPD often use these defenses.

Reaction formation is manifested by behavior that is in stark contrast to that which an individual believes about himself or herself. For example, 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 for the child to overidealize the parent who abused, neglected, and abandoned him or her and maintain the image of the over-idealized 'good parent' within consciousness while splitting off the 'bad' parent along with the 'bad self' associated with negative feelings. That splitting defense persists into adult life in those individuals with borderline personality disorder and the split-off bad parent will be projected unto individuals perceived as abusive or neglectful. As a result, someone with BPD can begin a relationship by over-idealizing the other person via the splitting defense but will not be able to sustain that over-idealization. In psychoanalytic object relations theory this is referred to as an attempt to maintain an over-idealized 'self' ('good' self-other object representations) while splitting off the devalued 'self' ('bad' split-off self-other object representations) associated with negative feelings of fear, anger, guilt, and grief. However, it is not possible for these individuals to sustain stable behaviors, emotions, or relationships. Individuals with BLPD or NPD tend to view others in either 'black or white' terms and also tend to 'split' members of a therapeutic team into either good or bad therapists or therapeutic team members. They will begin therapy by over-idealizing their therapists or team members until feelings of anger or disappointment emerge, at which point, they will suddenly devalue those individuals and break off the relationships 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 also 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 splitting, '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 that 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, 1996b) 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 so that the interviewer should obtain objective information from external sources as well as by observing patterns of behaviors in the areas of social relations and work functioning (Western, 1997). Some possible external sources might include the use of instruments. Instruments may include: The Personality Inventory for DSM-5 (PID-5)—Adult. 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), and 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 & Sanders, 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, 2004), 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.

The DSM-5 recommended the use of a Level 2 online inventory for use in validating and to acquire additional information regarding a personality disorder. Krueger, Derringer, Marko, Watson, and Skodol (2012) developed the Personality Inventory for the DSM (PID-5)-Adult. The PID-5 contains 220 self-administered items that identify 25 personality trait facets and 5 domains (negative affect, detachment, antagonism, disinhibition, and psychotism). Additional instruments include:

1. Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998)
2. The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; DiNardo, Brown, & Barlow, 1994)

3. The Inventory of Interpersonal Problems (IIP-64; Horowitz, Alden, Wiggins, & Pincus, 2000)
4. The Personality Disorders Questionnaire-4 (Hyler, 1994)
5. The Millon Clinical Multiaxial Inventory-III (Millon et al., 1997)
6. The Minnesota Multiphasic Personality Inventory-2 (Somwaru & Ben-Porath, 1997)
7. The Structured Interview for the DSM-IV Personality Disorders (Pfohl et al., 1997)
8. The International Personality Disorder Examination (Loranger, 1999)
9. The Structured Interview for the DSM-IV (assesses all 10 personality disorders and uses a 5 year window; First et al., 1997)
10. The Personality Disorder Interview-IV (Widiger et al., 1995)
11. The Diagnostic Interview for DSM-IV Personality Disorders assesses 10 DSM-IV-TR personality disorders
12. The Coolidge Axis II Inventory (CATI; Coolidge & Merwin, 1992)
13. The Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley & Jackson, 2004), a self-administered questionnaire
14. The Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon et al., 1997)
15. The Narcissistic Personality Inventory (Raskin & Terry, 1988), a self-administered questionnaire
16. The Personality Diagnostic Questionnaire-4 (Hyler, 1994), a self-administered questionnaire
17. The Wisconsin Personality Inventory (Klein et al., 1993), a self-administered questionnaire

Young Schema Questionnaire (YSQ-SF; Young & Brown, 2001) has long and short forms and contains 18 schemas that include assessment information to match up with whatever a client probably has. Other schema inventories assess for the most likely origin of each schema, degree of schema avoidance, and common ways a client overcompensates for certain schemas.

Instruments for Specific Personality Disorders

Antisocial Personality-Composite International Diagnostic Interview (CIDI; Robins et al., 1988)

1. 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 (Leising, Rehbein, & Eckardt, 2009).

Borderline Personality Disorder-The Revised Diagnostic Interview (DIB-R; Zanarini, Gunderson, Frankenburg, et al., 1989; Zanarini, 2009). This instrument provides scales for impulse action patterns, affects, cognition and interpersonal relations.

Narcissistic Personality Disorder--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 for making a differential diagnosis of personality disorder is to determine whether the individual's symptoms represent a state or trait disorder. The key feature of a state personality disorder 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 et al. (2003) researched four personality disorders (borderline-BPD, schizotypal-STPD, avoidant-AVPD, and obsessive-compulsive-OCPD) across three cultural groups (African Americans, Hispanic Americans, and Caucasian Americans). Their findings indicated that there are higher rates of BPD in Hispanics than in Caucasians and African Americans and 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 should be exercised until additional research is available.

In assessing for pathology with culture and ethnicity it is important to understand how the individual perceives and expresses a problem, the interaction between the clinician and the person, and if the person decides to seek treatment. Therefore, it is important for the clinician to become familiar with language, behavior, and the interpersonal style of clients of culture.

Interview Process:

A diagnosis of personality disorder, 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 identifying a cluster diagnosis can sometimes be made in order to facilitate treatment.

During the first part of the interview the diagnostician should observe variations in several elements of functioning (client cognition, affect, behavior, and physiology). Observations of cognitive functioning may reveal vagueness, derealization, paranoia, projections, and magical thinking. Observations of emotional and affective functioning may reveal an inability to modulate affect or a range of emotions (intensity of emotion). Observations of physiological functioning may reveal perspiring, restlessness, and agitation while observations of behavior may reveal compulsiveness, sneering, lying or distortions of fact, and behavior indicating disdain and distrust.

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 a personality disorder. 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 behaviors as normal rather than 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. Counselors must be careful to demonstrate genuine nondefensiveness and noncompetitiveness while, at the same time, remaining sensitive to how the client perceives the counselor's verbal and nonverbal communication. If the client perceives the counselor as critical, he or she will feel rejected and become defensive. A realistic self-evaluation will lessen the need for fantasies and exaggerations. In addition, correcting narcissistic traits includes learning to change destructive ways of relating in order to establish stable, mature relationships rather than dependent or dominating ones.

Cognitive and interpersonal therapies have been found to be effective with many personality disorder clients (Beck & Freeman, 1990).

Couple's therapy may be somewhat effective when one member can be objective toward understanding the problems and need for change when the other member has been diagnosed with a personality disorder (Links & Stockwell, 2002). Glikauf-Hughes and Wells (1995) recommended 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 four characteristics: acting out, defensiveness, 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 a narcissistic personality disorder: (a) corrective achievements, (b) corrective disillusionments, and (c) corrective relationships. If a narcissistic individual reflects on and chooses to value one or more of these achievements, he or she may be receptive to accomplishing change in the narcissistic self-concept. The authors suggested that if these achievements take place, a realistic self-evaluation would lessen the need for fantasies and exaggerations. In addition, correcting narcissistic traits includes learning to change destructive ways of relating in order to establish stable, mature relationships rather than dependent or dominating ones.

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. The schema questionnaires measures for 18 schemas and 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. The four main themes of schema therapy are early maladaptive schemas, core emotional needs, schema mode, and maladaptive coping (Young, Klosko, & Weishaar, 2003).
2. Schema therapy is recommended for clients whose disorders are significantly impacted by underlying personality disorders, of which BLPD is a prime example (Young & Brown, 2001). 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 that are surrender, avoidance and overcompensation. Research on effectiveness of treatment has focused primarily on mood and social functioning.
3. Dialectical behavior therapy (DBT), developed by Marsha M. Linehan at the University of Washington (Linehan, 1993b), is a biosocial treatment approach which focuses on helping clients 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.
4. Interpersonal psychotherapy (IPT): IPT has literature-based support to treat a number of diagnoses--mood disorders, depression, bulimia, and anxiety disorders (Bleiberg & Markowitz, 2005, 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.
5. 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, (5) adequate frustration tolerance and (6) ample financial resources. Clients diagnosed with a personality disorder who 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, 2006a). 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, Yeomans, & Kernberg, 2006). TFP 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 et al., 2006).
8. Mentalization-based psychotherapy (MBP) 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, foster 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, Lamarche, & Hilscher, 2005).
11. 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)

12. Family Therapy: There is limited research using family or couple's 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) described 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 et al., 2007).
13. 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, 2010).

Specific Personality disorder and 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:

Antisocial personality disorder is not amenable to psychoanalytic-based therapies. Cognitive therapy is a more preferable approach, with the major focus on helping the client understand how to create ownership of the problem and how distorted perceptions prevent the client from seeing himself the way others view him. This is often ineffective, however, since APD clients 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 clients 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 clients are (unlike those with other personality disorders) 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 client'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 client. 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 result 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 AvPD 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. Rosental 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

The APA cited the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions' prevalence rate of 2.4% (2013). Prevalence of AvPD in the general population is between 0.5% to 1.0% and as much as 10% in outpatient centers (APA, 2000). Herbert (2007) cited several studies suggesting that AvPD ranged from 5% to 6.6% and may be the 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 seven symptoms' 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, 2013, p. 673).

The AvPD individuals with the self-deserting characteristics 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 causes them to center more on the pain and anguish of past issues as 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, 1996a).

Comorbidity with personality disorder is greatest with schizoid, depressive, dependent, and paranoid personalities. Comorbidity 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, 1996b).

The differential diagnosis of avoidant personality disorder is most commonly with anxiety disorders (social phobia) because the two diagnoses are difficult to differentiate. Typically found during assessment are clients with social phobia who are strongly associated with panic disorder, while AvPD clients are often associated with eating disorders (Hummelen, Wilberg, Pedersen, & Karterud, 2007). Individuals with AvPD are also linked with a number of anxiety disorders including panic disorder, agoraphobic disorder, obsessive-compulsive disorder, generalized anxiety disorder and social anxiety disorder (Herbert, 2007). The assessor should also be alert to panic disorder and agoraphobic disorder. 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). The Inventory of Interpersonal Problems (IIP-64) is a screening measure for AvD (Leising, Rehbein, & Eckardt, 2009). The IIP-64 measures for affiliation and dominance.

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) recommended schema therapy for change and for a 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 experience 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.

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 avoid negative evaluations. The counselor should frame all interventions in a way that reduces the client's fear of rejection. Sperry (1999) recommended 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 process whereby these individuals can change in therapy is initiated through experiments, guided observation, and reenactment of early schema-related incidents (Sperry). An early treatment goal is to increase emotional tolerance. During the initial interview and early therapy sessions the client's lack of emotional self-awareness may be 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 therapeutic task involves teaching the client ways to improve awareness and reduce cognitive avoidance and hypervigilance as well as improve assertive communication through social skills training.

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), (c) recognize and understand his/her cognitive interpersonal patterns and styles (try new behaviors), and (d) 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.

Monitoring for social anxiety involves activities related to monitoring and blunting. Blunting is seeking out information for distraction while monitoring is seeking out information pertaining to

threat situations. The Coping Styles Questionnaire for Social Situations is consider a monitoring tool for monitoring and blunting (Mezo, McCabe, Antony, & Burns, 2005).

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, unstable interpersonal relationships, and negative 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) was initially used over 30 years ago for clients with symptoms that vacillated between psychosis and neurosis, the only two diagnostic categories that were used prior to 1980. Uncertain as to which of those two diagnoses could be used for individuals with unstable moods and brief psychotic episodes, clinicians used a variety of other diagnoses such as pseudo-neurotic schizophrenia and ambulatory schizophrenia for clients' unstable affects and behaviors, primitive defense mechanisms of denial and projection, and serious identity disorders. Thus, borderline personality was originally a broad diagnostic category that was refined into a more specific diagnosis using observations from psychoanalytic object-relations theory as described in the psychodynamic literature (Masterson, 1981; Rinsley, 1981) and it eventually became standardized in the APA's Diagnostic Statistical Manual (APA, 1994). This diagnosis eventually became refined even further and 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 posttraumatic 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%, 10% in outpatient 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' that are generally necessary from time to time, including hospitalization or partial hospitalization. Treatment is long-term with an experienced therapist who can establish an empathic relationship with the client, 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 becomes self-defeating, unreasonably angry toward the therapist, and threatens the therapeutic process, thus losing whatever success 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' client remains in therapy long enough she will be able to learn how to maintain a range of valid 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 that 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 that 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 comorbid 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% (Malin, 2012).
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 qualities (APA, 2000, 2013). The DSM-5 defines the APD as a pervasive pattern of disregard for and violation of the rights of others and begins typically after age 15. The client is to be at least 18 years of age and there is evidence of conduct disorder before age 15. This client typically

reveals manipulation, deceitfulness, irresponsibility, reckless safety issues, and failure to conform to social norms, decisions made on the spur of the moment, blame others, and minimize consequences.

DSM-5 diagnostic manual further describes the disordered anti-social individual as reflecting an enduring pattern of antisocial perceptions and ways 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).

Incidence:

The 12-month prevalence rate as cited in the DSM-5 is approximately 0.2% to 3.3% (APA, 2013). 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 receiving 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, accuracy of self-awareness, safety, relational development, and positive risk-taking to change.

Individuals with antipersonality 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. As young adolescents, they had likely displayed similar behaviors and been diagnosed with conduct disorder prior to becoming 18 years of age when the diagnosis of anti-social personality disorder became applicable.

Case reports frequently mention a strong need for stimulation such as novelty seeking and risk-taking behavior (Cloninger, 1986), low harm avoidance, lack of 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), described the antisocial personality client representative of 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 negative traits such as tension, irritability, and even rage. When assessing for ASPD the examiner should be aware of comorbidity with other disorders like substance use disorder, depression,

and anxiety, and most prevalent is another Cluster B disorder. Kaplan and Sadock (1998) recommended a full workup including a neurological examination. Research findings from EEG and soft neurological signs suggested that an individual with this disorder might have suffered minimal brain damage during childhood.

Symptoms likely to be found in a person diagnosed with ASPD include a pervasive disregard for 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 (Rodgers & Maniacci, 2006).

Hare, Hart, and Harpur (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 behavior, 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 sociopath.

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.

Clients diagnosed with ASPD tend to be covetous, reputation-defending, risk-taking, nomadic and malevolent (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) indicated 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, and 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) callousness/lack of compassion, (c) lack of remorse or guilt, and

(d) absence of conning/ manipulativeness (Gunderson & Gabbard, 2002). These authors recommended that the therapist who attempts to treat the violent client include an 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) pointed 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) used cognitive therapy to improve social functioning, social problem solving, moral functioning in relationship to others, and confront cognitive distortions. Six examples of cognitive distortions include (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. The authors' contention is that the ASPD client is capable of making risk-benefit evaluations of life situations.

According to psychodynamic psychotherapists, the background history for many clients diagnosed with ASPD is filled with childhood physical and psychological abuse, broken or nonexistent 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) cited 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 in the individual who has suffered early life trauma and lacks conscious access to the effects of traumatic memories. When asked to talk about a traumatic event, the client with this disorder expresses no emotion because it remains buried due to primitive psychological defenses of splitting and dissociation until a provocative event triggers an explosion of terrifying emotion. Such emotion is not subject to normal processing within the frontal cortex and is 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. Therapeutic work focuses on dealing with attachment difficulties and dysfunctional relationships.

Benveniste suggested 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

means of communicating his or her affective countertransference responses to the client is considered as integral to the client's improvement and healing as the client's communications to the therapist. Since behavioral dysfunction in ASPD is closely linked to abnormal attachments and dysfunctional relationships most of the therapeutic task involves helping the client establish functional relationships 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 skill training involves a five-step model including recognition, motivation, understanding, and insight and testing (Dolan, 1997). Cognitive behavioral therapy combined with hormonal pharmacotherapy to reduce libido has sometimes been recommended, or even ordered by the court, for clients guilty of sexual offenses (Gunderson & Gabbard, 2000). Unfortunately, individuals with ASPD are likely to prematurely discontinue voluntary 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 toward 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. (APA, 2013, p. 667)

Incidence:

APA (2013) cited 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. Last, it is important to control for the influence of comorbid 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 is 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 would 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) recommended 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 outpatient 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 Kohlenberg and Tsai (1991) at the University of Washington, is based on 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 that 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 identify 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 4 sessions of follow-up, with the follow-up sessions spread over a 6-month period. Psychotherapeutic effectiveness is enhanced when therapists adhere to the following guidelines: (a) listen with respect, (b) help the client become more logical and focused on problem solving, (c) empathize with emotional pain or distress but remain clinically objective about the client's descriptions of alleged injustice/abuse, and (d) avoid over-reacting to intense emotions.

In addition to individual psychotherapy, other treatment approaches have included group psychotherapy, outpatient 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. Eight symptoms describe the disorder. These include inflexibility, lack of spontaneity, excessive orderliness, perfectionism, and a need to maintain mental and interpersonal control (APA, 2000, 2013).

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, sometimes to the point of becoming hoarders. 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 are 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, pp. 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. Obsessively compulsive individuals usually relate to others with respect yet they tend to expect others to conform to their rules and style. They often seek approval from authority figures with whom they feel submissive 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 they will be uncomfortable when 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 includes 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 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 self-critical 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 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" (APA, 2013, 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 him 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 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 and a replacement partner will be sought out to avoid a pronounced fear of abandonment.

In summary, deriving from attachment theory, the key elements of the dependent personality are 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, and 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:

The APA (2013) cited data from the 2001-2002 Epidemiologic Survey to be 0.49%. DPD is the most frequently reported personality disorder. The DSM-IV-TR (2000) reported a frequency rate of 15% and 25% in hospital (Oldham et al., 1995) and 0% to 10% in outpatient (Klein, 1999). In 1997 the rate for women was 11% and 8% for males (Bornstein, 1997). Torgersen, Lygren, Oien, 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 authoritarianism are associated with increased likelihood for DPD later in life (Head, Baker & Williamson, 1991).

Assessment and diagnostic criteria:

This disorder, as described in the DSM-5 (APA , 2013), 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 eight:

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 (pp. 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 parent-child attachment during the early years and has been characterized as a separation-anxiety (DSM-III, 1980) and child symbiosis (Mahler, 1967).

Interview:

Sperry (1999) reported that individuals with dependent personality disorder tend to bond easily during the initial interview and first therapy hour. They generally are 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 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, childlike, lonely and abandoned (Millon, 1996). The interviewer should also observe for a possible attitude of acquiescence, 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 that may be narrow and reflect a limited self-awareness with a cognitive style that is naïve, unperceptive, and uncritical. Furthermore, in keeping with childlike 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 or live independently. 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 or she is able to take responsibility for change, follow through with medication requests, display evidence of improved assertiveness, 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 couple's 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 disorder, sexual sadism disorder, 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. These disorders are divided into courtship disorders (voyeuristic, exhibitionistic, frotteuristic) and algolagnic disorders (sexual masochism, sexual sadism). Courtship disorders involve distorted view and behaviors of courtship and algolagnic disorders involve pain and suffering.

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 persons unable to give legal consent" (King, 2014a, p. 15).

A paraphilic disorder is a paraphilia 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 Criteria 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 paraphilias 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 described eight specific paraphilic disorders: (1) voyeuristic disorder, (2) exhibitionistic disorder, (3) frotteuristic disorder, (4) sexual masochism disorder, (5) sexual sadism disorder, (6) pedophilic disorder, (7) fetishistic disorder, and (8) 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. According to Morrison (1995) pedophilic 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 disorder.

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) indicated 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 client with a paraphilic disorder 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 paraphilia 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 and 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 that 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, 1998; Hudson, Harrison, & Crosscup, 1981)
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 (Dinner, 2004), 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. Although there is no correlation between depression and epilepsy variables Lamber and Robertson (1999) reported that two-thirds of patients experience depression or depressive symptoms with epilepsy.

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 5 major groups: mood, anxiety, somatoform, alcohol, and eating disorders (Spitzer et al., 1995).

3. REFERENCES

The following references are cited for the content within this supplement. Those with double asterisks preceding the reference were cited within the 37 on-line scenarios and within the supplement. The second set of references is article sources for study that include selected disorders for assessment, instrumentation, treatment, and monitoring. There will not be references for all disorders or for all.

REFERENCE I

Aarsland, S, D., Larsen, J. P., Cummins, J. L., et al. (1999). Prevalence and clinical correlates of psychotic symptoms in Parkinson disease: A community-based study. *Archives of Neurology*, 56, 595–601.

Abel Screening Inc. (1995). *The Abel Assessment for Sexual Interest*. Atlanta, GA: Author.

**Abraham, S., & Llewellyn-Jones, D. (1997). *Eating disorders: The facts* (4th ed.) New York: Oxford University Press.

Achenbach, T. M. (1991a). *Manual for the child behavior checklist*. Burlington: University of Vermont¸ Department of Psychiatry.

Achenbach, T. M. (1991b). *Integrative guide for the 1991 CBCL/4-18, YSR, and TRF profiles*. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. M. (1991c). *Manual for Teacher's Report Form and 1991 profile*. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. M. (1992). *Manual for the Child Behavior Checklist/4-18 and 1991 profile*. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. M., & Edelbrock, C. S. (1986). *Manual for the Teacher's Report Form and Teacher Version of the Child Behavior Profile*. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. M., & Edelbrock, C. S. (1991). Manual for the Teacher's Report Form and Teacher Version of the Child Behavior Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. M., & Rescorla, L.A. (2001). *Manual for the ASEBA school-age forms & profile*. Burlington: University of Vermont, Research Center for Children, Youth & Families.

Addis, M. E., Hatgis, C., Cardemil, E., Jacob, K., Krasnow, A. D., & Mansfield, A. (2006). Effectiveness of cognitive-behavioral treatment for panic disorder versus treatment as usual in a managed care setting: 2-year follow-up. *Journal of Counseling and Clinical Psychology*, 74(2), 377-385.

Adler, D. A. (1990). Personality disorders: Treatment of the nonpsychotic chronic patient. *New Directions in Mental Health Services*, 47, 3-15.

Ahearn, W. H., Clark, K. M., MacDonald, R. P., & Chung, B. I. (2007). Assessing and treating vocal stereotypy in children with autism. *Journal of Applied Behavior Analysis,* 40, 263-275.

Aiken, L. R. (1997). *Psychological testing an assessment* (9th ed.). Boston: Allyn and Bacon.

Akiskal, H. S. (1983). Dysthymic Disorder: Psychopathology of proposed chronic depressive subtypes. *American Journal of Psychiatry*, 140, 11-20.

Albano, A. M., March, J., & Piacentini, J. (1999). Cognitive behavioral treatments for obsessive-compulsive disorders: In R. Ammerman, M. Hersen, & C. Last (Eds.). *Handbook of prescriptive treatments for children and adolescents* (pp. 193-215), Boston: Allyn and Bacon.

Albano, A. M., & Silverman, W. K. (1996). *Anxiety Disorders Interview Schedule for DSM-IV-Child version: Clinician manual*. San Antonio: Psychological Corporation.

Albin, R. L., & Mink, J. W. (2006). Recent advances in Tourette syndrome research. *Trends Neuroscience*, 9(3), 175-182.

Alden, L. (1992). Cognitive-interpersonal treatment of avoidant personality disorder. In P. Keller & S. Heyman (Eds.), *Innovations in clinical practice: A source book* (Vol. 2) pp. 5-21, Sarasota, FL: Professional Resources Exchange.

Aldred, C., Green, J., & Adams, C. (2004). A new social communication intervention for children with autism: Pilot randomized controlled treatment study suggesting effectiveness. *Journal of Children Psychology and Psychiatry*, 45, 1420-130.

Alexopoulas, G., Abrams, R., Young, R., & Shamoian, C. (1988). Cornell Scale for Depression in Dementia. *Biological Psychiatry*, 23, 271-284.

Allen, A. (2007). Cognitive-behavior therapy and other psychosocial interventions in the treatment of obsessive-compulsive disorder. *Psychiatric Annals*, 36(7), 474-479.

Allumbaugh, D. L., & Hoyt, W. T. (1999). Effectiveness of grief therapy: A meta-analysis. *Journal of Counseling Psychology*, 46(3), 370-380.

Alonso, P., Lopez-Sola, C., Gratacos, M., Fullana, M. A., Segalas, c., Real, E., Cardoner, N., Soriano-Mas, C., Harrison, B. J., Estivill, X., & Menchon, J. M. (2013). The interaction between Comt and Bdnf variants influences obsessive-compulsive-related dysfunctional beliefs. *Journal of Anxiety Disorder,* 27(3), 321-327.

Alpert, J. E., Maddox, A. J., Nierenberg, A., O'Sullivan, R., Pava, J. A., Worthington III, J. J., Biederman, J., Rosenbaum, J. F., & Fava, M. (1996). Attention deficit hyperactivity disorder in childhood among adults with major depression. *Psychiatry Res*, 62, 213-219.

Althof, R. R., Rettew, D. C., & Hudziak, J. J. (2003). Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder. *Psychiatric Annals*, 33(4), 245-252.

AACP Official Action. (1995). Practice parameters for the psychiatric assessment of children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34 (10), 1386-1402.

**American Counseling Association (2014). *American Counseling Association 2014 Code of Ethics.* Alexandria. VA: Author.

American Psychiatric Association. (1994*). Diagnostic and statistical manual of mental* disorders (4th ed.). Washington, DC: Author.

American Psychiatric Association. (1999). *Practice guideline for the treatment of patients with delirium*. *American Journal of Psychiatry*, 156, 1-15.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2002). Practice guideline for treatment of patients with bipolar disorder. American *Journal of Psychiatry*, 159, 1-50.

**American Psychiatric Association: *Diagnosis and Statistical Manual of Mental Disorders.(2013).* Arlington, VA, American Psychiatric Association.

American Psychiatric Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271-285.

Amsterdam, J. D., & Brunswick, D. J. (2003). Antidepressant monotherapy for bipolar type II major depression. *Bipolar Disorder*, 5, 388-395.

Andreasen, N. C. (1999). Understanding the causes of schizophrenia. *The New England Journal of Medicine*, 340(8), 645-647.

Andreasen, N. C., & Black, D. W. (1991). *Introductory textbook of psychiatry*. Washington, DC: American Psychiatric Press.

Andrews, G., Slade, T., & Issakidis, C. (2002). Deconstructing current comorbidity: Data from the Australian National Survey of Mental Health and Well-being. *British Journal of Psychiatry*, 181, 306-314.

Andrews, J., & Moore, S. (1991). Social cognition in the histrionic/overconventional personality. In P. A, Magaro (Ed.), *Cognitive bases of mental disorders* (pp. 11076). Newbury Park, CA: Sage

Angst, J. (1998). The emerging epidemiology of hypomania and bipolar II disorder. *Journal of Affective Disorders*, 50, 143-151.

Angst, J., Adolfisson, R., Benazzi, F., Gamma, A., Hantouche, E., Meyer, T. D. …..Scott, J. (2005). The HCL-32: Towards a self-assessment tool for hypomania symptoms for patients. *Journal of Affective Disorder*, 88, 217-233

Angus, L. (2012). Toward an integrative understanding of narrative and emotion processes in emotion-focused therapy of depression: Implications for theory, research and practice. *Psychotherapy Research,* 22(4), 367-380.

Antonuccio, D. O., Danton, W.G., & DeNelsky, G.Y. (1995). Psychotherapy versus medication for Depression: Challenging the conventional wisdom with data. *Professional Psychology: Research and Practice*, 26(6), 574–585.

Applebaum, A. (2006). Supportive psychotherapy for borderline patients. *Social Work in Mental Health*, 6, 145-155.

Applebaum, A. (2008). Supportive psychotherapy for borderline patients: An empirical approach. *American Journal of Psychology,* 66(4), 317-332.

**Appolinario, J. C., & McElroy, S. (2004). Pharmacological approaches in the treatment of binge eating disorder. *Current Drug Trends,* 5, 301-307.

Archer, R. P., Maruish, M., Imhof, E. A., & Piotrowski, C. (1991). Psychological test usage with adolescent clients: 1990 survey findings. *Professional Psychology: Research and Practice*, 22, 247-252.

Arentewicz, G. & Schmidt, G. (1983). *The treatment of sexual disorders*. New York: Basic Books.

**Arlinghause, K. A., Shoaib, A. M., & Price, T. R. P. (2005). Neuropsychiatric assessment. In J. M. Silver, T. W. McAlister, S. C. Yudofsy, *Textbook of traumatic brain injury* (pp, 63-65), Washington, D. C: American Psychiatric Association.

Armstrong, J., Putnam, F. W., Carlson, E., Libero, D. & Smith, S. (1997). Development and validation of a measure of adolescent dissociation: The Adolescent Dissociative Experience Scale. *Journal of Nervous and Mental Disease*, 185, 491-497.

Ashton, C. H., & Young, A. H. (1998). Drug-induced psychiatric disorders. In D. M. Davies, R. E. Ferner, & H. de Glanville Davies (Eds.). *Textbook of Adverse Drug Reactions* (5th d.; pp. 669–731). London: Chapman & Hall Medical.

Ayers, C. R., Sorrell, J. T., Thorp, S. R., & Wetherell, J. L. (2007). Evidence-based psychological treatments for late-life anxiety. *Psychology and Aging*, 22(1), 8-17.

Bach, P., Hayes, S. C., & Gallop, R. (2012). Long-term effects of brief acceptance and commitment therapy for psychosis. *Behavior Modification,* 36(2), 165-181.

Baer, L., & Greist, J. H. (1997). An interactive computer-administered self-assessment and self-help program for behavior therapy. *Journal of Clinical Psychiatry*, 58 (Suppl. 12), 23-27.

Bakker, A., van-Kesterer, P. J., Gooren, L. J., & Bezemer, P. D. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiat. Scand*, 87, 237-238.

**Baran, A. S., & Richert, A. C. (2003). Obstructive sleep apnea and depression. *Public Medical Review*, 8(2), 126-134.

Barkley, B. A. (1990). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment*. New York: Guilford.

Barkley, R. A. (1997). Major life activity and health outcomes associated with attention-deficit / hyperactivity disorder: *Journal of Clinical Bulletin*, 121, 65-94.

**Barrett, J. E., Williams, J. W., Oxman, T. E., Frank, E., Katon, W., Sullivan, M., Hegel, M. T., Cornell, J. E., & Sengupta, A. S. (2001). Treatment of dysthymia and minor depression in primary care. *The Journal of Family Practice,* 50(5), 405-412.

Barrett, P. M., Farrell, L., Pina, A., Peris, T. S., & Piacentini, J. (2008). Evidence-based psychosocial treatments for child and adolescent obsessive-compulsive disorder. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 131-155.

Basco, M. R., Glickman, M., Weatherford, P., & Ryser, N. (2000). Cognitive-behavioral therapy for anxiety disorders: Why and how it works. *Bulletin of the Menninger Clinic*, 64, A52-A71.

Basco, M. R., Merlock, M., & McDonald, N. (2003). Cognitive-behavioral strategies for the management of bipolar disorder. *Primary Psychiatry*, 10(5), 65-71.

Bateman, A., W., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry*, 156, 1563-1569.

Bateman, A. W., & Fonagy, P. (2003). The development of an attachment-based treatment program for borderline personality disorder. *Bull Menninger Clinic*, 67, 187-211.

Bateman, A. W., & Fonagy, P. (2006a). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: An 18-month follow-up. *Focus*, 4(2), 244-242.

Bateman, A. W., & Fonagy, P. (2006b). Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for cluster C personality disorder. *Focus*, 4(20), 234-243.

Bateman, A. W., & Fonagy, P. (2008). 8-year follow-up of patients treated for borderline personality disorder: Metallization-based treatment versus treatment as usual. *The American Journal of Psychiatry,* 165(5), 631-638.

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology*, 66(1), 53-88.

Beach, S. R. H., & O'Leary, K. D. (1992). Treating depression in the context of marital discord: Outcome and predictors of response of marital therapy versus cognitive therapy. *Behavior Therapy*, 23, 507-528,

Beamish, P. M., Granello, P. F., Granello, D. H., McSteen, P. B., Bender, B. A., & Hermon, D. (1996). Outcome studies in the treatment of panic disorder: A review. *Journal of Counseling and Development*, 74, 460-467.

Beck, A. T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York, NY: Greenberg Basic Books.

**Beck, A.T., & Freeman, A. (1990). *Cognitive therapy for personality disorders*. New York: Guilford.

**Beck, A. T., Freeman, A., Davis, D. D., et al. (2004). *Cognitive theory of personality disorders* (2nd ed.). NY: Guilford Press.

Beck, A. T., & Steer, R. A. (1990a). *Beck anxiety inventory manual*. San Antonia. TX: The Psychological Corporation.

Beck, A. T., & Steer, R. A. (1990b). *Manual for the Beck Anxiety Inventory*. San Antonia, TX: Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996a). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996b). *BDI-II Manual*. San Antonio: The Psychological Corporation, Harcourt Brace & Company.

Beidel, D. C. (1994). Anxiety disorders. In M. Hersen & S. M. Turner (Eds.), *Diagnostic interviewing* (2nd ed., pp. 55-77). New York: Plenum.

Beidel, D. C., Alfano, C. A., Kofler, M. J., Rao, P. A., Scharfstein, L., & Sarver, N. W. (2014). The impact of social skills training for social anxiety disorder: A randomized controlled trial. *Journal of Anxiety Disorder*, 28(8), 908-918.

Beidel, D. C., & Turner, S. M. (1991). Anxiety disorders. In M. Hersen & S. M. Turner (Eds.), *Adult psychopathology and diagnosis* (2nd ed., pp. 226-278). Washington, DC: American Psychological Association.

Beidel, D.C., Turner, S. M., & Cooley, M.R. (1993). Assessing reliable and clinically significant change in social phobia: Validity of the Social Phobia and Anxiety Inventory. *Behavior Research and Therapy*, 31, 331-337.

Beidel, D. C., Turner, S. M., & Morris, T. L. (1995). A new inventory to assess childhood social anxiety and phobia: The Social Phobia and Anxiety Inventory for Children. *Psychological Assessment*, 7, 73-79.

Beidel, D. C., Turner, S. M., & Morris, T. L. (1999). Psychopathology of childhood social phobia. *Journal of American Child and Adolescent Psychiatry*, 38, 643-650.

Bellack, A. S., & Meuser, K. T. (1993). Psychosocial treatment for schizophrenia. *Schizophrenia Bulletin*, 19, 317-336.

Bender, K. J. (1999). Maintaining medication for chronic depression. *Psychiatric Times*, 16(3). http://www.psychiatrictimes.com/depression/article/10168/49361 (accessed 9-04-2008)

Bender, K. J. (2008). Evidence grows for value of antipsychotics as antidepressant adjuncts. *Psychiatric Times*, 25(2). http://www.psychiatrictimes.com/display/article/10168/1147436 (accessed 9-04-2008)

Bennett, M., & Gillingham, K. (1991). The role of self-focused attention in children's attributions of social emotions to the self. *Journal of Genetic Psychology*, 152, 303-309.

Benson, D. G., & Cummings, J. L. (1986). A scheme to differentiate the dementias. In D. V. Jeste (Ed.), *Neuropsychiatric dementias* (pp. 2-25). Washington, DC: American Psychiatric Press.

Benveniste, D. (2006). A Psychodynamic approach. In F. Rotgers, and M. Maniacci, *Antisocial personality disorder: A practitioner's guide to comparative treatments* (pages 46), NY: Springer Publishing.

Berg, C. J., Rapoport, J. L., & Flament, M. (1986). The Leyton Obsessional Inventory-Child version. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 84-91.

Berg, K. C., Peterson, C. B., & Frazier, P. (2012). Assessment and diagnosis of eating disorders: A guide for professional counselors. *Journal of Counseling & Development,* 90, 262-290.

Bergin, A. E., & Garfield, S. L. (1994). *Handbook of psychotherapy and behavior change*. New York: Wiley.

Bergman, P. E., Smith, M. D., & Hoffman, N. C. (1995). Adolescent treatment: Implications for assessment, practice guidelines and outcome management. *Pediatric Clinical North America*, 42, 453-472.

Berman, E., Lief, H., & Williams, A. M. (1986). A model of marital interaction, In G. P. Sholevar (Ed.), *Handbook of Marriage and Marital Therapy* (pp. 3-34), Elmsford, NY: Peragmon.

Berman, J. R. (2005). Physiology of female sexual function and dysfunction. *International Journal of Important Research*, Supp 1, 544-551.

Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of supervision* (4th ed.). New York, NY: Pearson.

Bernstein, D. P., & Fink, L. (1998). *Childhood trauma questionnaire: A retrospective self-report*. San Antonia: Psychological Corporation.

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous Mental Disorders*, 174, 727-735.

Bernstein, N. (1996). *Treating the unmanageable adolescent.* New Jersey: Aronson.

Berscheid, E., Walster, E., & Bohrnstedt, G. (1973). The happy American body: A survey report. *Psychology Today*, 7, 119.

Bertolotti, G., Zotti, A. M., Michielin, P., Vidotto, G., & Sanavio, (1990). A computerized approach to cognitive behavior assessment: An introduction to CBA 2.0 primary scales. *Journal of Behavior Therapy and Experimental Psychiatry*, 21(1), 21-27.

Besag, F. M. (2001). Behavioral effects of the new anticonvulsants. *Drug Safety*, 24, 513–536.

Betchen, S. J. (2003). Suggestions for improving the intimacy in couples in which one partner has attention-deficit/hyperactivity disorder. *Journal of Sex & Marital Therapy*, 29, 103-124.

Bevins, R. A., & Palmatier, M. I. (2004). Extending the role of associative learning processes in nicotine addiction. *Behavioral and Cognitive Neuroscience Reviews*, 3, 143-158.

Bickman, L., Kelley, S. D., Breda, C., Andrade, A. R., & Riemer, M. (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: Results of randomized trial. *Psychiatric Services,* 62, 1423-1429.

Biederman, J., Baldessarini, R. J., Wright, V., Keenan, K., & Faraone, S. (1993). A double-blind placebo controlled study of desipramine in the treatment of ADD: II. Lack of impact of comorbidity and family history factors on clinical response. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 199-204.

Biederman, J., Faraone, S. V., Mick, E., Spencer, T., Wilens, T., Kiely, K., et al. (1995). High risk for attention deficit hyperactivity disorder among children of parents with childhood onset of the disorder. A pilot study. *American Journal of Psychiatry*, 152, 431-435.

Biederman, J., Newcorn, J., & Sprich, S. (1991). Comorbidity of attention deficit hyperactivity disorder with conduct, depressive, anxiety, and other disorders. *American Journal of Psychiatry*, 148, 564-577.

Bing, E. G., Burnam, M. A., Longshore, D., et al. (2001). Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States. *Archives of General Psychiatry*, 58, 721–728.

Bisson, J. L., Ehlers, H., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatment of post-traumatic stress: Systematic review and meta-analysis. *British Journal of Psychiatry,* 190(2), 97-104.

Bixler, E. O., Kales, A., Soldatos, C. R., Kales, J. D., & Healey, S. (1979). Prevalence of sleep disorders in the Los Angeles metropolitan area. *American Journal of Psychiatry*, 136, 1257-1262.

Blake, D. D., Weathers, E., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., et al. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress*, 8, 75-90.

Blake, D. D., Weathers, E., Nagy, L. M., Kaloupek, D. G., Klauminzer, G., & Charney, D. S. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS-1. *Behavior Therapist*, 13, 187-188.

Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD checklist. *Behavior Research and Therapy*, 34, 669-673.

Blazer, D. G., Kessler, R.C., McGonagle, K. A., & Swartz, M.S. (1994). *The prevalence and distribution of major depression in a national community sample: The National Comorbidity* Survey. Durham, N.C.: Duke University Medical Center.

Bleiberg, K. L., & Markowitz, J. C. (2005). Interpersonal psychotherapy for post-traumatic stress disorder. *American Journal of Psychiatry,* 162, 181-183.

Bleiberg, K. L., & Markowitz, J. C. (2008). Interpersonal psychotherapy and depression. In D. Barlow (Ed.), *Clinical handbook of psychological disorders, Fourth Edition: A step by step*. Boston: Guilford Press.

Blehar, M., & Lewy, A. (1990). Seasonal and mood disorders: Consensus and controversy. *Psychopharmacology Bulletin*, 26, 465-494.

Blinder, B. J., Cumella, E. J., & Sanathara, V. A. (2006). Psychiatric comorbidity of female inpatients with eating disorders. *Psychoso Med,* 68(3), 454-462.

Bluett, E. J., Homan, K. J., Morrison, K. L., Levin, M. E.., & Twohig, M. P. (2014). Acceptance and commitment therapy for anxiety and OCD spectrum disorders: An empirical review. *Journal of Anxiety Disorders*, 28(6), 612-624.

Blum, H. (1973).The concept of erotized transference. *Journal of American Psycho-Anal Association*, 21, 61-76.

Bolton, E. E., Lambert, J. F., Wolf, E. J., Raja, S., Varra, A. A., & Fisher, L. M. (2004). Evaluating a cognitive-behavioral group treatment program for veterans with posttraumatic stress disorder. *Psychological Services*, 1(2), 140-146.

Bootzin, R. A., & Acocella, J. R. (1988). *Abnormal psychology: Current perspectives* (5th ed.). New York: McGraw Hill.

Bootzin, R. R., & Rider, S. P. (1997). Behavioral techniques and biofeedback for insomnia. In M. Pressman & W. Orr (Eds.), *Understanding sleep (pp. 315-338)*. Washington, DC: American Psychological Association.

Bordnick, P. S. (1997). Trichotillomania: A social worker's guide to practice. *Research on Social Work Practice*, 7, 216-228.

Borland, B. L., & Heckman, H. K. (1976). Hyperactive boys and their brothers: A 25-year follow-up study. *Archives General Psychiatry*, 33, 669-675.

Bornstein, R. F. (1997). Dependent personality disorder in the DSM-IV and beyond. *Clinical Psychology: Science and Practice*. 4, 175-187.

Boschen, M. J., Veale, D., Ellison, N., & Redell, T. (2013). The emetophobia questionnaire (EmetQ-13): Psychometric validation of a measure of specific phobia of vomiting (emetophobbia*). Journal of Anxiety Disorders,* 27(6), 670-677.

Boudewyns, P. A., Hyer, L., Woods, M. G., Harrison, W. R., & McCranie, E. (1990). PTSD among Vietnam veterans: An early look at treatment outcome using direct therapeutic exposure. *Journal of Traumatic Stress*, 3(3), 359-368.

Bowers, M. K., Brecher-Marer, S., Newton, B., Piotrowski, Z., Spyer, T. C., Taylor, W. S., & Watkins, J. G. (1971). Therapy of multiple personality. *International Journal of Clinical and Experimental Hypnosis*, 19, 57-65.

**Bowers, W. A., & Andersen, A. E. (1995). Inpatient treatment of anorexia nervosa. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders Vol. 2* (2nd ed., pp. 2179-2201). Washington, DC: American Psychiatric Press, Inc.

Boyd, J. H., Burke Jr, J. D., Gruenberg, E., Holzer, C. E., Rae, D. S., George, L. K., Karno, M., Stoltzman, R., McEvoy, L., & Nestadt, G. (1984). Exclusion criteria of DSM-III A study of co-occurrence of hierarchy-free syndromes. *Journal of Clinical Psychiatry*, 41, 983-989.

Bradford, E., & Lyddon, W. J. (1994). Assessing adolescent and adult attachment: An update. *Journal of Counseling and Development*, 73, 215-219.

Bradford, J. M. W. (1996). The role of serotonin in the future of forensic psychiatry. *Bulletin of American Academy of Psychiatry and the Law*, 24, 57-72.

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, 162(2), 214-227.

Bradley, S., Wachsmuth, R., Swinson, R., & Hnatko, G. (1990). A pilot study of panic attacks in a child and adolescent psychiatric populations. *Canadian Journal of Psychiatry*, 35, 526-528.

Brand, B. L., McNary, S., Classen, C., Lowenstein, R., Pain, C., & Putnam, F. (2009). A naturalistic study of dissociative identity disorder and dissociative disorder not otherwise specified patients treated by community clinicians. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1(3), 188-205.

Brannigan, G. G., & Decker, S. L. (2003). *Bender Gestalt II- Examiner's Manual*. Itasca, IL: Riverside Publishing.

Braun, B. G. (1984). Symposium on multiple personality. *Psychiatric Clinics of North America*, 7, 1-2.

Braun, B. G. (1986). Issues in the psychotherapy of multiple personality disorder. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 1-28). Washington, DC: American Psychiatric Press.

Brende, J. O. (1985). The use of hypnosis in post-traumatic conditions in posttraumatic stress disorder and the war veteran patient. In W. E. Kelly (Ed.), *Post-traumatic symptoms and recovery* (pp. 193-210). New York: Brunner/Mazel.

Brende, J. O., Dill, J. E., Dill, B., & Sibcy, G. A. (1998). Integrated diagnostic and treatment approach for the medical patient who has had psychological trauma. *Southern Medical Journal*, 91(4), 318-325.

Brende, J. O., Gfroerer, K. A., & Arthur, G. L. (1997). Validation and introduction to the Twelve Theme Post-traumatic Symptom and Fragmentation Assessment. *Georgia Journal of Professional Counseling*, 5(1), 63-74.

Brende, J. O., & McCann, I. L. (1984). Regressive experiences in Vietnam veterans. *Journal of Contemporary Psychotherapy*, 13, 57-73.

Breslau, N., Kessler, R. C., & Peterson, E. L. (1998). PTSD assessment with a structured interview: Reliability and concordance with a standardized clinical interview. *International Journal of Methods Psychiatric Residence*, 7, 121-127.

Breslau, N., Peterson, E. L., Kessler, R. C., & Schultz, L. R. (1999). Short Screening for DSM-IV Posttraumatic Stress Disorder. *American Journal of Psychiatry*, 156(6), 908-911.

Breuer, J., & Freud, S. (1893). Studies in hysteria1. On physical mechanisms of hysterical phenomena: Preliminary communications. In J. Strachey (Ed.), *Standard Edition*, (Vol.2) London: Hogarth Press.

**Brewerton, T. D. (1999). Bing eating disorder: Diagnosis and treatment options. *CNS Drugs*, 11(5), 351-361.

Briere, J. (2004). *Psychological assessment of adult posttraumatic states: Phenomenology, diagnosis, and measurement* (2nd ed.). Washington, DC: American Psychological Association.

Brown, C. H., Wyman, P. A., Guo, J., & Pena, J. (2006). Dynamic wait-listed designs for randomized trials: New designs for prevention of youth suicide. *Clinical Trials*, 3(3), 259-271.

Brown, E. J., Heimbert, R. G. & Juster, H. R. (1995). Social phobia subtype and avoidant personality disorder: Effect on severity of social phobia, impairment, and outcome of cognitive behavioral treatment. *Behavior Therapy*, 26, 467-486.

Brown, J. T., & Stoudemire, A. (1983). Normal and pathological grief. *JAMA*, 250, 378.

Brown, L., Sherbenou, R. J., & Dollar, S. J. (1982). *Test of Nonverbal Intelligence*. Austin, TX: Pro-Ed.

Brown, M. B. (2000). Diagnosis and treatment of children and adolescents with attention-deficit/hyperactivity disorder. *Journal of Counseling & Development*, 78, 195-202.

Brown, T. A., Barlow, D. H., & Liebowitz, M. R. (1994). The empirical basis of generalized anxiety disorder. *American Journal of Psychiatry*, 151, 1272-1280.

Brown, T. A., Di Nardo, P. A., & Barlow, D. H. (1994). *Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV)*. San Antonio, TX: Psychological Corporation.

Brown, T. A., O'Leary, T. A., & Barlow, D. H. (1993). Generalized anxiety disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (2nd ed., pp. 137-188). New York: Guilford.

Brown, T. M., & Stoudemiere, A. (1998). Psychiatric side-effects of prescription and over the counter medications. *Recognition and Management*. Washington, DC: American Psychiatric Press.

Bruininks, R. H., Woodcock, R. W., Weatherman, R. F., & Hill, B. K. (1984). *Scales of Independent Behavior*. Allen, TX: Developmental Learning Materials.

Brunello, N., Akiskal, H., Boyer, P., Gessa, G. L., Howland, R. H., Langer, S. Z., Mendlewicz, J., Paes de Souza, M., Placidi, G. F., Racagni, G., & Wessely, S. (1999). Dysthymia: Clinical picture, extent of overlap with chronic fatigue syndrome, neuropharmacological considerations, and new therapeutic vistas. *Journal of Affective Disorders*, 51(1-3), 275-290.

Bryant, R. A., Harvey, A. G., Dang, S. T., & Sackville, T. (1998). Assessing acute stress disorder: Psychometric properties of a structured clinical interview. *Psychological Assessment*, 10(3), 215-220.

Bryant, R. A., Moulds, M.L., Guthrie, R. M., Dang, S. T., & Nixon, R. D. V. (2003). Imaginal exposure alone and imaginal exposure with cognitive restructuring in treatment of posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology,* 71, 706-712.

**Bryant, R. A., Moulds, M. L., Guthrie, R. M., & Nixon, R. D. V. (2005). The additive benefit of hypnosis and cognitive-behavioral therapy in treating acute stress disorder. Journal of *Counseling and Clinical Psychology,* 73(2), 334-340.

Bulik, C. M., Devlin, B., Bacanu, S. A., Thornton, L., Klump, K. L., Fichter, M. M. et al. (2003). Significant linkage on chromosome 10p in families with bulimia nervosa. *American Journal of Human Genetics*, 72, 200-207.

Burge, S., Amodei, N., Elkin, B., Catala, S., Andrew, S., Lane, P., & Seales, P. (1997). An evaluation of two primary care interventions for alcohol abuse among Mexican-American patients. *Addiction*, 92(12), 1705-1716.

**Burket-Smith, M. (2001). Somatization and chronic pain. *Acta Anaesthesiologica Scandinavica*, 45(9), 114-1120.

Burnam, M. A., Hough, R. L., Karno, M. Escobar, J. I., & Telles, C. A. (1987). Acculturation and lifetime prevalence of psychiatric disorders among Mexican Americans in Los Angeles. *Journal of Health Social Behavior*, 28, 89-102,

Burnam, M. A., Wells, K. B., Leake, B., & Landsverk, J. (1988). Development of a brief screening instrument for detecting depressive disorders. *Med Care*, 26, 775-789.

Butcher, J., & Williams, C. L. (1992). *The Minnesota Multiphasic Personality Inventory-Adolescent.* Minneapolis, MN: University of Minnesota Press.

Butchner, N., Williams, C. L., Graham, J. R., Archer, R. P., Tellegen, A., Ben-Porath, Y. S., & Kaemmer, B. (1992). *MMP I-Minnesota* Multiphasic Personality Inventory-Adolescent. Manual for Administration, Scoring, and Interpretation. Minneapolis: University of Minnesota Press.

Buysse, D. J., Morin, C. M., & Reynolds, C. F. (1995). In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed., pp. 2397-2445). Washington, DC: American Psychiatric Association Press.

Buysse, D. J., & Reynolds, C. F. (1990). Insomnia. In M. J. Thorpy (Ed.), *Handbook of sleep disorders* (pp. 375-433). New York: Marcel Dekker.

Buysse, D. J., Reynolds, C. F., Monk, T. H., Berman, S. R., & Kupfer, D. J. (1989). The Pittsburgh Sleep Quality Index: A new instrument for psychiatric practice and research. *Psychiatry Research*, 28, 193-213.

Caetano, R. (1992). Relationship between two ways of measuring alcohol dependence. *Addictive Behavior*, 17, 237-246.

Caldwell, D. C. (1949). Psychopathia transexualis. *Sexology*, 16, 274-280.

Callaghan, G. M., Summers, C. J., & Weidman, M. (2003). The treatment of histrionic and narcissistic personality disorder behaviors: A single-subject demonstration of clinical improvement using functional analytic psychotherapy. *Journal of Contemporary Psychotherapy*, 33(4), 321-339.

Campbell, S. S., Dawson, D., & Anderson, M. W. (1993). Alleviation of sleep maintenance insomnia with timed exposure to bright light. *Journal of American Geriatrics Society*, 41, 829-836.

Cantor, A. (1996). The Bender-Gestalt Test (BGT). (In C. S. Newmark, *Major Psychological Assessment Instruments (2nd ed*., pages 400-430). Needleham Heights: Simon & Schuster.

Capuzzi, D., & Gross, D. R. (2007). *Counseling and psychotherapy: Theories and interventions* (4th ed.). Upper Saddle River, NJ: Pearson

Carlson, E. B., Putnam, F. W., Ross, C. A., Torem, M., Coons, P., Dill, D. L., Lowenstein, R. J., & Braun, B. G. (1993). Validity of the Dissociative Experience Scale in screening for multiple personality disorder: A multicenter study. *American Journal of Psychiatry*, 150, 1030-1036.

Carmel, M. R., Linkugel, J. D., & Bevins, R. A. (2007). Nicotine as a conditioned stimulus: Impact of attention-deficit/hyperactivity disorder medications. *Experimental and Clinical Pharmacology*, 15(5), 501-509.

Carney, C. E. (2013). Sleep therapy is expected to gain a wider role in depression treatment. *New York Times*, November 24.

Carney, C. E. & Edinger, J. (2013). Overcoming insomnia: A cognitive-behavioral therapy approach.

Carpenter, W. T. (2014). Porous diagnostic boundaries: A new emphasis for the bulletin. *Schizophrenia Bulletin,* 30(1), 1-2. doi:a0.1093/schbul/sbt164

Carrington, P., & Ephron, H. S. (1978). Using meditation with psychotherapy. In J. L. Fossage, & P. Olsen (Eds.), *Healing: Implications for psychotherapy*. New York: Human Sciences.

Carroll, B. J. (1998). *Carroll Depression Scales-Revised (CDS-R): Technical manual*. Toronto: Multi-Health Systems, Inc.

Carroll, B. J., Feinberg, M., Smouse, P. E., et al. (1981). The Carroll Rating Scale for Depression-development, reliability and validation. *British Journal of Psychiatry,* 138, 194-200.

Carsky, M. (2013). Supportive psychoanalytic therapy for personality disorder. *Psychotherapy,* 50(3), 443-448.

Carter, C. (2008, July 7). Make believe or mental disorder: Fraud in emotional harm and neuropsychological injury claims. *Claims Management Strategies for Resolution*. Retrieved http://claims-management.theclm.org/home/article/make-believe-or-mental-disorder.

Cella, D., Riley, W., Stone, A., Rothrock, N. Reeve, B., Yount, S., et al. (2010). The Patient-Reported Outcomes Measurement Information System (PROMIS) developed and tested its first wave of adults self-reported health outcome item banks: 2005-2008. *Journal of Clinical Epidemiology*, 63(11), 1179-1194. 1097/01.mir.0000258615.42478.55

Centorrino, F., Meyers, A. L., Ahl, J., Cincotta, S. L., Zun, L., Gulliver, A. H., Kinon, B. J., & Houston, J. P. (2007). An observational study of the effectiveness and safety agitation in patients with bipolar mania or schizophrenia/ schizoaffective disorder. *Human Psychopharmacology*, 22, 455-462. Herbert, J. D. & Forman, E. M. (2013).

Chaffin, M., & Shultz, S. K. (2001). Psychometric evaluation of the Children's Impact of Traumatic Events Scale-Revised. *Child Abuse & Neglect*, 25(3), 401-411.

Chambers, W. J., Puig-Antich, J., Hirsch, M., Paez, P., Ambrosini, P. J., Tabrizi, M. A., & Davies, M. (1985). The assessment of affective disorders in children and adolescents by semistructured interview. Test-retest reliability of the schedule for affective disorders and schizophrenia for school-age children, present episode version. *Archives General Psychiatry,* 42(7), 696-702.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7-18.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P., et al. (1996). An update on empirically validated therapies. *The Clinical Psychologist*, 49, 5-18.

Chapin, T. (2014). Strategies for self-regulation: Rediscovering the physiological basis of behavior. *Counseling Today,* 57(5), 22-25.

Chavia, D. A., Grilo, C. M., Shea, M. T., Yen, S., Gunderson, J. G., Morey, L. C., Skodol, A. E., Stout, R. L., Zanarini, M. C., & Hcglashan, T. H. (2003). Ethnicity and four personality disorders. *Comprehensive Psychiatry*, 44(6), 483-491.

Chorpita, B. F., Moffitt, C. E., & Gray, J. A. (2005). Properties of the Revised Child's Anxiety and Depression Scale in a clinical sample. *Behaviour Research and Therapy*, 43, 309-322.

**Chu, J. A. (1998). *Rebuilding shattered lives: The responsible treatment of complex post traumatic and dissociative disorders*. New York: John Wiley & Sons.

Chung, H., Culpepper, L., DeWester, J. N., Grieco, R. L., Kaye, N. S. , Lipkin, M., Rosen, S. J., & Ross, R. (2007). Treatment by phase: Pharmacologic management of bipolar disorder. *The Journal of Family Practice*, 56(11), S19-S27.

Clark, D. M. (1986). A cognitive approach to panic. *Behavior Research and Therapy*, 24, 461-470.

Clark, D. M., Ehlers, A., Hackmann, A., McManus, F., Fennell, M., Grey, N., Waddington, W., & Wild, J. (2006). Cognitive therapy versus and applied relaxation in social phobia: A randomized controlled trail. *Journal of Counseling and Clinical Psychology*, 74(3), 568-578.

Clark, D. M., Ehlers, A., McManus, F., Hackmann, A., Fennell, M., Campbell, H., …Louis, B. (2003). Cognitive therapy versus fluoxetine in generalized social phobia: A randomized placebo-controlled trial. *Journal of Consulting and Clinical Psychology,* 71(6), 1058-1067.

Clark, D. M., Salkovskis, P. M., Hackmann, A., Wells, A., Ludgae, J., & Gelder, M. (1999). Brief cognitive therapy for panic disorder: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 67(4), 583-588.

Clarkin, J. F., Yeomans, F., & Kernberg, O. F. (2006). *Psychotherapy for borderline personality: Focusing on object relations*. New York: Wiley.

Clement, S. (1986). The identification of alcohol-related problems by general practitioners. *British Journal of Addiction*, 81(2), 257-64.

Cloninger, R. (1986). A systematic method for clinical description and classification of personality variants. *Archives of General Psychiatry*, 44, 573-588.

Clum, G. A., Clum, G. A., & Surls, R. (1993). A meta-analysis of treatment for panic disorder. *Journal of Consulting and Clinical Psychology*, 61, 317-326.

Cochran, S. D. (1984). Preventing medical noncompliance in the outpatient treatment of bipolar affective disorders. *Journal of Consulting and Clinical Psychology*, 52, 873-878.

**Cohen-Kettenis, P. T., & Gooren, L. J. G. (1999). Transsexualism: A review of etiology, diagnosis and treatment. *Journal of Psychosomatic Research*, 46(4), 315-333.

Cohen, P., Cohen, J., Kasn, S., Velez, C. N., Hartmark, C., Johnson, J., Rojas, M., Brook, J., & Streunig, E. L. (1993). An epidemiological study of disorders in late childhood and adolescence-I. Age-and gender-specific prevalence. *Journal of Child Psychology and Psychiatry*, 34, 851-867.

Compton, S. N., Walkup, J. T., Albano, A. M., Piacentini, J. C., Birmaher, B., Sherrill, J. T., . . . March, J. S. (2010). Child/adolescent anxiety multimodal study (CAMS): Rationale, design, and methods. *Child and Adolescent Psychiatry and Mental Health, 4*, 1.

Coolidge, F. L. (1993). *The Coolidge Axis II Inventory: Manual.* Colorado Springs, CO: University of Colorado.

Coolidge, F. L., & Merwin, M. M. (1992). Reliability and validity of the Coolidge Axis II Inventory: A new inventory for the assessment of personality disorders. *Journal of Personality Assessment*, 59, 223-238.

Comer, R. J. (1996). *Fundamentals of abnormal psychology*. New York: W. H. Freeman and Co.

Comer, R. J. (1996) *Fundamentals of abnormal psychology. Avoidant personality disorder* (3rd ed., pp.428-430). New York: Worth.

Conners, C. K. (1989) *Conners Rating Scales Manual*. North Tonowanda, NY: Multi-Health Systems.

Conners, C. K., Sitarenios, G., Parker, J. D. A., & Epstein, J. N. (1998). The Revised Conners' Parent Rating Scale (CPRS-R): Factor structure, reliability, and criterion validity. *Journal of Abnormal Child Psychology*, 26(4), 257-267.

Cooper, J. (1970). The Leyton Obsessional Inventory. *Psychological Medicine*, 1, 48-64.

Cooper, M. J., Cohen-Tovee, E., Todd, G., Wells, A., & Tovee, M. (1997). The Eating Disorder Belief Questionnaire: Preliminary development. *Behavior Research and Therapy*, 35, 381-388.

Cooper, M., Todd, G., Turner, H., & Wells, A. (2007). Cognitive therapy for *bulimia nervosa*: An A-B replication series. *Clinical Psychology and Psychotherapy*, 14, 402-411.

Cooper, M., Todd, G., Woolrich, R., Somerville, K., & Wells, A. (2006). Assessing eating disorder thoughts and behaviors: The development and preliminary evaluation of two questionnaires. *Cognitive Therapy and Research*, 30, 551-570.

Cooper, N. A., & Clum, G. A. (1989). Imaginal flooding as a supplementary treatment for PTSD in combat veterans: A controlled study. *Behavior Therapy*, 3, 381-391.

Cooper, P. J., Taylor, M. J., Cooper, Z., & Fairburn, C. (1986). The development and validation of the Body Shape Questionnaire. *International Journal of Eating Disorders*, 6, 485-494.

Coplan, J. D., Tiffon, L., & Gorman, J. M. (1993). Therapeutic strategies for the patient with treatment-resistant anxiety. *Journal of Clinical Psychiatry*, 54, 69-74.

**Corbin, L. J., Hanson, R. W., Hopp, S. A., & Whitley, A. C. (1988). Somatoform disorders: How to reduce overutilization of health care services. *Journal of Psychosocial Nursing Mental Health Services*, 26, 31-34.

**Coryell, W. (2005). Rapid cycling bipolar disorder: Clinical characteristics and treatment options. *CNS Drugs,* 19(7), 557-569.

Costa, P. T., & Widiger, T. (1993). Personality disorders and the five-factor model of personality (Ed.). Washington, DC: American Psychological Association.

Costello, A. J., Edelbrock, C., Kalas, R., Dulcan, M. S., & Klaric, S. H. (1984). Development and testing of the NIMH Diagnostic Interview Schedule for Children (disc) in a clinic population: Final report. Rockville, MD: Center for Epidemiological Studies.

**Craske, M. G. (1999). *Anxiety disorders: Psychological approaches to theory and treatment*. Los Angeles: Westview Press.

**Craske, M. G., & Barlow, D. H. (1993). Panic disorder and agoraphobia. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (pp. 1-47). New York: Guilford Press.

Craske, M. G., & Barlow, D. H. (2008). Panic disorder and agoraphobia. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (4th ed., pp. 1-64). New York, NY: Guilford Press.

Craske, M. G., Niles, A. N., Burklund, L. J., Wolitzky-Taylor, K. B., Viladaga, J. C., Arch, J. J., Saxbe, D. B., & Lieberman, M. D. (2014). Randomized controlled trial of cognitive behavior therapy and acceptance and commitment therapy for social phobia: Outcomes and moderators. *Journal of Consulting and Clinical Psychology*, 82(6), 1034-1048. doi: 10.1037/a0037212.

Crome, E., & Baillie, A. (2014). Mild to severe social fears: Ranking types of feared social situations using item response theory. *Journal of Anxiety Disorders,* 28(5), 471-479.

Crowley, T., Richardson, D., & Goldmeier, D. (2006). Recommendations for the management of vaginismus: BASHH special interest group for sexual dysfunction. *International Journal of STD Aids*, 17(1), 14-18.

Crozier, W. R., & Burnham, M. (1990). Age-related differences in children's understanding of shyness. *British Journal of Developmental Psychology*, 8, 179-185.

Cummings, J. L. (1992). Depression and Parkinson's disease: A review. *American Journal of Psychiatry*, 149, 443–454.

Cummings, J. L., & Benson, D. G. (1983). *Dementia: A clinical approach*. Boston: Butterworth Publishers.

Cunningham, A. B., & Schreibman, L. (2008). Stereotypy in autism: The importance of function. *Research in Autism Spectrum Disorders*, *2*, 469-479. doi:10.1016/j.rasd.2007.09.006

**Cyranowski, J. M., Aarestad, S. L., & Andersen, B. L. (1999). The role of sexual self-schema in a diathesis-stress model of sexual dysfunction. *Applied and Preventive Psychology*, 8(3), 217-228.

Daeppen, J. B., Yersin, B., Landry, U., Pecoud, A., & Decrey, H. (2000). Reliability and validity of the Alcohol Use Disorders Identification Test (AUDIT) Imbedded within a general health risk screening questionnaire: Results of a survey in 332 primary care patients. *Alcoholism: Clinical and Experimental Research,* 24(5), 659-665.

David-Ferdon, C., & Kaslow, N. J. (2008). Evidence-based psychosocial treatment for child and adolescent depression. *Journal of Clinical Child & Adolescent Psychology,* 37(1), 62-104.

Davidson, J. R. T., Potts, L. S., Richichi, E. A., Krishnan, R., Ford, S. M., Smith, R. D., & Wilson, W. (1991). The Brief Social Phobia Scale. *Journal of Clinical Psychiatry*, 52, 48-51.

DeBord, J. B. (1989). Paradoxical interventions: A review of the recent literature. *Journal of Counseling & Development*, 67(7), 394-398.

**DeLima, M. S. & Hotopf, M. (2003). Benefits and risks of pharmacotherapy for dysthymia. *Drug Safety,* 26(1), 55-64.

Delinsky, S. S., & Wilson, G. T. (2006). Mirror exposure for the treatment of body image disturbance. *International Journal of Eating Disorders*, 39, 108-116,

Derogatis, L. R. (1975). *Derogatis Sexual Functioning Inventory.* Baltimore, MD: Clinical Psychometrics Research.

Derogatis, L. R. (1994). *SCL-90-R Symptom Checklist-90-R*. Minneapolis: Pearson.

DeRogatis, L. R. (1997). The DeRogatis Interview for Sexual Functioning: An introductory report. *Journal of Sex and Marital Therapy*¸ 23, 291-304.

DeRubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology,* 66(1), 37-52.

De Shazer, S. (1991). *Putting difference to work*. New York, NY: Norton.

deVente, W., Majdandic, M., Voncken, M. J., & Beidel, D. C., & Bogels, S. M. (2014). The SPAI-18, a brief version of the Social Phobia and Anxiety Inventory: Reliability and validity in clinically referred and non-referred samples. *Journal of Anxiety Disorders*, 28(2), 140-147.

Dia, D.A. (2001). Cognitive-behavioral therapy with a six-year-old boy with separation anxiety disorder: A case study. *National Association of Social Workers*, 2692M 1260128.

Diefenbach, G. J., Reitman, D., & Williamson, D. A. (2000). Trichotillomania: A challenge to research and practice. *Clinical Psychology Review*, 20, 289-309.

Dilsaver, S., & Akiskal, H. S. (2005). High rate of unrecognized bipolar mixed states among destitute Hispanic adolescents referred for "major depressive disorder". *Journal of Affective Disorders*, 84, 179-186.

DiNardo, P., Brown, T. A., & Barlow, D. H. (1994). *The anxiety disorder schedule for DSM-IV: Lifetime version* (ADIS-IV-L). San Antonio, TX: Psychological Corporation.

Dinner, M .D. (2004). Depressive symptoms with Type 1Diabetes Mellitus. *Psychiatry and Behavioral Sciences*, 61, 450-458.

Dishion, T. J., French, D. C., & Patterson, G. R (1995). The development and ecology of antisocial behavior. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology, Vol. 2. Risk, disorder, and adaptation* (pp. 421-471). New York: Wiley.

Dixon, L. B., Dickerson, F., Bellack, A. C., Bennett, M., Dickenson, D., Goldberg, R. W., & Kreyenbuhl, J. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36, 49-70.

Dixon, M. R., & Johnson, T. E. (2007). The gambling functional assessment (GFA): An assessment device for identification of maintaining variables of pathological gambling. *Analysis of Gambling Behavior,* 1, 44-49.

Dolan, B. A. (1997). *A community-based therapeutic community: The Henderson hospital in a community Based therapeutic community for* offenders (p. 47-74). Ed. C. E. Jones, Woodward R. Chichester, England: Wiley and Sons.

Dolan, B. & Coid, J. (1993). *Psychopathic and antisocial personality disorders: Treatment and research issues*. London, UK: Gaskell.

Domino, G. (2000). *Psychological testing: An introduction*. Upper Saddle River, NJ: Prentice Hall.

Doyle, R. (2004). The history of attention-deficit/hyperactivity disorder. *Psychiatric Clinics of North America,* 17, 203-214.

Drew, A., Baird, G., Baron-Cohen, S., Cox, A., Slonims, V., Wheelwright, S., et al. (2002). A pilot randomized control trial of a parent training intervention for pre-school children with autism: Preliminary findings and methodological challenges. *European Child and Adolescent Psychiatry,* 11, 266-272.

Drummond, R. J., & Jones, K. D. (2006). *Assessment procedures for counselors and helping professionals* (6th ed.). Upper Saddle River, N.J.

**Dunn, K. M., Croft, P. R., & Hackett, G. I. (1999). Association of sexual problems with social, psychological, and physical problems in men and women: A cross sectional population survey. *Journal of Epidemiology and Community Health*, 53(3), 144-148.

Dunne, F. (2004). Gestational diabetes. *Diabetic Medicine,* 21, 6-8. Doi: 10.1111/j.1464-5491.2004.1302d.x

Eaton, W. W., Shao, H., Neustadt, G., Lee, B. H., Bienvenu, O. J., & Zandi, P. (2008). Population-based study of first onset and chronicity in major depressive disorder. *Arch Gen Psychiatry*. 65(5), 513-520.

Ebly, E. M., Parhad, I. M., Hogan, D. B., & Fung, T. S. (1994). Prevalence and types of dementia in the very old: Results from the Canadian study of health and aging. *Neurology*, 44, 1593-1600.

**Eckert, E. D., & Mitchell, J. E. (1989). An overview of the treatment of anorexia nervosa. *Psychiatric Medicine*, 7, 293-315.

Edinger, J. D. (1987). Sleep history questionnaire for evaluating insomnia complaints. In P. A. Keller & S. R. Heyman (Eds.), *Innovations in clinical practice: A sourcebook* (Vol. 6, pp. 295-303). Sarasota, FL: Professional Resource Exchange.

Edinger, J. D., Coleman, E. A., Cole, C., Richards, K. C., Kennedy, R. L., Goodwin, J. A., Hutchins, L. F., & Mack, K. (2011). Subjective sleep quality, objective sleep characteristics, insomnia symptom severity, and daytime sleepiness in women aged 50 and older with nonmetastatic cancer. *Oncology Nursing Forum,* 38(4), 314-325.

Edinger, J. D., Olsen, M. K., Stechuchak, K….Carney C. E. (2009). Cognitive-behavioral therapy for patients with primary insomnia or insomnia associated predominately with mixed psychiatric disorders: A randomized clinical trial. *Sleep,* 32(4), 499-510.

Edinger, J. D., Wohlgemuth, W. K., Radtke, R. A., Marsh, G. R., & Quillian, E. (2001). Cognitive behavioral therapy for treatment of chronic primary insomnia. *Journal of American Medical Association,* 285, 1856-1864.

Edwards, M. C., Schultz, E. G., & Long, N. (1995). The role of the family in the assessment of attention deficit hyperactive disorder. *Clinical Psychology Review*, 15, 375-394.

Eisen, J. L., Phillips, K. A., Baer, L., Beer, D. A., Atala, K. D., & Rasmussen, S. A. (1998). The Brown Assessment of Beliefs Scale: Reliability and validity. *American journal of Psychiatry,* 155, 102-108. [PubMed]

**Eisendrath, S. J. (1995). Factitious disorders and malingering. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders Vol. 2* (2nd ed., pp. 1803-1818). Washington, DC: American Psychiatric Press, Inc.

Ekman, P (2003). *Emotions revealed: Recognizing faces and feelings to improve communication and emotional life*. New York: Henry Holt and Company.

Elhai, J. D., Gray, M. J., Kashdan, T. B., & Franklin, C. L. (2005). Which instruments are most commonly used to assess traumatic exposure and posttraumatic effects?: A survey of traumatic stress professionals. *Journal of Traumatic Stress,* 18(5), 541-545.

**Elkin, I. (1994). The NIMH treatment of depression collaborative research program: When we began and where we are. In A. E. Bergin & A. Garfield (Eds.). *Handbook of psychotherapy and change* (4th ed.). New York: John Wiley & Sons, Inc.

Ellison, J. M. (1996). *Integrative treatment of anxiety disorders* (Ed.). Washington, DC: American Psychiatric Press.

**Ellison, J. W., & Ross, C. A. (1997). Two-year follow-up of inpatients with dissociative identity disorder. *The American Journal of Psychiatry*, 154(6), 832-839.

**Emmelkamp, P. M. G. (1994). Behavior therapy with adults. In A. E. Bergin, & S. L. Garfield, (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., 379-427). New York: John Wiley & Sons.

Endicott, J., & Spitzer, R. L. (1978). A diagnostic interview: The Schedule for Affective Disorders and Schizophrenia. *Archives of General Psychiatry*, 35, 837-844.

Erford, B. T. (2013). In B. T. *Erford, Assessment for counselors* (2nd ed.). Belmont, CA: Brooks/Cole.

Erford, B. T. (2015). *40 techniques every counselor should know, 2/E.* New York, NY: Pearson.

Erford, B. T., Eaves, S. H., Bryant, E. M., & Young, K. A (2010). *35 techniques every counselor should know.* Upper Saddle River, NJ: Merrill.

Erford, B. T., Erford, B. M., Lattanzi, G., Weller, J., Schein, H., Wolf, E, ….Peacock, E. (2011). Counseling outcomes for school-age youth with depression from 1990-2008: A meta-analysis. *Journal of Counseling & Development*, 9, 439-457.

Erford, B. T., Paul, L. E., Oncken, C., Kress, V. E., & Erford, M. R. (2014). Counseling outcomes for youth with oppositional behavior: *A meta-analysis. Journal of Counseling & Development,* 92(1), 13-24.

Erk, R. R. (2000). Five frameworks for increasing understanding and effective treatment of attention-deficit/hyperactivity disorder: Predominantly inattentive type. *Journal of Counseling & Development,* 78, 389-399.

Espie, C. A. (2011). The daytime impact of DSM-5 insomnia disorder: Comparative analysis of insomnia subtype form the Great British Sleep survey (n -11,129) Paper presented at the World-sleep 2011, Kyotto. Japan. In B. I. Voinesci., Szdmtagptai & D. Daniel. Sleep disturbance, circadian preference and symptoms of adult attention deficit hyperactivity disorder (ADHD). *Journal of Neural Transmission*, 119, 1195-1204

Espie, C. A., Brooks, D. N., & Lindsay, W. R. (1989). An evaluation of tailored psychological treatment of insomnia. *Journal of Behavior Therapy & Experimental Psychiatry*, 20, 143-153.

Espie, C. A., Lindsay, W. R., Brooks, D. N., Hood, E. M., & Turvey, T. (1989). A controlled comparative investigation of psychological treatments for chronic sleep onset insomnia. *Behavior Research and Therapy*, 27, 79-88.

Essau, C., Conradt, J. & Peterson, F. (1999). Frequency and comorbidity of social phobia and social fears in adolescents. *Behaviour Research and Therapy*, 37, 831-843.

Ettner, R. (1999). *Gender loving care: A guide to counseling gender-variant clients*. New York: W. W. Norton & Company.

Evans, S., Ferrando, S., Findler, M., Stowell, C., Smart, C., & Haglin, D. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder. *Journal of Anxiety Disorders*, 22, 716-721.

Evans, W. M. (1998). Assessment and diagnosis of the substance use disorders (SUDS). *Journal of Counseling and Development*, 76, 325-333.

Everall, I. P., Drummond, S., & Catalan, J. (2004). *Guidelines for the prescribing of medication for mental health disorders for people with HIV* infection (Draft) (Council Report CR127). London: Royal College of Psychiatrists. On-line at www.rcpsych.ac.uk/publications/cr/council/cr127.doc.

Everly, G. S. (1989). *The clinical guide to the treatment of the human stress response*. New York: Plenon.

Ewing, J. A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of Medical Association*, 252, 1905-1907.

Exner, J. E. (1993). *The Rorschach: A comprehensive system, Volume 1: Basic foundations* (3rd ed.). New York: Wiley.

Eyberg, S. M., & Robinson, E. A. (1983). Dyadic Parent-Child Interaction Coding System: A manual. *Journal of Child Psychology*, IZ, 347-357.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behaviors. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 215-237.

Fairbank, J. A., & Keane, T. M. (1982). Flooding for combat-related stress disorders: Assessment of anxiety reduction across traumatic memories. *Behavior Therapy*, 13, 499-510.

Fairburn, C. G. (2005). Evidence-based treatment of anorexia nervosa. *International Journal of Eating Disorders*, 37 (Suppl.). S26-S-30.

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders.* New York, NY: Guilford.

Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or self-report questionnaire? *International Journal of Eating Disorders*, 16, 363.

Fairburn, C. G., & Cooper, Z. (1993). The Eating Disorders Examination (12th ed.). In C. G. Fairburn & G. T. Wilson (Eds.), *Binge eating: Nature, assessment, and treatment* (pp. 317-360). New York, NY: Guilford Press.

Fairburn, C. G., Jones, R., & Peveler, R. C. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry*, 48, 463-469.

**Falsetti, S. A. (2003). Cognitive-behavioral therapy in the treatment of posttraumatic stress disorder. *Primary Psychiatry*, 10(5), 78-82.

Faraone, S. V. (2004). Genetics of adult attention deficit hyperactivity disorder. *Psychiatric Clinics of North America*, 27, 303-321.

Farrel, J. M., Shaw, J. A., & Webber, M. A. (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: A randomized controlled trial. *Journal of Behavior Therapy Experimental Psychiatry*, 40(2), 317-328.

Feder, B. J. (2006, September 10). Battle lines in treating depression. *New York Times*, p. 21.

Feiner, A. H. (1994). Comments on contradictions in the supervisory process. *Contemporary Psychoanalysis*, 30, 57-75.

Feldman, H. A., Goldstein, I., & Hatzichristou, D. (1994). Impotence and its medical and psychosocial correlates: Results of the Massachusetts male aging study. *Journal of Urology*, 151, 54-61.

Felmingham, K., Kemp, A., Williams, L., Das, P., Hughes, G., Peduto, A., & Bryant, R. (2007). Changes in anterior cingulated and amygdala after cognitive behavior therapy of posttraumatic stress disorder. *Psychological Science*, 18(2), 127-129.

Fenson, L., Dale, P. S., Reznick, J. S., Thal, D., Bates, E., Hartung, J. P., Pethick, S., & Reilly, J. S. (1993). *The MacArthur Communicative Development Inventories: User's guide and technical* manual. San Diego, CA: Singular Publishing Group.

Fergusson, D. M., Horwood, L. J., & Lloyd, M. (1991). Confirmatory factor models of attention deficit and conduct disorder. *Journal of Child Psychology and Psychiatry*, 323, 257-274.

Fernbacher, S., & Plummer, D. (2005). Cultural influences and consideration in Gestalt therapy. In A. L. Woldt & M. Toman (Eds), *Gestalt theory: History, theory, and practice* (pp. 117-132). Thousand Oaks, CA: Sage.

**Finney, J. W., & Moos, R. H. (1998). Psychopharmacological treatments of substance use disorders. In P. Nathan & J. Gorman (Eds.), *A guide to treatments that work* (pp. 127-155). New York: Oxford University Press.

First, M. B., Gibbon, R. L. & Spitzer, R. L. et al. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders, (SCID-II).* Washington, CD: American Psychiatric Press.

First, M. B., Spitzer, R. L., Gibbon, R. L., & Williams, J. B. W. (2002). *Structured clinical interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. (*SCID-I/P) New York State Psychiatric Institute, November, 2002.

Fiscalini, J. (1997). On supervisory parataxis and dialogue. *Contemporary Psychoanalysis*, 21, 591-608.

Fisher, P. L., & Wells, A. (2008). Metacognitive therapy for obsessive-compulsive disorder: A case series. *Journal of Behavior Therapy and Experimental Psychiatry*, 39, 117-132.

Flannery-Schroeder, E. C., & Kendall, P. C. (2000). Group and individual cognitive-behavioral treatments for youth with anxiety disorders: A randomized clinical trial. *Cognitive Therapy & Research*, 24, 251-279.

Flegal, K. M., Carroll, M. D., Odgen, C. L., & Curtin, L. R. (2010). Prevalence and trends in obesity among US adults, 1999-2008. *Journal of the American Medical Association,* 303, 223-319.

Fluoxetine Bulimia Nervosa Collaborative Study Group. (1992). Fluoxetine in the treatment of bulimia nervosa. *Archives of General Psychiatry*, 49,139-147.

Foa, E.B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment.* 9:445–451.

Foa, E. B., Hearst-Ikeda, D., & Perry, K. J. (1995). Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology*, 63, 948-955.

Foa, E. B., Hembree, E. A., Cahill, s. P., Rauch, S. A. M., Riggs, D. S., Feeny, N. C., et al. (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology*, 73, 953-964.

Foa, E. B., Huppert, J. D., Leibert, S., Langner, R., Kichic, R., Hajcak, G., & Salkovskis, P. M. (2002). The Obsessive- compulsive Inventory: Development and validation of a short version. *Psychological Assessment*, 14, 485-496.

Foa, E. B., Keane, T., & Friedman, M. (2000). Guidelines for treatment of PTSD. *Journal of Traumatic Stress*, 13(4), 539-588.

Foa, E., Keane, T., Friedman, M., & Cohen, J. A. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Press.

Foa, E. B., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology*, 59(5), 715-723.

Fogarty, F., Russell, J. M., Newman, S. C., et al. (1994). Epidemiology of psychiatric disorders in Edmonton. *Mania Acta Psychiatrica Scandinavisa Supplement,* 376, 16-23.

Foley, D. J., Monjan, A. A., Brown, S. L., & Simonsick, E. M. (1995). Sleep complaints among elderly persons: An epidemiologic study of three communities. *Sleep*, 18, 425-432.

Folstein, M. F., Folstein, S., & McHugh, P. R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinicians. *Journal of Psychiatric Research*, 12, 189.

Fong, M. L. (1995). Assessment and DSM-IV diagnosis of personality disorders: A primer for counselors. *Journal of Counseling & Development*, 73(6), 635-639.

Fong, M. L., & Silien, K. A. (1999). Assessment and diagnosis of DSM-IV anxiety disorders. *Journal of Counseling and Development*, 77, 209-217.

**Ford, C. V. (1984). Somatizing disorders. In H. B. Roback (Ed.), *Helping patients and their families cope with medical problems* (pp. 39-59). San Francisco, CA: Jossey-Bass.

**Ford, C. V. (1986). The somatization disorder. *Psychosom*, 27, 327-337.

Ford, C. V. (1995). Somatoform and factitious disorders. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed.). Washington, DC: American Psychiatric Association Press.

Ford, D. & Kamerow, D. (1989). Epidemiological study of sleep disturbances and psychiatric disorders: An opportunity for prevention? *Journal of the American Medical Association*, 262, 1479-1484.

Fountoulakis, K. N., Grunze, H., Panagiotidis, P., & Kaprinis, G. (2008). Treatment of bipolar depression: An update. *Journal of Affective Disorders*, 109, 21-34.

Fountoulakis, K, N., Vieta, E, Sanchez-Moreno, J., Kaprinis, S. G., Goikolea, J. M., & Kaprinis, G. S. (2005). Treatment guidelines for bipolar disorder: A critical review. *Journal of Affective Disorder*, 86(1), 1-10.

Fountoulakis, K. N., Vieta, E., Siamouli, K., Valenti, M., Stamatia, M., Oral, T., Fresno, D., Giannakopoulos, P., & Kaprinis, G. S. (2007). Treatment of bipolar depression: A complex treatment for a multi-faceted disorder. Annals of General Psychiatry, 6, 27. doi: 10.1186/1744-859X-6-27

Frank, E., Swartz, H. A., & Kupfer, D. J. (2000). Interpersonal and social rhythm therapy: Managing the chaos of bipolar disorder. *Biological Psychiatry*, 48, 593-604.

Frank, E., Swartz, H. A., & Kupfer, D. J. (2007). Interpersonal and social rhythm therapy: An intervention addressing rhythm dysregulation in bipolar disorder. *Journal of Clinical Neroscience,* 9(3), 325-332.

Frank, J., Mistretta, P., & Will, J. (2008). Diagnosis and treatment of female sexual dysfunction. *American Family Physician*, 77(5), 635-642.

Franklin, M. E., Abramowitz, J. S., Kozak, M. J., Levitt, J. T., & Foa, Ed. B. (2000). Effectiveness of exposure and ritual prevention for obsessive-compulsive disorder: Randomized compared with nonrandomized samples. *Journal of Consulting and Clinical Psychology*, 68(4), 594-602.

Franklin, M. E., Ledley, D. A., & Foa, E. B. (2008). Response prevention. In W. T. O'Donohue and J. E. Fisher (Eds.), *Cognitive behavior therapy: Applying empirically supported techniques in your practice* (2nd ed., pp. 445-451). Hoboken, NJ: Wiley.

Franzoi, S. & Shields, S. A. (1984). The Body Esteem Scale: Multidimensional structure and sex difference in a college population. *Journal of Personality Assessment*, 48, 173-178.

French, G. D., & Harris, C. J. (1999). *Traumatic Incident Reduction (TIR)*. New York: CRC Press.

**Fresco, D. M., & Heimberg, R. G. (2001). Empirically supported psychological treatments for social phobia. *Psychiatric Annals*, 31(8), 489-495.

Frick, P. J., Lahey, B. B., Applegate, B., Kerdyck, L., Ollendick, T., Hynd, G. W., Garfinkel, B., Greenhill, L., Biederman, J., Barkley, R. A., McBurnett, K., Newcorn, J., & Waldmon, I. (1994). DSM-IV field trials for the disruptive behavior disorders: Symptom utility estimates. *Journal of the Academy of Child and Adolescent Psychiatry*, 33, 529-539.

Friedle, R. O. (2004). *Borderline personality disorder demystified: An essential guide for understanding and living with BPD*. New York: Marlowe & Company.

Fromm, E. (1977). An ego-psychological theory of altered states of consciousness. *International Journal of Experimental Hypnosis*, 15, 372-387.

Fruzzetti, A. E., Santisteban, D. A., & Hoffman, P. D. (2007). Dialectical behavior therapy with families. In L. A. Dimeff & K. Koerner, (Eds.). *Dialectical Behavior Therapy in Clinical Practice*. New York: Guilford Press.

Fyer, A. J., Mannuzza, S., Chapman, T. F., Liebowitz, M.R., & Klein, D. F. (1993). A direct interview family study of social phobia. *Archives of General Psychiatry*, 50(4), 286-203.

Gabbard, G. O. (1994). *Psychodynamic psychiatry in clinical practice: The DSM-IV* (pp 89-112). Washington, DC: American Psychiatric Press.

Gabbard, G. O. (2001). Psychoanalysis and psychoanalytic psychotherapy, In J. Livesley *in Handbook of personality disorders: Theory, research, and treatment (*Ed., pp. 359-3p76), NY: Guilford.

Garfinkel, P. E., Lin, B., Goering, P., Spegg, C., Goldbloom, D., Kennedy, S. H., Kaplan, A. S., & Woodside, D. B. (1995). Bulimia nervosa in a Canadian community sample: Prevalence, comorbidity, early experiences and psychosocial functioning. *American Journal of Psychiatry*, 152, 1052-1058.

Garland, S. N., Carlson, L. E., Stephens, A. J., Antle, M. C., Samuels, C., & Campbell, T. S. (2014). Mindfulness-based stress reduction compared to cognitive behavioral therapy for the treatment of insomnia. *Journal of Clinical Psychology*, 32(5), 449-459.

Garner, D. M., & Garfinkel, P. E. (1979). Eating Attitudes Test (EAT-40). *Psychological Medicine,* 9, 273-279.

Garner, D. M., Olmstead, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The Eating Attitudes Test: Psychometric features and clinical correlates. *Psychological Medicine,* 12, 871-878.

Garner, D. M., Olmstead, M. P., & Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia and bulimia. *International Journal of Eating Disorders,* 2(2), 15-34.

Gatewood, J. W., Organ, C. H., & Mead, B. T. (75). Mental changes associated with hyperparathyroidism. *American Journal of Psychiatry*, 132, 129-132.

Gaudiano, B. A., Nowlan, K., Brown, L. A., Epstein-Lubow, G., & Miller, L. W. (2012). An open trial of a new acceptance-based behavioral treatment for major depression with psychotic features. *Journal of Counseling & Development,* 37(3), 324-355.

Ghaemi, S. N., Boiman, E. E., & .Goodwin, F. K. (2000). Diagnosing bipolar disorder and antidepressants: A naturalistic study. *Journal of Clinical Psychiatry*, 61, 804-804.

Ghaziuddin, M., Weidmer-Mikhall, N., & Ghaziuddin, N. (1983). Comorbidity disorders associated with Asperger syndrome/high functioning autism: A community and clinic-based study. *Journal of Disability Research*, 42(4), 279-283.

Gilliam, C. M., & Cottone, R. R. (2005). Couple or individual therapy for the treatment of depression?: An update of the empirical literature. *The American Journal of Family Therapy*, 33, 265-272.

Gintner, G. G. (1995). Differential diagnosis in older adults: Dementia, depression, and delirium. *Journal of Counseling and Development*, 73, 346-351.

Gioia, G. A., Isquith, P. K., Guy, S. C., & Kenworthy, L. (2000). Behavior rating inventory of executive function. *Child Neuropsychology,* 6(3), 235-238.

Gitlin, M. J., Swendsen, J., Heller, T. L., & Hammen, C. (1995). Relapse and impairment in bipolar disorder. *American Journal of Psychiatry*, 152, 1635-1640.

Glickauf-Hughes, C., & Wells, M. (1995). T*reatment of the masochistic personality. An interactional object-relations approach to psychotherapy*. Northvale, NJ: Jason Aronson Inc.

Glueck, V. C., & Stroebel, C. F. (1975). Biofeedback and meditation in the treatment of psychiatric illness. *Comprehensive Psychiatry*, 16, 303-321.

Gluhoski, V. L. (1995). A cognitive approach for treating trichotillomania. *Journal of Psychotherapy Practice and Research,* 4, 277-285.

Goff, V., & Young, S. M. (1996). Improve depression management: By using employment-based benefits and services. *Exchange*, 26 (5), 14-15, 39.

Goldberg, R. F. (1987). Anxiety in the medically ill. In A. Stoudemire & B. S. Fogel (Eds.), *Principles of medical psychiatry* (pp. 177-204). New York: Grune and Stratton.

Goldman, R. N., Greenberg, L., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research*, 16, 536-546.

Goldstein, G., van Kammen, W., Shelly, C., Miller, D. J., & van Kammen, D. P. Y. (1987). Survivors of imprisonment in the Pacific Theater during World War II. *American Journal of Psychiatry*, 144, 1210-1213.

Goldstein, S. (1996). *Managing attention and learning disorders in late adolescence and adulthood*. New York: Wiley.

Gooding, V., & Kruth, M. (1991). Compliance with treatment in asthma and Munchausen syndrome by proxy. *Archives of Disease in Childhood*, 66, 956-960.

Goodman, A. (1993). Diagnosis and treatment of sexual addiction. *Journal of Sex & Marital Therapy*, 19(3), 225-251.

Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of American Academy of Child & Adolescent Psychiatry,* 40(11), 166-172.

Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Delgado, P., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale. I: Development, use and reliability. *Archives of General Psychiatry*, 46, 1006-1011.

**Goodwin, F. K., & Jamison, K. R. (1990). *Manic Depressive illness*. New York: Oxford University Press.

Goodwin, G., & Viea, E. (2005). Effective maintenance treatment-breaking the cycle of bipolar disorder. *European Psychiatry*, 20, 365-371.

Gordon, M. (1983). *The Gordon diagnostic system*. Boulder, CO: Gordon Systems.

Gordon, R. M. (2006). False assumptions about psychopathology, hysteria and the MMPI-2 Restructured Clinical Scales. *Psychological Reports*, 98(3), 870-872.

Gottdiener, W. D. (2006). Individual psychodynamic psychotherapy of schizophrenia: Empirical evidence for the practicing clinician. *Psychoanalytic Psychology*, 23, 583-589.

Gowers, S. G. (2005). Evidence based research in CBT with adolescent eating disorders. *Child and Adolescent Mental Health*, 11(1), 9-12.

Grace, J. B., Walker, M. P., & McKeith, I. G. (2000). A comparison of sleep profiles in patients with dementia with Lewy bodies and Alzheimer's disease. *International Journal of Geriatric Psychiatry*, 15, 1028-1033.

Graham, J. R. (2006). MMPI-2: *Assessing personality and psychopathology* (4th ed.). NY: Oxford University Press.

Granholm, E., Holden, J., Link, P. C., McQuaid, J. R., & Jeste, D. V. (2013). Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: Defeatist performance attitudes and functional outcome. *American Journal of Geriatric Psychiatry,* 21, 251-262.

Green, R. (1985). Gender identity in childhood and later sexual orientation: Follow-up of 78 males. *American Journal of Psychiatry*, 142, 399.

Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings.* Washington, DC: American Psychological Association.

Greenberg, L. (2004). Emotion-focused therapy. *Clinical Psychology and Psychotherapy*, 11, 3-16.

Greenberg, L. (2010). Emotion-focused therapy: A clinical synthesis. *Focus,* 8, 32-42.

Greenberg, L., & Goldman, R. N. (2008). The dynamics of emotion, love and power in an emotion-focused approach to couple therapy. *Person-Centered and Experiential Psychotherapies*, 7(4), 280-293.

Greenhill, L. L. (1998). Diagnosing attention-deficit / hyperactivity disorder in children. *Journal of Clinical Psychiatry*, 59(7), 31-41.

Greenspan, S. (1999). What is meant by mental retardation? *International Review of Psychiatry*, 11(1), 6-18.

Gregory, R. J. (2000). *Psychological Testing* (3rd ed.). Needham Heights, MA: Allyn & Bacon

Greiner, K. A., & Weigel, J. W. (1996). Erectile dysfunction. *American Family Physician*, 54(5), 1675-1682.

Greist, J. H., & Jefferson, J. W. (2007). Obsessive-Compulsive Disorder. *Focus*, 5(3), 283-298.

Griest, J. H., Marks, I. M., Baer, L., Kobak, K. A., Wenzel, K. W., Hirsch, M. J., et al. (2002). Behavior therapy for obsessive-compulsive disorder: Guided by a computer or by a clinician compared with relaxation as a control. *Journal of Clinical Psychiatry*, 63, 138-145.

Grilo, C. M., Masheb, R. M., Wilson, G. T., Gueorguieva, R., & White, M. A. (2011). Cognitive-behavioral therapy, behavioral weight loss, and sequential treatment for obese patients with binge-eating disorder: A randomized controlled trail. *Journal of Consulting and Clinical Psychology*, 79(5), 675-685.

Grilo, C. M., & White, M. A. (2011). A controlled evaluation of the distress criterion for binge eating disorder. Journal of *Consulting and Clinical Psychology*, 79(4), 09-514.

Grubaugh, A. L., Elhai, J. D., Cusach, K. J., Wells, C., & Freuh, B. C. (2007). Screening for PTSD in public-sector mental health settings: The diagnostic utility of the PTSD Checklist. *Depression and Anxiety*, 24, 124-129.

Gryczkowski, M. R., Tiede, M. S., Dammann, J. E., Jacobsen, A. B., Hale, L. R., & Whiteside, S. P. H. (2013). The timing of exposure in clinic-based treatment for childhood anxiety disorders. *Behavior Modification,* 37(1), 113-127.

Guarda, A. S. (2008). Treatment of anorexia nervosa: Insights and obstacles. *Physiological Behavior,* 94(1), 113-120.

Gucciardi, A. (2011, October). Antibiotics could be to blame for skyrocketing mental illness rate. *Natural Society Newsletter*. Retrieved 11-12-14, http://naturalsocieyt.com/antibiotics-could-be-to-blame-for-mental-illness-rates/

Guevremont, D. C., DuPaul, G. J., & Barkley, R. A. (1990). Diagnosis and assessment of attention deficit-hyperactivity disorder in children. *Journal of School Psychology*, 28, 51-78.

Gunderson, J. G., & Gabbard, G. O. (2000). *Psychotherapy for Personality Disorders*. Washington, D.C: American Psychiatric Press.

Gunderson, J. G., & Links, P. (1995). Borderline personality disorders. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed., pp. 2291-2309). Washington, DC: American Psychiatric Association Press.

Gunderson, J. G., Ronningstam, E., & Bodkin, A. (1990). The diagnostic interview for narcissistic patients. *Arch General Psychiatry*, 47, 676-680.

Gunderson, J. G., & Zarini, M. C. (1987). Current overview of the borderline diagnosis. *Journal of Clinical Psychiatry*, 48(8), 5-11.

Guze, S. M., & Perley, M. J. (1963). Observations on the natural history of hysteria. *American Journal of Psychiatry,* 119, 960-965.

Gyulai, L., Bauer, M. L., Bauer, M. S., Espana-Garcia, & Whybrow, C. (2003). Lithium challenge to the thyroid axis in rapid cycling affective disorder and healthy controls. *Biological Psychiatry*, 53, 899-905.

Hakstian, A. R., & McLean, P. D. (1989). Brief Screen for Depression. *Journal of Consulting and Clinical Psychology*, 1(2), 139-141.

Halmi, K. A., & Garfinkel, P. E., (1995) Eating disorders: General principles of outpatient treatment. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed., pp. 2085-2102). Washington, DC: American Psychiatric Association Press.

Hamilton, M. A. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry*, 23, 56-62. [PubMed]

Hamilton, M. A., & Kobak, K. A. (1995). Reliability and validity of the Hamilton Depression Inventory: A paper-and-pencil version of the Hamilton Depression Rating Scale Clinical Interview. *Psychological Assessment,* 7(4), 472-483.

Hankin, C. S., Spiro, A., Miller, D. R., & Kazis, L. (1999). Mental disorders and mental health treatment among U. S. Department of Veterans Affairs Outpatients: The veterans' health study. *Journal of Psychiatry*, 156, 1924-1930.

Hare, R. D. (2003). *The Hare psychopathy checklist—revised* (2nd ed.). Toronto, Ontario,: Multi-health Systems.

Hare, R. D., Hart, S. D., & Harpur, T. J. (1991). Psychopathy and the DSM-IV criteria for Antisocial Personality Disorder. *Journal of Abnormal Psychology*, 100, 391-398.

Harpin, R. E., Lieberman, R. P., Marks, I.,… et al. (1982). Cognitive-behavior therapy for chronically depressed patients: A controlled pilot study. *Journal of Nervous Mental Disorders*, 170, 295-301.

Harrington, E. E. (1993). *Depressive disorder in childhood and adolescence*. New York: Wiley.

Harrington, R., Whittaker, J., Shoebridge, P., & Campbell, F. (1998). Systematic review of efficacy of CBT in childhood and adolescent depressive disorders. *British Medical Journal*, 316, 1559-1563.

**Harris, C. V., & Wiebe, D. J. (1992). An analysis of response prevention flooding procedures in the treatment of adolescent obsessive compulsive disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 23(2), 107-115.

**Harris, M., Glozier, N., Ratnavaclei, R., & Grunstein, R. A. (2000). Obstructive sleep apnea and depression. *Medical Sleep Review,* 13(6), 437-444.

Harrison, J. P., & Franklin, M. E. (2012). Pediatric trichotillomania. *Current Psychiatric Reports,* 14(3), 188-196. doi 10.1007/s11920-012-0269-8

Harry Benjamin International Gender Dysphoria Association. (1985). Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons. *Archives of Sexual Behavior*, 14(1), 1985.

Harvey, A. G., Belanger, L., Talbot, L. Eidelman, P. …Morin, C. M. (2014). Comparative efficacy of behavior therapy, cognitive therapy, and cognitive-behavioral therapy for chronic insomnia: A randomized control trial. *Journal of Counseling and Clinical* Psychology, 82(4), 670-683.

Hathaway, S. R., & McKinley, J. C. (1967*). Minnesota Multiphasic Personality Inventory manual*. New York: Psychological Corporation

Hatzichristou, D., Rosen, R. C., Broderick, G. et al. (2004). Clinical evaluation and management strategy for sexual dysfunction in men and women. *Journal of Sexual Medicine*, 1(1), 49-57.

Hauri, P. J. (2000). The many faces of insomnia. In D. I. Mostofsky & D. H. Barlow (Eds.), *The management of stress and anxiety in medical disorders* (pp 143-194). Hillsdale, NJ: Erlbaum.

Hawkins, P., & Shohet, R. (2000). *Supervision in the helping professions: An individual, group and organizational approach* (2nd ed.). Philadelphia: Open University Press.

Hawton, K. (1995). Treatment of sexual dysfunctions by sex therapy and other approaches. *British Journal of Psychiatry*, 167, 307-314.

Hayes, S. C., Strosahl, K. D., & Williams, K. G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change.* New York, NY: Guilford Press.

Haynes, R., Corey G., & Moulton P. (2003). *Clinical supervision in the helping profession: A practical guide*. Pacific Grove CA: Thomson.

Head, L. S., & Gross, A. M. (2008). Systematic desensitization. In W.T. O'Donohue and J. E. Fisher (Eds.), *Cognitive behavioral therapy: Applying empirically supported techniques in your practice* (2nd ed., pp. 542-549). Hoboken, NJ: Wiley.

Head, S. B., Baker, J. D., & Williamson, D.A. (1991). Family environment characteristics and dependent personality disorder. *Journal of Personality Disorders*, 5, 256-263.

**Health Hub (2013, June). Diseases and conditions: Factitious disorders. *HealthHub,* Cleveland Clinic. Retrieved 11-14-2014, http://my.clevenlandclinic.org/health/dieases_conditions/hic_An_Overview_of Factitious Disorders

Heilman, K. M., Bowers, D., & Valenstein, E. (1985). Emotional disorders associated with neurological diseases. In K. M. Heilman and E. Valenstein (Eds.), *Clinical neuropsychology* (pp. 377-402). New York, NY: Oxford University Press.

Heimberg, R. G., & Becker, R. E. (2002). *Cognitive behavioral group therapy for social phobia: Basic mechanisms and clinical strategies*. New York, NY: Guilford Press.

Heimberg, R. G., Holt, C. S., Schneier, F. R., Spitzer, R. L., & Liebowitz, M. R. (1993). The issue of subtypes in diagnosis of social phobia. *Journal of Social Phobia*, 7, 249-269.

Heinrich, H., Gevensleben, H., & Strehl, U. (2007). Annotation: Neurofeedback-train your brain to behaviour. *Journal of Child Psychology Psychiatry*, 48(1), 3-16.

Hensley, P.L., & Clayton, P. J., (2008). Geriatric psychiatry (July 1). *Psychiatric Times*. 25(8), 45-50.

Herbert, J. D. (2007). Avoidant personality disorder. In W. O'Donohue, K. Fowler, & S. O. Lilienfeld, *Personality Disorders: Toward the DSM-5* (pp. 279-305), Thousand Oaks, CA: Sage Publications.

Herbert, J. D., & Forman, E. M. (2011). *Acceptance and mindfulness in cognitive behavior therapy* (Eds.). Hoboken, NJ: Wiley.

Herbert, J. D., & Forman, E. M. (2012). Mindfulness and acceptance techniques. In J. A. Dozois (Ed.), *Cognitive behavioral therapy: A complete reference guide.* Hoboken, NJ: Wiley.

Herbert, J. D. & Forman, E. M. (2013). Caution: The differences between CT and ACT may be larger (and smaller) than they appear. *Behavior Therapy,* 44(2), 218-223.

Herbert, J. D., Gaudiano, B. A., Rheingold, A. A., Moirtra, E., Myers, V. H., Dalyrymple, K. L., & Brnadsma, L. L. (2009). Cognitive behavior therapy for generalized social anxiety disorder in adolescents: A randomized controlled trial. *Journal of Anxiety Disorders,* 23, 167-177.

Herman, J. L. (1980). Sex offenders: A feminist perspective. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp. 177-193). New York: Plenum.

Hersen, M., Bellack, A. S., Himmelhoch, J. M., & Thase, M. E. (1984). Effects of social skills training, amitriptyline, and psychotherapy in unipolar depressed women. *Behavior Modification,* 15, 21-40.

Hill, C. L. & Spengler, P. M. (1997). Dementia and depression: A process model for differential diagnosis. *Journal of Mental Health Counseling*, 19(1), 23-50.

Hill, N. R., & Beamish, P. M. (2007). Treatment outcomes for obsessive-compulsive disorder: A critical review. *Journal of Counseling and Development*, 85, 504-510.

Hilsenroth, M. J., Holdwick, D. J. H., Castlebury, E.D., & Blais, M. A. (1998). The effects of DSM-IV cluster B personality disorder symptoms on the termination and continuation of psychotherapy. *Psychotherapy*, 35, 163-176.

Himle, M. B., Caprioretti, M. R., Hayes, L. P., Ramanujam, K., Scahill, L., Sukhodolsky, D. G., Wilhelm, S., Dickersbach, T., Peterson, A. L., Specht, M. W., Walkup, J. T., Chang, S., & Piacentini, J. (2014). Variables associated with tic exacerbation in children with chronic tic disorders. *Behavior Modification,* 38(2), 163-183.

Hinrichsen, G. A. (1990). *Mental health problems and older adults*. Santa Barbara, CA: ABC-CLIO.

Hinshaw, S. P., Lahey, B. B., & Hart, E. L. (1993). Issues of taxonomy and comorbidity in the development of conduct disorder. *Development and Psychopathology*, 5, 31-49.

Hirschfeld, R. M.A. (2002). The Mood Disorder Questionnaire: A simple, patient-rated screening instrument for bipolar disorder. *Primary Care Companion Journal of Clinical Psychiatry*, 4, 9-11.

Hirschfeld, R. M. A., Allen, M. H., McEvoy, J. P. Jr., Keck, P. E. Jr., & Russell, J. M. (1999). Safety and tolerability or oral loading divalrocx sodium in acutely manic bipolar patients. *Journal of Clinical Psychiatry*, 60, 815-818.

Hirschfeld, R. M. A., Holzer, C., Calabrese, J., Weissman, M., Reed, M. & et al. (2003). Validity of the Mood Disorder Questionnaire: A general population Study. *Journal of Clinical Psychiatry*, 160, 178-180.

Hirschfeld, R. M. A., & Vornik, L. A. (2005). Bipolar disorder-costs and comorbidity. *American Journal of Managed Care*, 11(3), S85-S90.

Hirschfeld, R. M. A., Williams, J. B.W., Spitzer, R. L., Caalabrese, J. R., Flynn, L., Keck, P.E., et al. (2000). Development and validation of a screening instrument for bipolar spectrum disorder. The Mood Disorder Questionnaire. American *Journal of Psychiatry*, 157(11), 1873-1875.

Hirschfeld, R. M. A., Young, A. H., & McElroy, S. (2003). Recognizing morbidities associated with bipolar disorder. *Primary Psychiatry*, 5(Suppl), 1-12.

Ho, B. C., Andreasen, N. C., & Flaum, M. (1997). Dependence on public financial support early in the course of schizophrenia. *Psychiatric Services*, 48, 948-950.

Hodges, K. (1994). Structured interviews for assessing children. *Journal of Child Psychiatry,* 34(1), 49-68.

Hodges, K., Kline, J., Fitch, P., McKnew, D., & Cytryn, L. (1981). The Child Assessment Schedule: A diagnostic interview for research and clinical use. *Catalog of Selected Documents in Psychology*, 11, 56.

Hodgson, R. J., & Rachman, S. (1977).Obsessional-compulsive complaints. *Behavior Research and Therapy*, 15, 389-395.

Hofmann, S. G. (2007). Cognitive factors that maintain social anxiety disorder: A comprehensive model and its treatment implications. *Cognitive Behavioral Therapy,* 36(4), 193-209.

Hofmann, S. G., & Barlow, D. H. (2002). Social phobia (social anxiety disorder). In D. H. Barlow (Ed.), *Anxiety and its disorders* (pp. 454-476). New York, NY: Guilford Press.

Hofmann, S. G., Heinrich, N., & Muscovitch, D. A. (2004). Changes in self-perception during treatment of social phobia. *Journal of Consulting and Clinical Psychology*, 72, 588-596.

Hofmann, S. G., Muscovitch, D. A., Kim, H. J., & Taylor, A. N. (2004). Changes in self-perception during treatment of social phobia. *Journal of Consulting and Clinical Psychology,* 72, 588-596.

**Hofmann, S. G., & Thompson, M. C. (2002). *Treating chronic and severe mental illness: A handbook of empirically supported interventions.* New York: Guilford Press.

Hogan, T. P. (2005). Widely used psychological tests. In G. P. Koocher, J. C. Norcross, & S. S. Hills (Eds.), *Psychologists' desk reference* (2nd ed., pp. 101-104). New York, NY: Oxford University Press.

Hogan, T. P., & Rengert, C. (2008). Test usage in published research and the practice of counseling: A comparative review. *Measurement and Evaluation in Counseling and Development,* 41, 51-56.

Hollander, E., & Dell'Osso, B. (2006). Approaching treatment-resistant obsessive-compulsive disorder with brain stimulation interventions: The state of the art. *Psychiatric Annals*, 36(7), 480-488.

Hollon, S. D. (1999). The prevention of depression and anxiety. *Prevention & Treatment*, 2, 274-291.

**Hollon, S. D., & Beck, A. T. (1994). Cognitive and cognitive behavioral therapies. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 428-466). New York: John Wiley & Sons.

**Hollon, S. D., Thase, M. E. & Markowitz, J. C. (2002). Treatment of prevention of depression. *Psychological Science in the Public Interest*, 3: 39-77

Holloway, E. L. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage Publications.

Holroyd, S., Currie, L., & Wooten, G. F. (2001). Prospective study of hallucinations and delusions in Parkinson's disease. *Journal of Neurology, Neurosurgery and Psychiatry*, 70, 734–738.

Hope, D. A., Herbert, J. D., & White, C. (1995). Diagnostic subtype, avoidant personality disorder, and efficacy of cognitive-behavioral group therapy for social phobia. *Cognitive Therapy and Research*, 19(4), 399-417.

Hopko, D. R., Reas, D. L., Beck, J., Stanley, M. A., Wetherell, J. L., Novy, D. M., & Averill, P. M. (2003). Assessing worry in older adults: Confirmatory factor analysis of the Penn State Worry Questionnaire and psychometric properties of an abbreviated model. *Psychological Assessment,* 15(2), 173-183.

Horne, A. M., & Sayger, T. V. (1990). *Parent Rating Form*. Unpublished document, Athens, GA: The University of Georgia.

Horowitz, L. M., Alden, L. E, Wiggins, J. S., & Pincus, A. L. (2000). *Inventory of interpersonal problems: Manual*. San Antonia, TX: The Psychological Corporation.

Horowitz, M. J. (1991). *Hysterical personality style and the histrionic personality disorder*. Northvale, NJ: Jason Aronson.

Horowitz, M. J. (1997). Psychotherapy for histrionic personality disorder. *Journal of Psychotherapy Practice and Research*, 6, 93-107.

Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine*, 41(3), 209-218.

Hudson, J. I., Hiripi, E., Pope, H. G., Jr., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, 61, 348-358. doi . 10.1016/j. biopsych. 2006.3.040

Hudson, J. I., Mangweth, B., Pope, Jr., DeCol, C., Housmannn, A., Gutweinger, S., Larid, N. M., Bibel, W., & Tsuang, M. T. (2003). Family study of affective spectrum disorder. *Archive of General Psychiatry*, 60, 170-177.

Hudson, W. W., (1998). Index of sexual satisfaction. In C. M. Davis, W. L. Yarber, R. Bauserman, G. Shreer, & S. L. Davis (Eds), Handbook *of sexuality-related measures* (pp 512-513). Thousand Oaks, CA: Sage.

Hudson, W. W., Harrison, D. F., & Crosscup, P. C. (1981). A short-form scale to measure sexual discord in dyadic relationship. *Journal of Sex Research*, 17, 157-174.

Hudziak, J., Heath, A., Madden, P., Reich, W., Bucholz, K. K., Slutske, W., et al. (1998). Latent class and factor analysis of DSM-IV ADHD: A twin study of female adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 848-857.

Hummelen, B., Wilberg, T., Pedersen, G., & Karterud, S., (2007). The relationship between avoidant personality disorder and social phobia. *Comprehensive Psychiatry,* 48(4), 348-356.

Hurst, K., Read, S., & Wallis, A. (2012). Anorexia nervosa in adolescents and Maudsley-family based treatment. *Journal of Counseling & Development,* 90, 339-345.

Hutt, M. L. (1977). *The Hutt Adaptation of the Bender Gestalt Test*. New York: Grune & Stratton.

Hyler, S. E. (1994). *Personality Diagnostic Questionnaire-4(PDQ-4).* NY: New York State Psychiatric Institute.

Hyler, S. E., & Rieder, R. O. (1994). *Personality Diagnostic Questionnaire-4.* New York: Authors.

Insel, T. R., Donnelly, E., Lalakea, M., Alterman, I. S., & Murphy, D. L. (1983). Neurological and neuropsychological studies of patients with obsessive-compulsive disorder. *Biology Psychiatry*, 18, 741-751.

Ippen, C. G., Ford, J., Racusin, R., Acker, R., Bosquet, M., Rogers, K., Ellis, C., Schiffman, J., Ribbe, D., Cone, P., Lukovitz, M., & Edwards, J. (2002). *Traumatic Events Screen Inventory-Parent Report Revised (PPR).* National Center for PTSD: VA Medical Center and Regional Office.

Irwin, M. R., Cole, J. C., & Nicassio, P. M. (2008). Comparative meta-analysis of behavioral interventions for insomnia and their efficacy in middle-aged adults and in the older adults 55+ years of age. *Health Psychology,* 25(1), 3-14.

Jackson, B., & Farrugia, D. (1997). Diagnosis and treatment of adults with attention deficit hyperactivity disorder. *Journal of Counseling & Development*, 75, 312-319.

Jackson, S. E., & Lue, T. F. (1998). Erectile dysfunction: Therapy health outcomes. *Urology*, 51(6), 874-882.

Jacobson, E. (1938). *Progressive relaxation*. Chicago: University of Chicago Press.

Jaffe, S. (1998). Evaluation of adolescents for substance abuse. *Primary Psychiatry*, 5(7), 71-75.

Janowsky, D. S., Yousef, M. K., & Davis, J. M. (1974). Interpersonal maneuvers of manic patients. *American Journal of Psychiatry*, 131(3), 250-255.

Jocelyn, L. J., Casiro, O. G., Beattie, D., Bow, J., & Kneisz, J. (1998). Treatment of children with autism: A randomized controlled trial to evaluate a caregiver-based intervention program in community day-care centers. *Journal of Developmental and Behavioral Pediatrics*, 19(5), 326-334.

Johns, M. W. (1991). A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep*, 14(6), 540-545.

Johnson, L. A., & Safranek, S. (2005). What is the most effective treatment of ADHD in children? *The Journal of Family Practice*, 54(2), 166-168.

**Johnson, W. G., Tsoh, J. Y., & Varnado, P. J. (1996). Eating disorders: Efficacy of pharmacological and psychological interventions. *Clinical Psychology Review*, 16, 457-478.

Jones, K. D. (2012). Dimensional and cross-cutting assessment in the DSM-5. *Journal of Counseling & Development,* 90(4), 481-487.

**Jorge, R. E. (2005). Neuropsychiatric consequences of traumatic brain injury: A review of recent findings. *Current Opinion in Psychiatry*, 18 (3), 289-99.

Juarascio, A. S., Forman, E. M., & Herbert, J. A. (2010). Acceptance and commitment therapy versus cognitive therapy for the treatment of comorbid eating pathology. *Behavior Modification*, 34(2), 175-190.

Juarascio , A. S., Shaw, J., Forman, E., Timko, C. A., Herbert, J., Butryn1, M., Bunnell, D., Matteucci, A., & Lowe, M. (2013). Acceptance and commitment therapy as a novel treatment for eating disorders: An initial test of efficacy and mediation. *Behavior Modification,* 37(4), 459-489.

Juhnke, G. A., Vace, N. A., Curtis, R. C., Coll, K. M., & Paredes, D. M. (2003). Assessment instruments used by additions counselors. *Journal of Addictions & Offender Counseling*, 23, 66-72.

Jung, C. J. (1954). Therapeutic value of abreaction. In C. J. Jung, Collected papers, Part II, Vol.16, *The practice of psychotherapy*. New York: Pantheon Books.

Juster, H. R., & Heimberg, R. G. (1995). Social phobia: Longitudinal course and long-term outcome of cognitive-behavioral treatment. *Psychiatric Clinics of North America,* 18(4), 821-842.

Juster, H. R., & Heimberg, R. G., & Engelberg, B. (1995). Self-selection and sample selection in a treatment study of social phobia. *Behaviour Research and Therapy,* 33, 321-324.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using he wisdom of your body and mind to face stress, pain, and illness*. New York, NY: Dell.

Kafka, M. P., & Prentky, R. A. (1994). Preliminary observations of DSM-III-R Axis I comorbidity in men with paraphilias and paraphilia-related disorders. *Journal of Psychiatry*, 55(11), 481-487.

Kanter, J. W., Kohlenberg, R J., & Loftus, E. F. (2002). Demand characteristics, treatment rationales, and cognitive therapy for depression. *Prevention & Treatment*, 5(Article 41), 1-16.

Kaplan, H. I., & Sadock, B. J. (1998). *Synopsis of psychiatry: Behavioral sciences/ clinical psychiatry* (8th ed.). Baltimore: Williams & Wilkins.

Karacostas, D. D., & Fisher, G. L. (1993). Chemical dependency in students with and without learning disabilities. *Journal of Learning Disabilities*, 26, 491-495.

Karasu, T. B. (1989). Supportive psychotherapy. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry* (pp. 1459-1461). Baltimore: Williams & Wilkins.

Karno, M., & Golding, J. M. (1991). Obsessive-compulsive disorder. In L. N. Robins & D. A. Regier (Eds.), *Psychiatric disorders in America: The epidemiologic catchment area study* (pp. 204-219). New York: Free Press

Karno, M., Golding, J. M., Sorenson, S. B., & Burnam, M. A. (1989). The epidemiology of obsessive-compulsive disorder in five U. S. Communities. *Archives of General Psychiatry*, 45, 1094-1099.

Kasper, S. (2004). Quetiapine is effective against anxiety and depressive symptoms in long-term treatment of patients with schizophrenia. *Depression and Anxiety*, 20, 44-47.

**Kates, N., & Craven, M. (1998). *Managing mental health problems: A practical guide to primary care*. Seattle: Hogrefe and Huber Publishers.

Kaufman, A. S. (1990). *Assessing adolescent and adult intelligence*. Boston: Allyn & Bacon.

Kay, S. R., Fiszbein, A., & Opler¸ L. A. (1987). The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, 13, 261-276.

Kaye, W. H., Bulik, C. M., Thornton, L., Barbarich, N., & Masters, K. (2004). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *American Journal of Psychiatry*, 161, 2215-2221.

Kazdin, A. E. (1993). Psychotherapy for children and adolescents: Current progress and future research directions. *American Psychologist*, 48, 644-657.

Kazdin, A. E. (1995). *Conduct disorder in childhood and adolescence (2nd ed.)*. Thousand Oaks, CA: Sage.

Kazdin, A. E. (1996). Problem solving and parent management in treating aggressive and antisocial behavior. In E. D. Hibbs & P. S. Jensen (Eds.), *Child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 377-408). Washington, DC: American Psychological Association.

Kazdin, A. E. (1998). Psychosocial treatments for conduct disorder in children. In P. Nathan & J. Gorman (Ed.), *A guide to treatments that work* (pp. 65-89). New York: Oxford University Press.

Keable, D. (1989). *The management of anxiety: A guide for therapists* (2nd ed.). New York: Churchill Livingstone.

Keane, T. M. (1998). Psychological and behavioral treatments of posttraumatic stress disorder. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 398-407). New York: Oxford University Press.

Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology*, 56, 85-90.

Keane, T., Fairbank, J., Caddell, J., Zimering, R., Taylor, K., & Mora, C. (1989). Clinical evaluation of a measure to assess combat exposure. *Psychological Assessment,* 1, 53-55.

Keane, T. M., Malloy, P. F., & Fairbank, J. A. (1984). Empirical development of an MMPI subscale for the assessing of combat-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 52, 888-891.

Keck, P. E. Jr., (2006). Long-term management strategies to achieve optimal function in patients with bipolar disorder. *Journal of Clinical Psychiatry*, 67(suppl), 19-24.

Keel, P. K., & Haedt, A. (2008). Evidence-based psychosocial treatments for eating problems and eating disorders. *Journal of Clinical Child and Adolescent Psychology*, 37(1), 39-61.

Keith, S. J. (1997). Pharmacologic advances in the treatment of schizophrenia. *The New England Journal of Medicine*, 337(12), 851-852.

**Keller, A. S. (1980). Group therapy with gender identity patients. *International Group Psychotherapy*, 30, 481-489.

Keller, M. B. (1994, February, 7-11). Depression in the United States: Unrecognized and under treated. In: R. J. Cadieux, Ed., *Depression in the United States. Postgraduate Medicine: A Special Report*. McGraw-Hill Healthcare Publications.

Keller, M. B., McCullough, J. P., Klein, D. N., et al. (2000a). Drug-psychotherapy combo found highly effective in depression study. *Science Daily*. May 24.

Keller, M. B., McCullough, J. P., Klein, D. N., et al. (2000b). A comparison of nefazodone, the cognitive behavioral analysis system of psychotherapy and their combination for the treatment of chronic depression. *Journal of New England Medicine*, 342, 1462-1470.

Kellet, S. (2007). A time series evaluation of the treatment of histrionic personality disorder with cognitive analytic therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, 389-405.

Kemp, S. L., Korkman, M., & Kirk, U. (2000). *Essentials of NEPSY assessment*. Boston: Wiley Publishing.

Kendall, P. C. (2000). *Cognitive-behavioral therapy for anxious children: Therapist manual* (2nd ed.). Ardmore, PA: Workbook Publishing.

Kenney, C., Kuo, S. H., & Jimenez-Shahed, J. (2008). Tourette's syndrome. *American Family Physician*, 77(5), 651-658.

Keschner, M., Bender, M. B., & Strauss, I. (1938). Mental symptoms associated with brain tumors: A study of 530 verified cases. *JAMA*, 110, 714.

Kessler, L. G., Cleary P. D., & Burke, J. D., Jr. (1985). Psychiatric disorders in primary care. *Archives of General Psychiatry*, 42, 583-590.

Kessler, R. C., Berglund, P., Demier, O., Jin, R., Koretz, D., Merikangas, K. R., Rush, A. J., Walters, E. E., & Wang, P. S. (2003). Results from the National Comorbidity Survey Replication (NCS-R), *JAMA*, 289, 3095-3105.

Kessler, R. C., Berglund, P., Demier, O., Jin, R., Merikangas, K. R., Koretz, D., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Arch General Psychiatry*, 62(6), 593-602. doi:10.1001/archpsyc.62.6.593

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives General Psychiatry*, 51, 8-19.

Kessler, R. C., Somnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National comorbidity survey. *Archives of General Psychiatry*, 52, 1048-1060.

Ketter, T. A., Post, R. M., & Theodore, W. H. (1999). Positive and negative effects of antiepileptic drugs in patients with seizure disorders. *Neurology*, 53 (suppl. 2), S53–S67.

King, J. H. (2013a.). The DSM-5 does not make diagnosis. *Counseling Today*, 56(1), 18-21,

King, J. H. (2013b). Understanding and using the DSM-5. *Counseling Today*, 56(2), 18-20.

King, J. H. (2013c). Assessment and diagnosis of autism spectrum disorder. *Counseling Today*, 56(3), 18-20.

King, J. H. (2013d). Assessment and diagnosis of PTSD and skin-picking disorder. *Counseling Today,* 56(4), 20-22.

King, J. H. (2013e). Assessment and diagnosis of disruptive mood dysregulation disorder. *Counseling Today,* 56(5), 18-20).

King, J. H. (2013f). Assessment and diagnosis of neurocognitive disorders. *Counseling Today*, 56(6), 20-22.

King, J. H. (2014a). Assessment and diagnosis of schizophrenia spectrum disorders. *Counseling Today*, 56(7), 12-14.

King, J. H. (2014b). Assessment and diagnosis of sexual and gender-related disorders. *Counseling Today*, 56(8), 12-15.

King, J. H. (2014c). Assessment and diagnosis of sleep-wake disorders. *Counseling Today*, 56(9), 12-15.

King, J. H. (2014d). Assessment and diagnosis of psychotic and bipolar-related disorders. *Counseling Today,* 56(11), 12-15.

King, J. H. (2014e). Assessment and diagnosis of anxiety, somatic symptom and related disorders. *Counseling Today*, 56(12), 12-15.

King, J. H. (2014f). Assessment and diagnosis of dissociative and trauma-and stressor-related disorders. *Counseling Today,* 57(1), 12-15.

King, J. H. (2014g). Assessment and diagnosis of depressive and bereavement. *Counseling Today*, 57(2), 12-15.

King, J. H. (2014h). Assessment and diagnosis of disruptive, impulse-control and conduct disorder. *Counseling Today*, 57(3), 12-17.

King, J. H. (2014i). Assessment and diagnosis of obsessive-compulsive and related disorders. *Counseling Today,* 57(4) 12-15.

King, J. H. (2014j). Assessment and diagnosis of substance-related and behavioral addictive disorders. *Counseling Today,* 57(5), 12-14.

King, J. H. (2014k). Assessment and diagnosis of neurodevelopmental disorders. Counseling Today, 57(6), 12-15.

King, M. B. (1989). Eating disorders in a general practice: Prevalence, characteristics and follow-up at 12 to 15 months. *Psychological Medicine*, (Monograph Supplement), 14.

Kirby, R. S. (1994). Impotence: Diagnosis and management of male erectile dysfunction. *BMJ*, 308, 957-961.

Kirby, D., Short, L., Collins, J., Rugg, D., Kolby, L., Howard, M., et al. (1994). School-based program to reduce sexual risk behaviors: a review of effectiveness. *Public Health Reports,* 109, 339-360.

Kirk, S. A. (2004). Are children's DSM diagnoses accurate? *Brief Treatment and Crisis Intervention*, 4(3), 255-270.

Klein, A., & Kowall, N. (1998). Alzheimer's disease and other progressive dementias. In L. Volicer & A. Hurley (Eds.), *Hospice care for patients with advanced progressive dementia*. New York: Spring Publishing Co., Inc.

Klein, D. N. (1999). Depressive personality: Reliability, validity, and relation to dysthymia. *Journal of Abnormal Psychology*, 99, 412-421.

Klein, M. H., Benjamin, L. S., Rosenfeld, R., et al. (1993). The Wisconsin Personality Disorders Inventory: Development, reliability, and validity. *Journal of Personality Disorder*, 7, 285-303.

Klerman, G. L. (1990). History and development of modern concepts of anxiety and panic. In J. C. Ballenger (Ed.), *Clinical aspects of panic disorder.* New York, NY: Wiley-Liss.

**Klerman, G. L., Weissman, M. M., Markowitz, J., Glick, I., Wilner, P. J., Mason, B., & Shear, M. K. (1994). Medication and psychotherapy. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 734-782). New York: John Wiley & Sons.

**Kluft, R. P. (1995) Dissociative identity disorder. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed.). Washington, DC: American Psychiatric Association Press.

Kluznik, J., Spleed, N., VanValkenburg, C., & Magraw, R. (1986). 40 years follow-up of U.S. prisoners of war. *American Journal of Psychiatry*, 143, 1443-1446.

Knoblock, P. (2013). Assessment and diagnosis of body dysmorphic disorder and teens. *Counseling Today*, 56(6), 12-13.

Kobak, K. A., Greist, J. H., Jefferson, J. W., Katzelnick, D. J., & Henk. H. J. (1998). Behavioral versus pharmacological treatments of obsessive-compulsive disorder: A meta-analysis. *Psychopharmacology*, 136(3), 205-216.

Koegel, R. L., Koegel, L. K., Vernon, T. W., & Brookman-Frazee, L. I. (2010). Empirically supported pivotal response treatment for children with autism spectrum disorders. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapy for children and adolescents* (2nd ed., pp. 327-343). New York, NY: Guildford Press.

Kohlenberg, R. J. & Tsai, M. (1991). *Functional analytic psychotherapy: A guide for creating intense and curative therapeutic relationships*. New York: Plenum.

Koocher, G. P., Norcorss, J. C., & Hill, S. S. (2005). *Psychologist's desk reference* (2nd ed, pp. 117-118), New York, NY: Oxford University Press.

Koran, L., Thienemann, M., & Davenport, R. (1996). Quality of life for patients with obsessive-compulsive disorder. *British Journal of Psychiatry*, 156, 51-54.

Korkman, M., Kirk, U., & Kemp, S. (2007). NEPSY-II (2nd ed.): *Administration Manual*. San Antonio, TX: Psych Corp.

Kovacs, M. (2003). *Children's Depression Inventory*: Technical manual update. North Tonawands, NY: Multi-Health Systems.

Krakow, D., Sandoval, R., Schrader, B., Keuhne, L., McBrodie, L., & Yau, C. L., et al. (2001). Treatment of chronic nightmares in adjudicated adolescent girls in a residential facility. *Journal of Adolescent Health*, 29, 94-100.

Krisanaprakornkit, T., Krisanaprakornkit, W., Piyavhatkul, N., & Laopaiboon, M. (2006). *Meditation therapy for anxiety disorders* (review). The Cochrane Collaboration: Wiley Publishers.

Krishnan K. R. (2005).Psychiatric and medical comorbidities of bipolar disorder. *Psychosom Med*. 67(1), 1-11.

Kroenke, K., Spitzer, R. L., & Williams, J. (2001). The PHQ-9 validity of a Brief Depression Severity measure. *Journal of General Medicine,* 16(9), doi:10..1046/J.1525-149.2001.016009606.X

Kroenke, K., Spitzer, R. L., & Williams, J. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Medical Care,* 41(11), 1284-1292.

Kronenberger, W. G., & Meyer, R. G. (1996). *The child clinician's handbook*. Needham Heights, MA: Allyn & Bacon.

Krueger. R. F., Derringer, J., Markon, K. E., Watson, D., & Skodol. A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine,* 42, 1879-1890.

Kuipers, E., Garity, P., Fowler, D., Freeman, D., Dunn, G., & Bebbington, D. (2006). Cognitive, emotional, and social processes in psychosis: Refining cognitive behavioral therapy for persistent positive symptoms. *Schizophrenia Bulletin,* 30, S24-S31.

Kukull, W. A., Highdon, R., Bowen, J. D., McCormick, W. C., Teri, L., Schellenberg, G. D., van Belle, G., Jolley, L., & Larson, E. B. (2002). Dementia and Alzheimer disease incidence: A prospective cohort study. *Archives of Neurology*, 59, 1737-1746.

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, R., & Weiss, D. S. (1990). *Trauma and the Vietnam War generation*. New York: Brunner/Mazel.

Kupfer D. J. (2005). The increasing medical burden in bipolar disorder. *JAMA*. 293(20), 2528-2530.

Kushner, M. G., Sher, K. J., & Beitman, B. D. (1990). The relation between alcohol problems and the anxiety disorders. *American Journal of Psychiatry*, 147, 685-695.

Lack, C. W., & Storch, E. A. (2008). The use of computers in the assessment and treatment of obsessive-compulsive disorder. *Computers in Human Behavior,* 24, 917-929.

LaGreca, A. M., & Stone, W. L. (1993). The Social Anxiety Scale for Children-Revised: Factor structure and concurrent validity. *Journal of Clinical Child Psychology*, 22, 17-27.

Laing, J. (1988). Self-report: Can it be of value as an assessment technique? *Journal of Counseling & Development,* 67, 60-61.

**Lam, R. W., Tam, E. M., Shiah, I. S., Yatham, L. M., & Zis, A. P. (2000). Effects of light therapy on suicidal patients with winter depression. *Journal of Clinical Psychiatry*, 61, 30-32.

Lambert, M. V., & Robertson, M. M. (1999). Depression in epilepsy: Etiology, phenomenology and treatment. *Epilepsia*, 40 (suppl. 10), S21–S47.

Langley, A. K., Bergman, R. L., McCracken, J., & Piacentinni, J. C. (2004). Impairment in childhood anxiety disorders: Preliminary examination of the Child Anxiety Impact Scale-Parent version. *Journal of Child Adolescent Psychopharmacology*, 14, 105-114.

Laurent, J., Swerdlik, M., & Ryburn, M. (1992). Review of validity research on the Stanford-Binet Intelligence Scale: Fourth Edition. *Psychological Assessment*, 4, 102-112.

Law, D. (2011). *Goal based outcomes (GBOs): Some useful information*. Internal CORC publication; Available at www.corc.uk.net.

Law, D. (2012). *A practical guide to using user feedback and outcome tools to inform clinical practice in child & adolescent mental health* (Ed.). CYP-IAPT Outcomes and Evaluation task and finish Group (OEG). http://www.iapt.nhs.uk/silo/files/rom-dec11-03.pdf

Lawson, D. H. (1998) Epidemiology. In D. M., Davies, R. E. Ferner & H. de Glanville, *Textbook of Adverse Drug Reactions* (5th ed.) (eds.; pp. 6–19). London: Chapman & Hall Medical.

**Lazarus, A. A. (1992). The multimodal approach to the treatment of minor depression. *American Journal of Psychotherapy*, 46, 50-57.

Lazowski, L. E., Miller, F. G., Boye, M. W., & Miller, G. A. (1998). Efficacy of the Substance Abuse Subtle Screening Inventory-3 (SASSI-3) in identifying substance dependence disorders in clinical settings. *Journal of Personality Assessment*, 71(1), 114-128.

Leary, M. R. (1983). Social anxiousness: The construct and its measurement. *Journal of Personality Assessment*, 47, 66-75.

Leary, T. (1957). *Interpersonal diagnosis of personality*. New York: Ronald.

Leckman, J. F., Riddle, M. A., Hardin, M. T., Ort, S. L., Swartz, K. L., Stevenson, J., & Cohen, D. J. (1989). The Yale Global Tic Severity Scale: Initial testing of a clinician-rated scale of tic severity. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 566-573.

Lee, C. W., (2008). Crucial processes in EMDR: More than imaginal exposure. *Journal of EMDR Practice & Research,* 2(4), 262-268. doi: 10.1891/1933-3196.2.4.262

Lees, A. J. (1988). The nighttime problems of Parkinson's disease. *Clinical Neuropharmacology*, 11, 512-519.

**Lehman, C. L., Brown, T. A., & Barlow, D. H. (1998). Effects of cognitive-behavioral treatment for panic disorder with agoraphobia on concurrent alcohol abuse. *Behavior Therapy*, 29, 423-433.

Leibert, T. I. (2006). Making change visible: The possibilities in assessing mental health counseling outcome. *Journal of Counseling & Development,* 84, 108-113.

Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, 160, 1223-1232.

Leising, D., Rehbeing, D., & Eckardt, J. (2009). The Inventory of Interpersonal Problems (IIP-64) as a screening measure for avoidant personality disorder. *European Journal of Psychological Assessment*, 25(1), 16-22.

Leon, A. C., Olfson, M., Portera, L., Farber, L., & Sheehan, D. V. (1997). Assessing psychiatric impairment in primary care with the Sheehan Disability Scale. *International Journal of Psychiatry in Medicine*, 27, 93-105.

**Leonard, H. L., Swedo, S. E., March, J. S., & Rapoport, J. L. (1995). Obsessive compulsive disorder. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* Vol. 1 (2nd ed., pp. 301-313). Washington, DC: American Psychiatric Press, Inc.

Leslie, R. S. (2002). New federal privacy regulations: What you need to know and do. *Family Therapy Magazine,* 1(2), 41-43.

Levine, S. B., Risen, C. B., & Althof, S. E. (1990). Essay on the diagnosis and nature of paraphilia. *Journal of Sex & Marital Therapy*, 16(2), 89-102.

**Levitt, J. T., Hoffman, E. C., Grisham, J. R., & Barlow, D. H. (2001). Empirically supported treatments for panic disorder. *Psychiatric Annals*, 31(8), 478-487.

Levy, K. N., Meehan, K. B., Kelly, K. M., Reynosa, J. S., Weber, M., Clarkin, J.F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 74, 1027-1040.

Lewin, A. B., & Piacentini, J. (2010). Evidence-based assessment of child obsessive compulsive disorder: Recommendations for clinical practice and treatment research. *Child & Youth Care Forum*, 39(2), 73-89. http://www.ncbi.nlm.nih.gov/pubmed/20376181

Libman, E., Rothenberg, I., Fichten, C. S., & Amsel, R. (1985). The SSES-E: A measure of sexual-efficacy in erectile functioning. *Journal of Sex and Marital Therapy*, 11, 233-244.

Liebowitz, M. R. (1987). Social phobia. *Modern Problems of Pharmacopsychiatry*, 22, 141-173.

Light, M. J., & Sheridan, M. S. (1990). Munchausen syndrome by proxy and apnea (MBPA): A survey of apnea programs. *Clinical Pediatrics*, 29, 162-168.

Lilienfeld, S. O., & Andrews, B. P. (1996). Development and preliminary validation of a self-report measure of psychopathic personality traits in noncriminal populations. *Journal of Personality Assessment*, 66, 488-524.

**Linehan, M. M. (1993a). *Skills training manual for treating borderline personality disorder*. NY: Guilford.

**Linehan, M. M. (1993b) *Cognitive–behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Links, P. S., & Stockwell, M. (2002). The role of couple therapy in the treatment of Narcissistic Personality Disorder. *American Journal of Psychotherapy*, 56(4), 522-539.

Lion, J. R. & Bachy-Rita, G. (1970). Group psychotherapy with violent outpatients. *International Journal of Psychotherapy*, 20, 185-191.

Lipp, M. (1977). *Respectful treatment: The human side of medical care.* New York: Harper & Row.

Livesley, W. J., & Jackson, D. N. (2004). *Dimensional Assessment of Personality Problems-Basic Questionnaire*. Port Huron, MI, Sigma Assessment Systems.

Livesley, W. J., Schroeder, M. L., & Jackson, D. N. (1990). Dependent person disorder and attachments. *Journal of Personality Disorders*, 4, 131-140.

Lock, J., & Grange, D. l. (2005). Family-based treatment of eating disorders. *International Journal of Eating Disorders*, 37(S1, S64-S67. doi: 10.1002/eat.20122

Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist*, 10, 3-42.

Loge, D. V., Staton, D., & Beatty, W. W. (1990). Performance of children with ADHD on tests sensitive to frontal lobe dysfunction. *Journal of American Academy of Child and Adolescent Psychiatry*, 29, 540-545.

Logsdon, R. G., McCurry, M., & Teri, L. (2007). Evidence-based psychological treatments for disruptive behaviors in individuals with dementia. *Psychology and Aging*, 22(1), 28-36.

Lonigan, G., Elbert, J. C., & Johnson, S. B. (1998). Empirically supported psychosocial intervention for children: An overview. *Journal of Clinical Child Psychology*, 27, 138-145. doi: 10.127/s1537442jccp2702_1

Looper, K. J., & Kirmayer, L. J. (2002). Behavioral medicine approaches to somatoform disorder. *Journal of Consulting and Clinical Psychology*, 70(3), 810-827.

Loranger, A. W. (1999). *International Personality Disorder Examination (IPDE).* Odessa, FL: Psychological Assessment Resources.

Lord, C., Risi, S., Lambrecht, L., Cook, E. H., Jr., DiLavore, P. C., Pickles, A., Rutter, M. (2000). The autism diagnostic observation schedule: A standard measure of social and communication deficits associated with the spectrum of autism. *Journal of Autism Developmental Disorder,* 30(3), 205-223.

Lord, C., Rutter, M., & LeCouteur, A. (1994). Autism diagnostic interview-Revised: A revised version of a diagnostic interview for caregivers of individuals with possible pervasive developmental disorders. *Journal of Autism Developmental Disorder*, 24(5), 659-685.

Lovaas, O. I. (1981). *Teaching developmentally disabled children: The me book.* Baltimore: University Park Press.

Lovaas, O. I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, 55, 3-9.

Lovaas, O. I. (2002). *Teaching individuals with developmental delays: Basic intervention techniques*. Austin, TX: PRO-ED

Lowe, B., Zipfel, S., Buchholz, C., Dupont, Y., Reas, D. L., & Herzog, W. (2001). Long-term outcome of anorexia nervosa in a prospective 21-year follow-up study. *Psychology of Medicine*, 31, 881-890.

Lubar, J. F., Swartwood, M. O., Swartwood, J. N., & O'Donnel, P. H. (1995). Evaluation of the effectiveness of EEG neurofeedback training for ADHD in clinical setting as measured by changes in T. O. V. A. scores, behavioral ratings, and WISC-R performance. *Biofeedback Self-Regulation*, 20(1), 83-99.

Lucas, A. R., Beard, C. M., O'Fallon, W. M., & Kurland, L. T. (1991). 50 year trends in the incidence of anorexia nervosa in Rochester, Minn.: A population based study. *American Journal of Psychiatry*, 148, 917-922.

Lyneham, H. J., Sburlati, E. S., Abbott, M. J., Rapee, R. M., Hudson, J. L., Tolin, D. F., & Carlson, S. E. (2013). Psychometric properties of the Child Anxiety Life Interference Scale (CALIS). *Journal of Anxiety Disorders*, 27(7), 711-719.

Macciocchi, S. N., & Barth, J. T. (1996). The Halstead-Reitan Neuropsychological Test Battery (HRNTB). In C. S. Newmark (Ed.), *Major psychological assessment instruments (*2nd ed., pp. 431-459). Boston: Allyn and Bacon.

Mahler, M. S. (1967). *On human symbiosis and the vicissitudes of individuation*. In the selected papers of Margaret S. Mahler (Vol. 1, pp. 77-98). New York: International University Press.

Maier, W., Gansicke, M., Freyberger, H. J., Liunz, M., Huen, R., & Lecrubier, Y. (2000). Generalized anxiety disorder (ICD-10) in primary care from a cross-cultural perspective: A valid diagnostic entity? *Acta Psychiatrica Scandinavica*, 101, 29-36.

Maine, M., Davis, W. N., & Shure, J. (2009). *Effective clinical practice in the treatment of eating disorders: The heart of the matter*. New York: Routledge.

Maletzsky, B. M. (1998). The paraphilias: Research and treatment. In P. Nathan & J. Gorman (Ed.), A *guide to treatments that work* (pp. 472-500). New York: Oxford University Press.

Malin, T. (2012). The top 10 reasons against the use of no-suicide contracts. *Genesee Health Systems,* retrieved 8-24-2014.

March, J. S., Parker J. D., Sullivan, K., Stallings, P., & Conners, C. K. (1997). The Multi-dimensional Anxiety Scale for Children (MASC): Factor structure, reliability, and validity. *Journal of the American Academy of Child and Adolescent Psychiatry,* 36, 554-563.

**Markowitz, J. C. (2005). Interpersonal therapy. In: J. M. Oldham, A. E. Skodol, & Y D. S. *Bender, Personality Disorders,* pp. 321-388), Arlington, VA: American Psychiatric Publishing.

**Markowitz, J. C., & Klerman, G. L. (1991). *Manual for interpersonal therapy of dysthymia*. Unpublished manuscript. New York: Cornell University Medical College.

**Marks, I. M. (1981). Review of behavioral psychotherapy, I: Obsessive-compulsive disorders. *American Journal of Psychiatry*, 138, 584-592.

Martell, C., D., Addis, M., & Jacobsen, N. (2001). *Depression in context: Strategies for guided action*. New York, NY: Guilford.

Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral activation for depression: A clinician's guide*. New York, NY: Guilford Press.

**Martens, W. H. (2001). Agitation therapy for antisocial and psychopathic personalities: an outline. *American Journal of Psychotherapy*, 52(2), 234-250.

Martino, S., Carroll, K. M., Charla, N., & Rounsaville, B. J. (2006). A randomized controlled pilot study of motivational interviewing for patients with psychotic and drug use disorders. *Addiction*, 101, 1479-1492.

Masters, W. H. & Johnson, V. E. (1970). *Human sexual inadequacy*. Boston: Little & Brown.

Masterson, J. F. (1981). *The narcissistic and borderline disorders: An integrated developmental approach*. NY: Brunner/Mazel

Mastin, D. F., Bryson, J., & Corwyn, R. (2006). Assessment of sleep hygiene using the Sleep Hygiene Index. *Journal of Behavioral Medicine,* 29(3), 223-227.

Matheny, K. B., Brack, G. L., McCarthy, C. J., & Penick, J. M. (1996). The effectiveness of cognitively-based approaches in treating stress related symptoms. *Psychotherapy*, 33(2), 305-320.

Matheny, K. B., & Riordan, R. (1992). *Stress and strategies for lifestyle management*. Atlanta, GA: Georgia State University Business Press.

Mattes, J. A., Boswell, L., & Oliver, H. (1984). Methylphenidate effects on symptoms of attention deficit disorder in adults. *Archives General Psychiatry*, 41, 1059-1064.

Mattick, R. P., & Clark, J. C. (1989). Development and validation of measures of social phobia, scrutiny, fear and social interaction anxiety. Unpublished manuscript. In R. G. Heimberg, M. R. Hope & F. R. Schneider (Eds.), *Social phobia* (p. 205). New York: Guilford Press.

Mattick, R. P., & Clark, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behavior Research and Therapy*, 36, 455-470.

Maurice, C., Green, G., & Foxx, R. M. (1996). *Making a difference: Behavioral interventions for autism*. Austin, TX: Pro-Ed.

**Mavissakalian, M. R., & Prien, R. F. (1996). *Long-term treatments of anxiety disorders (Ed.)*. Washington, DC: American Psychiatric Press.

Mayfield, D., McLeod, G., & Hall, P. (1974). The CAGE Questionnaire: Validation of a new alcoholism instrument. In N. S. Schutte & J. M. Malouff (Eds.), *Sourcebook of adult assessment strategies* (p. 33), New York: Plenum Press.

Mays, M., & Croake, J. W. (1997). *Treatment of depression in managed care.* New York: Brunner/Mazel Publishers.

Mazzeo, S. E. (1999). Modification of an existing measure of body image preoccupation and its relationship to disordered eating in female college students. *Journal of Counseling Psychology*, 46, 42-50.

McCabe, M. P. (1998). Sexual Function Scale: History and current factors. In C. Davis, W. Yarber, R. Bauseman, G. E., Schreer S. Davis & G. Schreer (Eds.), *Handbook of sexuality-related measures* (p. 275). Thousand Oaks, CA: Sage

McCarter, R. H. G. (1996). Panic disorder: Cognitive-behavioral treatment and its integration with pharmacotherapy. In J. M. Ellison (Ed.), *Integrative treatment of anxiety disorders*. Washington, DC: American Psychiatric Press, Inc.

**McCarthy, B. W. (1990). Treating sexual dysfunction associated with prior sexual trauma. *Journal of Sex and Marital Therapy*, 16, 142-146.

McConaughy, S. H. (1996). The interview process. In M. J. Breen & C. R. Fiedler (Eds.), *Behavioral approach to assessment of youth with emotional behavioral disorders* (pp. 181-224). Austin, TX: Pro Ed.

McCracken, J. T, McGough, J.., Shah, B., Cronin, P., Hong, D., McDougle, C. J., ….McMahon, D. (2002). Risperidone in children with Autism and serious behavioral problems. *New England Journal of Medicine*, 347(5), 314-321.

McCurry, S. M., Logsdon, R. G., Teri, L., & Vitiello, M. V. (2007). Evidence-based psychological treatments for insomnia in older adults. *Psychology and Aging*, 22(1), 18-27.

McCurry, S. M., Reynolds, C. F., & Ancoli-Israel, S. (2000). Treatment of sleep disturbance in Alzheimer's disease. *Sleep Medicine Reviews*, 4, 603-628.

McDonald, S. D., & Calhoun, P. S. (2010). The diagnostic accuracy of the PTSD Checklist: A critical review. *Clinical Psychology Review*, 30, 876-987.

McElroy, S. , Frye, M. A., Suppes, T., Dhavale, D., Keck, P. E., Leverich, G. S., Kirk L. A., Denicoff, D., Nolen, W. A., Kupka, R., Grunze, H., Walden, J. & Post, R. M. (202).Correlates of overweight and obesity in 644 patients with bipolar disorder. *Journal of Clinical Psychiatry,* 63(3), 207-213.

McGlashan, T. H., & Kristal, J. H. (1995) Schizophrenia-related disorders and dual diagnosis. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed., pp. 1055-1058). Washington, DC: American Psychiatric Association Press.

McGoldrick, M., & Gerson, R. (1985). *Genograms in family assessment*. New York: W. W. Norton.

McHugh, R. K., & Behar, E. (2009). Readability of self-report measures of depression and anxiety. *Journal of Consulting and Clinical Psychology*, 77(6), 1100-1112.

McKay, D., Abramowitz, J. S., Taylor, S., & Asmundson (Eds.). (2009). *Current perspectives on the anxiety disorders: Implications for DSM-V and beyond.* New York: Springer.

McKay, D., & Bouman, T. K. (2008). Enhancing cognitive-behavioral therapy for monosymptomatic hypochondriasis with motivational interviewing: Three case illustrations. *Journal of Cognitive Psychotherapy: An International Quarterly*, 22(2), 154-166.

McLean, C. P., & Foa, E. B. (2013). Dissemination and implementation of prolonged exposure therapy for posttraumatic stress disorder. *Journal of Expert Neurother, 11(8), 1151-1163.*

McLellan, A. T., Loborsky, L., Woody, G. E., & O'Brien, C. P. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous and Mental Diseases*, 168, 26-33.

**McLeod, D. R. (1997). Psychosocial treatment of obsessive-compulsive disorder. *International Review of Psychiatry*, 9, 119-133.

**McMyler, C., & Pryjmachuk, S. (2008). Do 'no suicide' contracts work? Journal of *Psychiatric MentaHealth Nursing*, 15(6), 512-522.

Meise, U., & Fleishhacker, W. W. (1996). Perspectives on treatment needs in schizophrenia. *British Journal of Psychiatry*, 168 (suppl 1), 9-16.

Meltzer, H., Gill, B., & Petticrew, M. (1995). *OPCS surveys of psychiatric morbidity in Great Britain*. Report no I. The prevalence of psychiatric morbidity among adults aged 16-64 living in private households in Great Britain. HMSO, London.

Mendez, M. F., Ala, T., & Underwood, K. L. (1992). Development of scoring criteria for the Clock Drawing Task in Alzheimer's disease. *The American Geriatrics Society*, 40, 1095-1099.

Merikangas, K. R., Angst, J., & Isler, H. (1990). Migraine and psychopathology. Results of the Zurich cohort study of young adults. *Archives of General Psychiatry*, 47(9), 849-853.

Meston, C. M., Hull, E., Levin, R. J., & Sipski, M. (2004). Disorders of orgasm in women. *Journal of Sexual Medicine*, 1(1), 66-68.

Metalsky, G. L., & Joiner, T. E., Jr., (1997). The Hopelessness Depression Symptom Questionnaire. *Cognitive Therapy and Research,* 21(3), 359-384.

**Metz, M. E. & Weiss, K. E. (1992). A group therapy format for the simultaneous treatment of marital and sexual dysfunctions: A case illustration. *Journal of Sex and Marital Therapy*, 18, 173-187.

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behavior Research and Therapy*, 28, 487-495.

Meyers, B., & Carver, C. S. (2000). Negative childhood accounts, sensitivity, and pessimism: A study of avoidant personality disorder features in college students. *Journal of Personality Disorders*, 14, 233-248.

Meyers, W. C., Burket, R. C., & Otto, T. A. (1993). Conduct disorder and personality disorders in hospitalized adolescents. *Journal of Clinical Psychiatry*, 54, 21-26.

Mezo, P. G., McCabe, R. E., Antony, M. M., & Burns, K. (2005). Psychometric validation of a monitoring-blunting measure for social anxiety disorder: The Coping Styles Questionnaire for Social Situations (CSQSS). *Depression and Anxiety*, 22(1), 20-27

Michelson, D., Adler, L., Spencer, T. J.,….Milton, D. (2003). Atomoxetine in adults with ADHD: Two randomized, placebo-controlled studies. *Biological Psychiatry*, 53, 1120120.

Milkowitz, D. J. (2004). Family therapy. In S. L. Johnson, & R. L. Leahy (Eds.). *Psychological treatment of bipolar disorders* (pp. 184-204). New York, NY: Guilford.

Miller, R. S., Johnson, J. A., & Johnson¸ J. K. (1991). Assessing the prevalence of unwanted childhood sexual experiences. *Journal of Psychology and Human Sexuality*, 4, 43-54.

Miller, R. S., McGlashan, T. H., Woods, S. W., Stein, K., Driesen, N., Corcoran, C. M., & Davidson, L. (1999). Symptom assessment in schizophrenia prodromal states. *Psychiatric Quarterly*, 70, 273-311.

Millon, T. (1981). *Disorders of personality: DSM-III Axis II*. New York: Wiley & Sons.

Millon, T. (1983). *Millon Clinical Multiaxial Inventory manual*. Minneapolis, MN: Interpretive Scoring Systems.

Millon, T. (1996). *Disorders of personality DSM-IV and beyond* (2nd ed.). New York: John Wiley & Sons, Inc.

Millon, T. & Davis, R. D. (1996a). *Disorders of personality DSM-IV and beyond*. NY: John Wiley & Sons.

Millon, T., & Davis, R. D. (1996b). The Millon Clinical Multiaxial Inventory-III (MCMI-III). In C. S. Newmark, *Major Psychological Assessment Instruments*, 2nd ed., pages 108-147). Needleham Heights: Simon & Schuster.

Millon, T., & Grossman, S. (2007). *Resolving difficult clinical syndromes: A personalized psychotherapy approach*. Hoboken, NJ: Wiley.

Millon, T., Millon, C., & Davis, R. (1994). *MCMI-III manual.* Minneapolis, MN: National Computer Systems.

Millon, T., Millon, C., & Davis, R. (1997). *MCMI-III Manual* (2nd ed.). Minneapolis, MN: National Computer Systems.

Milner, C. E., & Belicki, K. (2010). Assessment and treatment of insomnia in adults: A guide for clinicians. *Journal of Counseling and Development*, 88(2), 236-244.

Milville, M. L., Gelso, G. J., Panny, R., Liu, W., Touradji, P., Holloway, P. & Fuetes, J. (1999). Appreciating similarities and valuing differences: the Millville-Guzman University-Diversity Scale. *Journal of Counseling Psychology*, 46, 291-307.

Mitchell, J. T. (1988). The history, status and future of critical debriefing stress debriefings. *Journal of Emergency Medical Services*, 13(11), 46-48.

Moe, A. M., & Docherty, N. M. (2014). Schizophrenia and the sense of self. *Schizophrenia Bulletin*, 40(1), 161-169. Doe: 10.1093/schbul/sht121.

Mogge, N. L., & Lepage, J. P. (2004). The assessment of depression inventory (ADI): A new instrument used to measure depression and to detect honesty of response. *Depress Anxiety*, 20(3), 107-113.

Mollica, R., Caspi-Yavin, Y., Lavelle, J., Tor, S., Yang, T., Chan, S., Pham, T., Ryan, A., & deMarneffe, D. (1995). *Manual for the Harvard Trauma Questionnaire*. Brighton, MA: Indochinese Psychiatry Press.

Monastra, V., Lynn, S., Linden, M., Lubar, J. F., Gruzelier, J., & LaVaque, T. J. (2005). Electroencephalographic biofeedback in the treatment of attention-deficit hyperactivity disorder. *Applied Psychophysiology and Biofeedback*, 30(2), 95-114.

Money, J., & Lehne, G. K. (1999). Gender identity disorder. In R. T. Ammerman, M. Hersen & C. G. Last (Eds.), *Handbook of prescriptive treatments for children and adolescents* (2nd ed., pp. 214-228). Boston: Allyn and Bacon.

Monk, T. H., Buysse, D. J., Kennedy, K. S., Pods, J. M., DeGrazia, J. M., & Miewald, J. M. (2003). Measuring sleep habits without using a diary: the sleep timing questionnaire. *Sleep*, 26(2), 208-212.

Montano, B. (2004). Diagnosis and treatment of ADHD in adults in primary care. *Journal of Clinical Psychiatry*, 65 (Suppl. 3), 18-21.

Montgomery, P., & Dennis, J. (2003). Bright light therapy for sleep problems in adults aged 60+. *Cochrane Database Syst Rev* (2): CD003403.

Montgomery, S. A., & Asberg, M. A. (1979). A new depression scale designed to be sensitive to change. *British Journal of Psychiatry*, 134, 382-389

Moreno, S., Magallon, Gill, M., Bauza, N., Roca, M., Del Hoyo, Y. L., & Garcia-Campayo, J. (2013). Effectiveness of group versus individual cognitive-behavioral therapy in patients with abridged somatization disorder: A randomized control trial. *Psychosomatic Medicine,* 75(6), 600-608. doi 10: 1097/PSY06013e31829a8904.

Morin, C. M. (1993). *Insomnia: Psychological assessment and management*. New York: Guilford Press.

Morin, C. M. (2004). Cognitive-behavioral approaches to the treatment of insomnia. *Journal of Clinical Psychiatry* (Suppl 65), 16, 33-40.

Morin, C. M., Cuthbert, J. P., & Schwartz, S. M. (1994). Nonpharmacological interventions for insomnia. *American Journal of Psychiatry*, 151, 1172-1180.

Morin, C. M., Hauri, P. J., Espie, C. A., Spielman, A. J., Buysse, D. J., & Bootzin, P. R. (1999). Nonpharmalogical treatment of chronic insomnia. *Sleep,* 22(8), 1134-1156.

Moritz, S., Treszl, A., & Rufer, M. (2011). A randomized controlled trial of a novel self-help technique for impulse control disorders: A study on nail-biting. *Behavior Modification,* 35(5), 56-485.

Morley, J. E. & Kaiser, F. E. (1993). Impotence: The internist's approach to diagnosis and treatment. *Advanced Internal Medicine*, 38, 151-168.

Morrison, J. (1993). *The first interview: A guide for clinicians.* New York: The Guilford Press. NBCC. (1999, September 30). NBCC Examinations: National Clinical Mental Health Counseling Examination (NCMHCE). Greensboro, NC: NBCC.

Morrison, J. (1995). *DSM-IV made easy.* New York: The Guilford Press.

Mortimer, A. M., Joyce, E., BalasMubramaniam, K., Choudary, P. C., & Saleem, P. T. (2007). Treatment with amisulpride and olanzapine improve neuropsychological function in schizophrenia. *Human Psychopharmacology*, 22, 445-454.

Mosher, D. & Anderson, R. (1986). Macho personality, sexual aggression, and reactions to guided imagery of realistic rape. *Journal of Research in Personality*, 20, 77-94.

Mueser, K. T., Lu, W., Rosenberg, H. H., & Wolfe, R. (2010). The trauma of psychosis: Posttraumatic stress disorder and recent onset psychosis. *Schizophrenia Research*, 116, 217-227.

Mueser, K. T., Rosenberg, S. D., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, W., Hamblen, J., Rosenberg, H. H., McHugh, G. J., & Wolfe, R. (2008). A randomized controlled trial of cognitive-behavioral treatment for posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 76(2), 259-271.

Muller, B. E., & Erford, B. T. (2012). Choosing assessment instruments for depression outcome research with school-aged youth. *Journal of Counseling & Development,* 90(2), 208-220.

Murray, H. A. (1943). *Thematic Apperception Test manual*. Cambridge, MA: Harvard University Press.

Murtagh, D. R., & Greenwood, K. M. (1995). Identifying effective psychological treatments for insomnia: A meta-analysis. *Journal of Consulting Clinical Psychology,* 63(1), 79-89.

**Musselman, D. L., Evans, D. L., & Nemeroff, C. B. (1998). The relationship of depression to cardiovascular disease epidemiology, biology and treatment. *Archives of General Psychiatry*, 55(7), 580-592.

Najavits, L. M., & Weiss, R. D. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorder: An empirical review. *Addiction*, 89, 679-688.

Nathan, P. E., & Gorman, J. M. (2002). A guide to treatments that work (2nd ed.). New York: Oxford University Press. *Anxiety Disorders*, 27(8), 788-792.

National Institute for Clinical Excellence (CE). (2004). *Treatment of anorexia nervosa, bulimia nervosa and elated eating disorders: A clinical guideline.* London: Author.

National Institute of Health Consensus Development Panel on Impotence. (1993). Impotence. *JAMA*, 270, 83-90.

NIH State-of-the-Science Conference Statement on Manifestations and Management of Chronic Insomnia in Adults. (2005). *NIH Consensus Science Statement*. Consensus.nih.gov2005/2005InsomniaSOSO26main.htm.

Nauta, M. H., Scholing, A., Rapee, R. M., Abbott, M., Spence, S. H., & Waters, A. (2004). A parent-report measure of children's anxiety: Psychometric properties and comparison with child-report in a clinic and normal sample. *Behavior Research and Therapy*, 42, 813-839.

Nelson, E. J. (2001). Divalproex sodium in sex offenders with bipolar disorders and comorbid paraphilias: An open retrospective study. *Journal of Affective Disorders*, 64, 249-255.

**Newhill, C. E., & Mulvey, E. P. (2002). Emotional dysregulation: The key to a treatment approach for violently ill individuals. *Clinical Social Work Journal,* 30(2), 157-171.

Newman, M. G., Zuellig, A. R., Kachin, K. E., Constantino, M. J., Przeworski, A., Erickson, T., Cashman-McGrath, T., Miller, M., Metzger, R., & Borkovec, T. (2002). Preliminary reliability and validity of the Generalized Anxiety Questionnaire-IV: A revised self-report diagnostic measure of generalized anxiety disorder. *Behavior Therapy*, 33, 215-233.

Newmark, C. S. (Ed.). (1996). *Major psychological assessment instruments* (2nd ed.). Boston: Allyn and Bacon.

**Nichols, D. S. (2001). *Essentials of MMPI-2 assessment.* NY: John Wiley & Sons, Inc.

**Nichols, K. S. (2007). Breaking impasses: strategies for working with high conflict personalities. *American Journal of Family Law*, 20, 226-233.

Nitkowski, D., Petermann, F., Buttner, P., Krause-Leipoldt, C., & Peterman, U. (2009). Behavior modification of aggressive children child welfare: Evaluation of a combined intervention program. *Behavior Modification,* 33(4), 474-492. doi: 10.1177/0145445509336700

Norris, F., & Perilla, J. (1996). Reliability, validity, and cross-language stability of the Revised Civilian Mississippi Scale for PTSD. *Journal of Traumatic Stress*, 9(2), 285-299.

Norton, G. R., McLeod, L., Gluertin, J., Hewitt, P. L., Walker, J. R., & Stein, M. B. (1996). Panic disorder or social phobia: Which is worse? *Behavior Research and Therapy*, 34, 273-276.

Nutt, D. J., Ballenger, J. C., & Lepine, J. P. (1999). Panic disorder: Clinical diagnosis, management and mechanisms. Malden, MA: Blackwell Science, Inc., patients with substance use disorders: An empirical review. *Addiction*, 89, 679-688.

Oakley, D. A. (2001). Hypnosis and suggestion in the treatment of hysteria. In P. W. Halligan, C. Bass & J. C. Marshall (Eds.), *Contemporary approaches to the study of hysteria, clinical and theoretical perspectives* (pp. 312-329). Oxford, United Kingdom: Oxford University Press.

O'Brien, C. P., & McKay, J. R. (1998). Psychopharmacological treatments of substance use disorders. In P. Nathan & J. Gorman (Eds.), *A guide to treatments that work*, (pp. 127-155), New York: Oxford University Press.

OCCWG, Obsessive Compulsive Cognitions Working Group. (2005). Psychometric validation of the obsessive belief questionnaire and interpretation of intrusions inventory. Part 2 Factor analyses and testing of a brief version. *Behaviour Research and Therapy*, 43, 1527-1542.

Odom, S., Hume, K., Boyd, B., & Stabel, A. (2012). Moving beyond the intensive behavior treatment versus eclectic dichotomy: Evidence-based and individualized programs for learners with ASD. *Behavior Modification,* 36(3), 270-297.

O'Donohue, W. T., Swingen, D. N., Dopke, C. A., & Regev, L. G. (1999). Psychotherapy for male sexual dysfunction: A review. *Clinical Psychology Review*, 19(5), 591-630.

Oldham, J. M., Skodol, A. E., Kellman, H.D., Hyler, S. E., Doidge, N., Resnick, L., & Gallaher, P. E. (1995). Comorbidity of Axis I and Axis II disorders. *American Journal of Psychiatry*, 152, 571-578.

Oomen, H. A., Schipperijn, A. J., & Drexhage, H. A. (1996). The prevalence of affective disorder and in particular of a rapid cycling of bipolar disorder in patients with abnormal thyroid function tests. *Clinical Endocrinology*, 45(2), 215-223.

Opjordsmoen, S. (1991) Paranoid (delusional) disorders in the light of a long-term follow up study. *Psychopathology*, 24, 287-292.

O'Shanick, G. J., Gardner, D. F., & Kornstein, S. G. (1987). In A. Stoudemire & B. S. Fogel (Eds.), *Principles of medical psychiatry* (pp. 177-204). New York: Grune and Stratton.

Őst, L. G. (1987). Age of onset in different phobias. *Journal of Abnormal Psychology*, 96, 223-229.

Ostrov, E., Marohn, R. C., Offer, D., Curtiss, G., & Feczko, M. (1980). The Adolescent Antisocial Behavior Checklist. *Journal of Clinical Psychology*, 36, 594-601.

Otto, M. W., & Gould, R. A. (1996). Maximizing treatment outcome for panic disorder: Cognitive-behavioral strategies. In M. W. Pollack (Ed.), *Logic and psychosocial strategies* (pp. 113-140). New York: Guilford Press.

Overholser, J. C. (1989).Accurate diagnosis of personality disorders: Some critical factors. *Journal of Contemporary Psychotherapy*, 19(1), 5-23.

Overholser, J. C., & Nasser, E. H. (2000). Cognitive-behavioral treatment of generalized anxiety disorder. *Journal of Contemporary Psychotherapy*, 30(2), 149-161.

Owens, J. S., Richerdson, L., Beilsteikn, E. A., Crane, A., Murphy, C. E., & Vancouver, J. B. (2005). School-based mental health programing with inattentive and disruptive behavior problems: First-year treatment outcome. *Journal of Attention Disorders,* 9, 261-274. doi: 101177/1087054705279299

Pallanti, S., Quercioli, L., Sood, E., & Hollander, E. (2002). Lithium and valproate treatment of pathological gambling: A randomized single-blind study. *Journal of Clinical Psychiatry*, 63(7), 559-564.

Palmer, R. L., Oppenheimer, R., Dignon, D. A., Chaloner, D. A., & Howells, K. (1990). Childhood sexual experiences with adults reported by two women with eating disorders: An extended series. *British Journal of Psychiatry*, 156, 699-703.

Pandy, G. (1990). Biochemical markers of predisposition to alcoholism. *Alcohol Health & Research World*, 3(14), 1-11.

Paniagua. E. A. (2001). *Diagnosis in a multicultural context: A casebook for mental health professionals*. Thousand Oaks, CA: Sage.

**Paradise, L., & Kirby, P. (2005). The treatment and prevention of depression: Implications for counseling and counselor training. *Journal of Counseling & Development,* 83, 116-119.

Paris, J. (2010). "Effectiveness of different psychotherapy approaches in the treatment of borderline personality disorder". *Current Psychiatry Reports* 12(1), 56–60.

Parker, J., & Penhale, B. (1998). *Forgotten people: Positive approaches to dementia care*. Brookfield, VT: Ashgate Publishing Company.

Parnell, T. F., & Day, D. O. (Eds.). (1998). *Munchausen by proxy syndrome: Misunderstood child abuse*. London: Sage Publications.

Paukert, A. L., Kraus-Schuman**,** C., Wilson**,** N., Snow, A. L., Calleo**,** J., Kunik**,** M. E.**,** & Stanley, M. A. (2013). The peaceful mind manual: A protocol for treating anxiety in persons with dementia. *Behavior Modification,* 37(5), 631-664.

Pavuluri, M. M., Henry, D. B., Nadimpalli, S. S., O'Connor, M. M., & Sweeney, J. A. (2006). Biological risk factors in pediatric bipolar disorder. *Biological Psychiatry*, 60(9), 936-941.

Pelham, W. E., & Fabiano, G. A. (2008). Evidence-based psychosocial treatments for attention-deficit/hyperactivity disorder. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 184-214.

Pelham, W. E., Gnagy, E. M., Greenslade, K. E., & Milich, R. (1992). Teacher ratings of DSM-III-R symptoms for the disruptive behavior disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 210-218.

Pelham, W. E., Gnagy, B., Greiner, A., Hoza, B., Sams, S., Martin, L., & Wilson, T. (1996). A summer treatment program for children with ADHD. In M. Roberts & A. LaGreca (Eds.), *Model programs for service delivery for child and family mental health* (pp. 193-213). Hillsdale, NJ: Erlbaum.

Perley, M. J., & Guze, S. B. (1962) Hysteria: The stability and usefulness of clinical criteria. *New England Journal of Medicine*, 266, 421-426.

Perry, G. P. & Orchard, J. (1992). *Assessment & treatment of adolescent sex offenders*. Sarasota, FL: Professional Resource Press.

Perry, J. C., & Jacobs, D. (1982). Overview: Clinical applications of the amytal interview in psychiatric emergency settings. *American Journal of Psychiatry*, 139, 552-559.

Persson, J., & Magnusson, P. (1989). Early intervention in patients with excessive consumption of alcohol: A controlled study. *Alcohol*, 6, 403-408.in the United States: Implications for policy and practice. *Journal of Counseling and Development,* 92(1), 90-98.

Peterson, C. H., Lomas, G. I., Neukrug, E. S., & Bonner, M. W. (2014). Assessment use by counselors: Implications for policy and practice. *Journal of Counseling & Development,* 92(1), 90l-98.

Peterson, H. W., & Martin, M. J. (1973). Organic disease presenting as a psychiatric syndrome. *Postgraduate Medicine*, 54, 78-82.

Petry, N. M. (2003). Patterns and correlates of gamblers anonymous attendance in pathological gamblers seeking professional treatment. *Addictive Behaviors*, 27, 1-14.

Petry, N. M., Ammerman, Y., Bohl, J., Doersch, A., Gay, H., Kadden, R., Molina, C., & Steinberg, K. (2006). Cognitive-behavioral therapy for pathological gamblers. *Journal of Consulting and Clinical Psychology*, 74(3), 555-567.

Pfohl, B., Blum, N., & Zimmerman, F. (1997). *Structured interview for DSM-IV personality*. American Psychiatric Press.

Phillips, B., & Ancoli-Israel, S. (2001). Sleep disorders in the elderly. *Sleep Medicine,* 2(2), 99-114.

Phillips, K. A., McElroy, S. L., Keck, P. E., Jr., Pope, H. G., Jr., & Hudson, J. I. (1993). Body dysmorphic disorder: 30 cases of imagined ugliness. *American Journal of Psychiatry,* 150(2), 8.

Phillips, K. A., McElroy, S. L., Keck, P. E., Jr., Pope, H. G., Jr., & Hudson, J. I. (2006). Delusional versus nondelusional body dysmorphic disorder: Clinical features and course of illness. *Journal of Psychiatric Research*, 40(2), 95-104.

Phinney, J. S., & Rosenthal, D. A. (1992). Ethnic identity in adolescence: Process, context, and outcome. In: G.R. Adams, T. P. Gullott and R. Montemayor, Editors, *Adolescent identity formation (pp. 145-172)*, Newbury Park, CA: Sage.

Piacentini, J. C., & Chang, S. W (2006). Behavioral treatments for tic suppression: Habit reversal training. *Advances in Neurology*, 99(3), 227-33. http://www.ncbi.nlm.nih.gov/pubmed/16536370

Piacentini, J., & Jaffer, M. (1996). Measuring functional impairment in youngsters with OCD: The Child OCD Impact Scale. Unpublished manuscript, available from the authors.

Piacentini, J., Woods, D. W., Schill, L., Wilhelm, S., Peterson, A. L., Chang, S., Ginsburg, G. S., Deckersbach, T., Dziura, J., Levi-Pearl, S., & Walkup, J. (2010). Behavior therapy for children with Tourette's disorder: A randomized control trial, *JAMA,* 303, 1929-1937.

Piacentini, J., Woods, D., Walkup, J., Scahill, L., Wilhelm, S., Peterson, A. L., Chang, S., Ginsburg, G. S., Dickersbach, T., Dziura, J., Levi-Pearl, S., & Walkup, J. T. (2010). Behavioral intervention effectively controls tics in children with Tourette syndrome. *Journal of the American Medication Association*, 303(19), 1929-37

Pickert, K. (2014, Feb 3). Being mindful. *Time*, 41-45.

Piotrowski, C., & Keller, J. W. (1989). Psychological testing in outpatient mental health facilities: A national study. *Professional Psychology: Research and Practice*, 20, 423-425.

Piper, We. E., Ogrodiniczuk, J. S., Lamarche, C., & Hilscher, T. (2005). Level of alliance, patterns of alliance, and outcome in short-term group therapy. *International Journal of Group Psychotherapy*, 55(4), 527-550.

Plazzi, G., Corsini, R., & Provini, F. (1997). REM sleep behavior disorders in multiple system atrophy. *Neurology*, 48, 1049-1097.

Pliszka, S. R. (1998). Comorbidity of attention-deficit/hyperactivity disorder with psychiatric disorder: An overview. *Journal of Clinical Psychiatry*, 59(7), 50-58.

Podell, J. L., Martin, E. D., & Kendall, P. C. (2008). Incorporating play within a manual-based treatment for children and adolescents with anxiety disorders. In A. Drewes (Ed.), *Blending play therapy with cognitive behavioral therapy: Evidence-based and other effective treatments and techniques* (pp. 165-178). New York, NY: Wiley.

Podell, J. L., Mychailyszyn, M., Edmunds, J., Puleo, C. M., & Kendall, P. C. (2010). The Coping Cat program for anxious youth: The FEAR plan comes to life. *Cognitive and Behavioral Practice*, 17, 132-141.

Pollets, D., Ducharme, S., & Pauporte, J. (1999). Psychological considerations in the assessment of erectile dysfunction. *Sexuality and Disability*, 17(2), 129-145.

Popli, A. P., Masand, P. S., & Dewan, M. J. (1992). Factious disorders with psychological symptoms. *Journal of Clinical Psychiatry*, 53, 315-318.

Porges, S. W. (2011). The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation. New York, NY: W. W. Norton.

Porkney, M. D., Miller, B. A., & Kaplan, H. B. (1972). The Brief MAST: A shortened version of the Michigan Alcohol Screening Test. *American Journal of Psychiatry*, 129, 343-345.

Potter, J. E. (2007). . A 60-year-old woman with sexual difficulties. JAMA, 297(6), 620-633.

Priebe, S., Roeder-Wanner, U. U., & Kaiser, W. (2000). Quality of life in first-admitted schizophrenia patients: A follow-up study. *Psychology of Medicine*, 30, 225-230.

Priest, R., & Smith, A. (1992). Counseling adult sex offenders: Unique challenges and treatment paradigms. *Journal of Counseling & Development*, 71, 27-32.

Prins, A., Quimette, P., Kimerling, R., Camerion, R. P., Hugelshofer, D.S., Shaw-Hegwer, J., Thraikill, A., Gusman, F. D.,& Sheikh, J. I. (2003). The primary care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry*, 9, 9-14.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Application to addictive behaviors. *American Psychologist,* 47, 1102-1114.

Puig-Antich, J., & Chambers, W. (1978). *The Schedule for Affective Disorders and Schizophrenia for School-aged Children.* New York: New York State Psychiatric Institute.

Putnam, F. W. (1991). Dissociative disorders in children and adolescents: A developmental perspective. *Psychiatric Clinics of North America*, 14, 519-532.

Putnam, F. W., Guroff, J. J., Silberman, E. K., Barbara, L., & Post, R. M. (1986). The clinical phenomenology of multiple personality disorders: Review of 100 recent cases. *Journal of Clinical Psychiatry*, 47(6), 285-293.

**Putnam, F. W., & Lowenstein, P. J. (1993). Treatment of multiple personality disorders: A survey of current practices. *The American Journal of Psychiatry*, 150(7), 1048-1952.

Putts, M. R. (2014). Recognizing trauma and posttraumatic stress disorder with symptoms in individuals with psychotic features. *Journal of Counseling and Development,* 92, 83-89.

Rachman, S., & de Silva, P. (1996). *Panic disorder: The facts*. New York: Oxford University Press.

Radloff, A., McArdle, J. J., Bockting, C. L. H., & Berking, M. (2014). Successful emotion regulation skills application predicts subsequent reduction of symptom severity during treatment of major depressive disorder. *Journal of Consulting and Clinical Psychology*, 82(2), 248-262.

Radloff, L.S. (1977). The CES-D scale: A self-report depression scale for research in the general population. Applied *Psychological Measurement*, 1, 385-401. doi:10.1177/014662167700100306

Rafaeli, E., Bernstein, D. P., & Young, J. (2011). *Schema therapy: Distinctive features*. New York, NY: Routledge.

*Ragsdale, K., Neer, S. M., Beidel, D. C., Frueh, B. C., & Stout, J. W. (2013). Posttraumatic stress disorder in OEF/OIF veterans with and without traumatic brain injury. *Journal of Anxiety Disorders,* 27(4), 420-426.

Randolph, C. (1998). Repeatable *Battery for the Assessment of Neuropsychological Status*. San Antonio, TX: Psychological Corporation.

Rappley, M. D., Mullan, P. B., Alvarez, F. J., Eneli, I. U., Wang, J., & Gardiner, J. C. (1999). Diagnosis of attention deficit/hyperactivity disorder and use of psychotropic medication in very young children. *Archives of Pediatric and Adolescent Medicine*, 153(10), 1039-45.

Raskin, R. N., & Hall, C. S. (1979). A narcissistic personality inventory. *Psychological Reports*, 45, 590.

Raskin, R. N., & & Terry, H. (1988). A principal-components analysis of the narcissistic personality Inventory and further evidence of its construct validity. *Journal of Social Psychology*, 54, 890-902.

Rasmussen, S. A., & Tsuang, M. T. (1986). Clinical characteristics and family history in DSM-III obsessive-compulsive disorder. *American Journal of Psychiatry*, 143, 317-322.

Ravindrum, A. V., Anisman, H., Merali, Z., Charbonneau, Y., Telner, J., Bialik, R. J., Wiens, A., Ellis, J., & Griffiths, J. (1999). Treatment of primary dysthymia with group cognitive therapy and pharmacotherapy: Clinical symptoms and functional impairments. *American Journal of Psychiatry*, 156(10), 1608-1617.

Rea, M. M., Thompson, M. C., Miklowitz, D. J., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family-focused treatment versus individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 71(3), 482-492.

Read, S. (1991). The dementias. In J. Sadavoy, L. W. Lazarus, & L. F. Jarvik (Eds.), *Comprehensive review of geriatric psychiatry* (pp. 287-309). Washington, DC: American Psychiatric Press.

Reas, D. L., Whisenhunt, B. L., Netemeyer, R., & Williamson, D. A. (2002). Development of the body checking questionnaire: A self-report measure of body checking behaviors. *International Journal of Eating Disorders*, 31(3), 324-333.

Reeves, J. C., Werry, J. S., Elkind, G. S., & Zametkia, A. (1987). Attention deficit, conduct, oppositional, and anxiety disorders in children. II Clinical characteristics. *Journal of American Academy of Children Adolescent Psychiatry*, 26, 144-155.

Regenold, W.T., Thapar, R. K., Marano, C, Gavirneni, S., & Kondapavuluru, P. V. (2003) Increased prevalence of type 2 diabetes mellitus among psychiatric inpatients with bipolar I affective and schizoaffective disorders independent of psychotropic drug use. *Journal of Affective Disorders*. 70(1), 19-26.

Regier, D. A. (1984). Lifetime prevalence of specific psychiatric disorders in three sites. *Archives of General Psychiatry*, 41, 949-958.

Regier, E., Touyz, S. W., & Beaumont, P. J. V. (2002). The Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ): Information regarding its psychometric properties. *International Journal of Eating Disorders*, 32, 24-38.

Reiss, S. (1980). Pavlovian conditioning and human fear: An expectancy model. *Behavior Therapy*, 11(3), 380-396.

Reitan, R. M., & Wolfson, D. (1993). The Halstead-Reitan Neuropsychological Test Battery: Theory and clinical interpretation (2nd ed.). Tucson, AZ: Neuropsychology Press.

Remar, R. B., Bounds, J. C., Rogers, C., & Hardin, D. (2011). *Issues of special importance to mental health professionals.* Atlanta, GA: Institute of Continuing Legal Education in Georgia.

Remely, T. P., Jr., & Herlihy, B. (2010). *Ethical, legal, and professional issues in counseling (3rd ed.).* Boston: Merrill.

Renner, K. H., Enz, S., Friedel, H., Merzbacher, G., & Laux, L. (2008). Doing as if: The histrionic self-presentation style. *Journal of Research in Personality*, 42, 1303-1322.

Resick, P. A., Jordan, C. G., Girelli, S. A., Hutter, C. K., & Marhoefer-Dvorak, S. (1988). A comparative outcome study of behavioral group therapy for sexual assault victims. *Behavior Therapy*, 19(3), 385-401.

Resnick, P. (1997). Malingering of post-traumatic disorders. In R. Rogers (Eds.), *Clinical assessment of malingering and deception* (2nd ed., pp. 130-152). New York: Guilford Press.

Reynolds, C. R., & Kamphaus, R. W. (1992). *Behavior Assessment System for Children*. Circle Pines, MN: American Guidance Services.

Reynolds, C. R., & Richmond, B. O. (1987). What I think and feel: A revised measure of Children's Anxiety Scale. *School Psychology Review*, 6, 271-280.

Reynolds, C. R., & Richmond, B. O. (2008). *Revised Children's Manifest Anxiety Scale, second edition (RCMAS-2):* Manual, Los Angeles, CA: Western Psychological Services.

Reynolds, W. M. (2002). *Reynolds Adolescent Depression Scale-Second Edition: Professional manual.* Odessa, FL: Psychological Assessment Resources.

Reynolds, W. M., & Kobak, K, A. (1995). Reliability and validity of the Hamilton Depression Inventory: A paper-pencil version of the Hamilton Depression Rating Scale Clinical Interview. *Psychological Assessment,* 7(4), 472-483.

Ribbe, D. (1996). Psychometric review of Traumatic Event Screening Instrument for Children (TESI-C). In B. H. Stram (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 386-387). Lutherville, MD: Sidran Press.

Ricard, M., Lutz, A., & Davidson, R. J. (2014a, October). Neuroscience reveals the secrets of meditation's benefits. *Scientific American,* 311(5),

Ricard, M., Lutz, A., & Davidson, R. J. (2014b, November). Mind of the meditator. *Scientific American,* 311(5), 39-45.

Riddle, M. A., Scahill, L., King, R., Hardin, M. T., Tobin, K. E., Ort, S. L., Leckman, J. F., & Cohen, D. (1990). Obsessive compulsive disorder in children and adolescents: Phenomenology and family history. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 766-772.

Rieger, E., Touyz, S. W., & Beumont, P. J. V. (2002). The Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ): Information regarding its psychometric properties. *International Journal of Eating Disorders,* 32(1), 24-38.

Riemann, D., Fischer, J., Mayer, G., & Peter, H. J. (2003). The guidelines for 'non-restorative sleep': Relevance for the diagnosis and therapy of insomnia. *Somnologie,* 7(2), 66-76.

Rienzi, B. M. (1992). Prevalence of undetected alcohol dependence in the mental health diagnostic interview. *Psychological Reports*, 70, 913-914.

**Riggs, D. S., & Foa, E. B. (1993). Obsessive-compulsive disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders*. New York: Guilford.

Rinsley D. B. (1981) Borderline psychopathology: The concepts of Masterson and Rinsley and beyond. *Adolescent Psychiatry*, 9, 259-74

**Rivto, P., Lewis, M. D., Irvine, J., Brown, L., Matthew, A., & Shaw, B. F. (2003). The application of cognitive-behavioral therapy in the treatment of substance abuse. *Primary Psychiatry,* 10(5), 72-77.

Robins, C. N., Helzer, J. E., Weissman, M. M., Orvaschel, H., Gruenberg, E., Brude, J. D., & Robins, C. N., Helzer, J. E., & Weissman, M. M. (1984). Lifetime prevalence of specific psychiatric disorders in three sites. *Archives of General Psychiatry*, 41, 949-958

Robins, L. N., Cottler, S., Bucholz, K., & Compton, W. (1995). *Diagnostic Interview Schedule for DSM-IV*. St. Louis, MO: Washington University Press.

Robins, L. N., Wing J., & Wittchen, H. U. (1988). The Composite International Diagnostic Interview: An epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. *Arch General Psychiatry*, 12, 1069-1077.

Rodgers, F., & Maniacci, M. (2006). *Antisocial personality disorder: A practitioner's guide to comparative treatments.* NY: Springer Publishing.

Roemer, L., Orsillo, S.M., & Salters-Pedneault, K. (2008). Efficacy of an acceptance-based behavior therapy for generalized anxiety disorder: Evaluation in a randomized trial. *Journal of Consulting and Clinical Psychology,* 76(6). 1083-1089.

Rogers, S. J., & Vismara, L. A. (2008). Evidence-based comprehensive treatment for early Autism. *Journal of Clinical Child and Adolescents Psychology*, 37(1), 8-38.

Ronningstam, E., Gunderson, J. G., & Lyons, M. (1995). Changes in pathological narcissism. *American Journal of Psychiatry*, 152, 253-257.

Rosen, J. C., Srebnik, D., Saltzberg, E., & Wendt, S. (1991). Development of a body image avoidance questionnaire. *Journal of Consulting and Clinical Psychology, 3(1), 32-37*.

**Rosenberg, R., & Doghramji, P. (2009). Optimal treatment of obstructive sleep apnea and excessive sleepiness. *Medical Sleep Review*, 26(3), 295-312.

Rosenthal, M. Z., Kim, K., Herr, N. R., Smoski, M. J., Cheavens, J. S., Lynch, T. R., & Kosson, D. S. (2011). Speed and accuracy of facial expression classification in avoidant personality disorders: A preliminary study. *Personality Disorders: Theory, Research, and Treatment*, 2(4), 327-377.

Ross, C. A. (1989). *Multiple personality disorder: Diagnosis, clinical features, and treatment*. New York: John Wiley & Sons.

**Ross, C. A. (1997). *Dissociative identity disorder: Diagnosis, clinical features, and treatment of multiple personality*. New York: John Wiley & Sons.

Ross, C.A., Heber, S., Norton, G. R., & Anderson, G. (1989). Differences between multiple personality disorder and other diagnostic groups on structured interviews. *Journal of Nervous and Mental Disorders*, 179(8), 487-491.

Ross, E. D., Homan, R. W., & Buck, R. (1994). Differential hemispheric lateralization of primary and social emotions. *Neuropsychiatry, Neuropsychology, and Behavioral Neurology*, 7, 1-9

Rothenberg, S. (1997). Introduction to sleep disorders. In M. Pressman & W. Orr (Eds.), *Understanding sleep* (pp. 57-72). Washington DC: American Psychological Association.

Roundy, L. M., & Horton, A. L. (1990). Professional and treatment issues for clinicians who intervene with incest perpetrators. In A. L. Horton, B. L. Johnson, L. M. Roundy & D. Williams (Eds.), *The incest perpetrator* (pp. 164-189). Newbury Park, CA: Sage.

Rowa, K., & Anthony, M. M. (2005). Psychological treatment for social phobia. *Canadian Journal of Psychiatry*, 50(6), 308-315.

Roy-Byrne, P., Stein, M., Bystrisky, M., & Katon, A. (1998). Pharmacotherapy of panic disorder. *Journal of American Board Family Practice*, 11(4), 282-290.

Rush, A. J., Carrmody, T. J., Ibrahim, H. M., …Kashner. (2000). The Inventory of Depressive Symptomatology (IDS): Clinician (IDS-C) and self-report (IDS-SR) ratings of depressive symptoms. *International Journal of Methods in Psychiatric Research,* 9, 45-59.

Rush, A. J., Gullion, C. M., Basco, M. R., Jarrett, R. B., & Trivedi, M. H. (1996). The Inventory of Depressive Symptomatology (IDS): Psychometric properties. *Psychological Medicine*, 26, 477-486.

Russell, T. A., Chu, E., & Phillips, M. L. (2006). A pilot study to investigate the effectiveness of emotion recognition remediation in schizophrenia using the micro-expression training tool. *British Journal of Clinical Psychology*, 45, 579-583.

Ryle, A. (1997). *Cognitive analytic therapy and borderline personality disorder: The model and the method*. Chichester: Wiley.

Ryle, A. (2004). The contribution of cognitive analytic therapy to the treatment of borderline personality disorder. *Journal of Personality Disorder*, 18. 3-35.

**Sadock, B. J., & Sadock, V. A. (2000). *Kaplan & Sadock's comprehensive textbook of psychiatry* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Sadock, B. J., & Sadock, V. A. (2007). *Kaplan and Saddock's synopsis of psychiatry* (10th ed.). Philadelphia, PA: Lippincott.

Sakheim, D., Hess, E. P., & Chivas, A. (1988). General principles for short-term inpatient work with multiple personality disorder patients. *Psychotherapy*, 25, 117-124.

Salter, A. C. (1988). *Treating child sex offenders and victims.* Beverly Hills, CA: Sage.

Salvia, J., Ysseldyke, J. E., & Bolt, S. (2007). *Assessment in special and inclusive education* (10th ed.). Boston: Houghton Mifflin Company.

SAMPSA (2014). Gambling problems: An introduction for behavioral health services providers. *SAMHSA Advisory*, 13(1), 1-8.

Sanavio, E. (1988a). Obsessions and compulsions: The Padua inventory. *Behavior Research and Therapy*, 26(2), 169-177.

Sanavio, E. (1988b). Pre-sleep cognitive intrusions and treatment of onset insomnia. *Behavior Research and Therapy*, 26, 451-459.

Sanderson, W. C., & Wetzler, S. (1995). Cognitive behavioral treatment of panic disorder. In G. M. Aunis & H. M. van Prang (Eds.), *Panic disorder: Clinical, biological, and treatment aspects*. New York: John Wiley & Sons.

Sargent, M. (1990). NIMH report: Panic disorder. *Hospital and Community Psychiatry*, 41, 621- 623.

Sattler, J. M. (2008). Assessment of children: Cognitive foundations (5th ed.).San Diego: Jerome M. Sattler, Publisher, Inc.

Saylor, C. F., Finch, A. J., Spirito, A., & Bennett, B. (1984). The Children's Depression Inventory: A systematic evaluation of psychometric properties. *Journal of Consulting and Clinical Psychology*, 52, 955-967.Research and Therapy, 26, 451-459.

Scahill, L., Riddle, M. A., McSwiggin-Hardin, M., Ort, S. I., King, R. A., Goodman, W. K., Cicchetti, D., & Leckman, J. F. (1997). Children's Yale-Brown Obsessive Compulsive Scale: Reliability and validity. *Journal of Academy of Child Adolescent Psychiatry*, 36(6), 844-852.

Scaini, S., Belotti, R., & Ogliari, A. (2014). Genetic and environmental contributions to social anxiety across different ages: A meta-analytic approach to twin data. *Journal of Anxiety Disorders,* 28(7), 650-656.

**Schaefer, L. C., Wheeler, C. C., & Futterweit, W. (1995) Gender identity disorders (Transsexualism). In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders*, (2nd ed., pp. 2015-2048). Washington, DC: American Psychiatric Association Press.

Schalet, B. D., Cook, K. F., Choi, S. W., & Cella, D. (2014). Establishing a common metric for self-reported anxiety: Linking the MASQ, PANAS, and GAD-7 to PROMIS Anxiety. *Journal of Anxiety Disorders,* 28(1), 88-96.

Schare, M. L., & Wyatt, K. P. (2013). On the evolving nature of exposure therapy. *Behavior Modification,* 37(2), 243-256.

Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., Winn, S., Robinson, P., Murphy, R., Neville, S., & Johnson-Sabine, E. (2007). A randomized controlled trail of family therapy and cognitive behavioral therapy guided self-care for adolescents with Bulimia Nervosa and related disorders. *American Journal of Psychiatry*, 164(4), 591-598.

Schmitz, N., Hatkamp, N., Kjuse, J., Franke, G. H., Reister, G., & Tress, W. (2000). The Symptom Check-List-90-R: A German validation study. *Quality of Life Research*, 9, 185-193.

**Schneider, L. S. (1999). Pharmacologic management of psychosis in dementia. *Journal of Clinical Psychiatry*, 60(1), 54-56.

Schneider, S., Blatter-Meunier, J., Herren, J., In-Albon, Adornetto, C., Meyer, A., & Lavalee, K. (2013). The efficacy of a family-based cognitive-behavioral treatment for separation anxiety disorder in children aged 8-13: A randomized comparison with a general anxiety program. *Journal of Counseling and Clinical Psychology*, (932-940).

Schnurr, P. P., Friedman, M. J., Engel, C. C., Foa, E. B., Shea, M. t., Chow, B. K., et al. (2007). Cognitive behavioral therapy for posttraumatic stress disorder in women: A randomized controlled trial. *The Journal of American Medical Association*, 297, 820-830.

Schopler, E., Reichler, R. J., DeVeills, R. F., & Daly, K. (1988). *The Childhood Autism Rating Scale*. Los Angeles: Western Psychological Services.

Schopp, L., Johnstone, B., & Merrell, D. (2000). Telehealth and neuropsychological assessment: New opportunities for psychologists. *Professional Psychology: Research and Practice,* 31, 179-183

Schopp, L., Reichler, R. J., De Vellis, R. F., & Daly, K. (1991). Childhood Autism Rating Scale. Los Angeles, CA: Western Psychological Services.

Schutte, N. A., & Malouff, J. M. (1995). *Sourcebook for adult assessment strategies*. New York: Plenum Press.

Schwartz, G. E., Davidson, R. J., & Goleman, D. J. (1978). Patterning of cognitive and somatic processes in the self-regulation of anxiety: Effects of meditation vs. exercise. *Psychomatic Medicine*, 40, 321-328.

Schwartzberg, S. S., & Halgin, R. P. (1991). Treating grieving clients: The importance of cognitive change. *Professional Psychology: Research and Practice*, 22, 240-246.

Schwitzer, A. M. (2012). Diagnosing, conceptualizing, and treating eating disorders not otherwise specified: A compromise practice model. *Journal of Counseling & Development,* 90, 281-289.

Segraves, R. T., & Althof, S. (1998). Psychotherapy of sexual dysfunctions. In P. Nathan & J. Gorman (Eds.), *A guide to treatments that work* (pp. 447-471). New York: Oxford University Press.

Seligman, L., & Hardenburg, S. A. (2000). Assessment and treatment of paraphilias. *Journal of Counseling and Development*, 78(1), 107-113.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive, systematic guide to treating mental disorders*. Hoboken, NJ: Wiley.

Shaffer, D. (1992). *The Diagnostic Interview Schedule for Children-Revised Version*. New York: Columbia University Division of Child and Adolescent Psychiatry.

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A Children's Global Assessment Scale (*CGAS). *Archives of General Psychiatry*, 40(11), 1228-1231

Shaffer, T. G., & Steiner, H. (2006). An application of DSM-IV's outline for cultural formulation: Understanding conduct disorder in Latino adolescents. *Aggression and Violent Behavior*, 11, 655-663.

Shallcross, L. (2013). Body language. *Counseling Today*, 56(1), 31-39.

Shapiro, C. M., & Dement, W. C. (1989). ABC of sleep disorders: Impact and epidemiology of sleep disorders. *British Medical Journal*, 306(6892), 1604-1607.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.

Shapiro, F. (1996). Eye movement desensitization and reprocessing (EMDR): Evaluation of controlled PTSD research. *Journal of Behavior Therapy and Experimental Psychiatry*, 27, 209-218.

Shapiro, J. R., Berkman, N. D., Brownley, K. A., Sedway, J. A., Lohr, K. N., & Bulik, C. M. (2007). Bulimia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders*, 40(4), 321-336.

Shear, M. K., Brown, T. A., Barlow, D. H., Money, R., Sholomskas, D. E., Woods, S. W., Gorman, W., & Papp, L. A. (1997). The Multicenter Collaborative Panic Disorder Severity Scale. *American Journal of Psychiatry*, 154, 1571-1575.

Shedler, J. & Westin, D. (1998). Refining the measurement of Axis II: A Q-sort procedure for assessing personality pathology. *Assessment*, 5, 333-353.

Shekter-Wolfson, L., Woodside, D. B., & Lackstrom, J. (1997). Social work treatment of anorexia and bulimia: Guidelines for practice. *Research on Social Work Practice*, 7(1), 5-31.

Shepherd, M., Cooper, B., Brown, A. C., & Kalton, G. W. (1966). *Psychiatric illness in general practice*. London: Oxford University Press.

Shoham, V., Bootzin, R. R., Rohrbaugh, M., & Urry, H. (1995). Paradoxical versus relaxation treatment for insomnia: The moderating role of reactance. *Sleep Research*, 24, 365.

Sholevar, G. P. (2005). *Family therapy*. In J. M. Oldham, A. E. Skodol, Y. D. S. *Bender, Personality Disorders*, pp.359-373, The American Psychiatric Publishing.

Siegel, B. (2004). *Pervasive Developmental Disorders Screening Test-II*. San Antonio: Harcourt Assessments.

Sierra, M., & Berrios, G. E. (2000). The Cambridge Depersonalization Scale: A new instrument for the measurement of depersonalization. *Psychiatry Research*, 93, 153-164.

Silverman, J. M., Pinkham, L., Horvath, T. B., Coccaro, E. F., Klar, H., Schear, S., Apter, S., Davidson, M., Mohs, R. C., & Siever, L. J. (1991). Affective and impulsive personality disorder traits in the relatives of patients with borderline personality disorder. *American Journal of Psychiatry,* 148, 1378-1385,

Silverman, W. K., & Albano, A. M. (1996). *The Anxiety Disorders Interview Schedule for DSM-IV: Child and parent versions*. San Antonio, TX: Psychological Corporation.

Silverman, W., K., Ortiz, C. D., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child and Adolescents Psychology,* 37(1), 156-183

Silverman, W. K., Pina, A. A., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amya-Jackson, F. L. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child & Adolescents Psychology*, 37(1), 105-130.

Simoneau, T., Miklowitz, D. J., Richards, J. A., Saleem, R., & George, E. L. (1999). Bipolar disorder and family communication: Effects of a psychoeducational treatment program. *Journal of Abnormal Psychology*, 108(4), 588-597.

Simpson, H. B., Maher, M. J., Wang, Y., Bao, Y., Foa, E. B., & Franklin, M. (2011). Patient adherence predicts outcome from cognitive behavior therapy in obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology*, 79(2), 247-252.

Singer, J., & Blagov, P. (2004). Self-defining memories, narrative identity, and psychotherapy: A conceptual model, empirical investigation and case report. In L. Angus & J. McLeod (Eds.), *Handbook of narrative and psychotherapy: Practice, theory and research (229-246)*. Thousand Oaks, CA: Sage Publications.

Sinzig, J., Dopfner, M., Lehmkuhl, G., & German Methylphenidate Study Group (2007). Long-acting methylphenidate has an effect on aggressive behavior in children with attention-deficit/hyperactivity disorder. *Journal of Child and Adolescent Psychopharmacology*, 17(4), 421-432.

Siqueland, L., Rynn, M., & Diamond, G. S. (2005). Cognitive behavioral and attachment based family for anxious adolescents: Phase I and II studies. *Anxiety Disorders,* 19, 361-381.

Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behaviors*, 7, 363-371.

Skodol, A. E. (2005). Manifestations, clinical diagnosis, and comorbidity. In: J. M. Oldham, A. Skodol, Y. D. S. Bender, *Personality Disorders,* (pp. 57-88), The American Psychiatric Publishing.

Slagle, D. M., & Gray, M. (2007). The utility of motivational interviewing as an adjunct to exposure therapy in the treatment of anxiety disorders. *Professional Psychology: Research and Practice*, 38, 329-337.

Slone, L. B., Norris, F. H., Murphy, A. D., Baker, C. K., Perilla, J. L., Diaz, D., Rodriguez, F. G., & Rodriguez, J. J. (2006). Epidemiology of major depression in four cities in Mexico. *Depression and Anxiety*, 23(3), 158-167.

Smith, C. S., Reilly, C., & Midkiff, K. (1989). Evaluation of three circadian rhythm questionnaires with suggestions for an improved measure of morningness. *Journal of Applied Psychology*, 74(5), 728-738.

**Smith, G. R. (1995). Somatization disorder and undifferentiated somatoform disorder. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed., pp. 1717-1733). Washington, DC: American Psychiatric Association Press.

Smith, M., Glass, G., & Miller, T. (1980). *The benefit of psychotherapy*. Baltimore, MD: Johns Hopkins University Press.

Smith, S. L., Sherrill, K. A., & Colenda, C. C. (1995). Assessing and treating anxiety in elderly persons. *Psychiatric Services*, 46, 36-42.

Solomon, Z. (1987). Combat-related PTSD among Israeli soldiers. *Bulletin Menninger Clinic*, 51, 80-95.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1993). *Foundations of therapeutic interviewing*. Boston: Allyn & Bacon.

Sommers-Flanagan, J. & Sommers-Flanagan, R. (1998). Assessment and diagnosis of conduct disorder. *Journal of Counseling and Development*, 76, 189-197.

Somwaru, D. P., & Ben-Porath, Y. S. (1997). *Development and reliability of MMPI-2 based personality disorder scales*. Paper presented at the 30th annual Workshop and Symposium on Recent Developments in the use of the MMPI-2 and MMPI-A. St. Petersburg, FL.

Sparrow, S. S., Balla, D. A., & Cicchetti, D. V. (1984). *Vineland Adaptive Behavior Scales*. Circle Pines, MN: American Guidance Service.

Spector, I. P., & Carey, P. (1990). Incidence and prevalence of the sexual dysfunction: A critical review of the literature. *Archives of Sexual Behavior*, 9, 389-408.

Spector, I. P., Carey, M.P., & Steinberg, L. (1996). The Sexual Desire Inventory: Development, factor structure, and evidence of reliability. *Journal of Sex & Marital Therapy*, 22(3), 175-190.

Spence, S. H., Barrett, P. M., & Turner, C. M. (2003). Psychometric properties of the Spence Children's Anxiety Scale. (SCAS) with young adolescents. *Anxiety Disorders,* 17, 605-625.

Spencer, T. J., Biederman, J., Ferone, S. W., Mick, E., Coffey, B., Gelleret, D., Geller, D., Kagan, J., Bearrman, S. K., & Wilens, T. (2001). Impact of tic disorders on ADHD outcome across the life cycle: Findings from a large group of adults with and without ADHD. *American Journal of Psychiatry*, 158(4), 611-617.

Spencer, T. J., Biederman, J., & Wilens, T. E. (2004). Nonstimulant treatment of adult attention-deficit/hyperactivity disorder. *Psychiatric Clinics of North America*, 27, 373-383.

Spencer, T., Biederman, J., Wilens, T. E., & Faraone, S. V. (1996). Pharmacotherapy of ADHD across the lifecycle: A literature review. *Journal of American Academy of Child Adolescence Psychiatry*, 35, 409-432.

Spencer, T., Biederman, J., Wilens, T. E., & Faraone, S. V. (1998). Adults with attention-deficit / hyperactivity disorder: A controversial diagnosis. *Journal of Clinical Psychiatry*, 59(7), 59-68.

Sperry, L. (1999). *Cognitive behavior therapy of DSM-IV personality disorders*. Philadelphia, PA: Brunner/Mazel.

Spielberger, C. D. (1973). *Preliminary manual for the State-Trait Anxiety Inventory for Children ("How I Feel Questionnaire").* Palo Alto, CA: Consulting Psychologists.

Spielman, A. J. & Glovinsky, P. B. (1997). The diagnostic interview and differential diagnosis for complaints of insomnia. In M. Pressman & W. Orr (Eds.), *Understanding sleep* (pp. 125-160). Washington DC: American Psychological Association.

Spielman, A. J., Saskin, P., & Thorpy, M. J. (1987). Treatment of chronic insomnia by restriction time in bed. *Sleep*, 10, 45-56.

Spitzer, R. L., Kroenke, K., Linzer, M., Hahn, S. R., Williams, J. B. W., deGruy, F. V., Brody, D., & Davies, M. (1995) Health-related quality of life in primary care patients with mental disorders. *JAMA*, 274(19), 1511-1517.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Lower, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine,* 166(10), 1092-1097.

Spitzer, R. L., Williams, J. B. W., Kroenke, K., Linzer, M., deGruy, F. V. III., Hahn, D. R., & Brody, D. (1994). Utility of a new procedure for diagnosing mental disorders in primary care: The PRIME-MD 1000 Study. *JAMA*, 272, 1749-1756.

Sroufe, A., & Siegel, D. (2011, March-April). The verdict is in: For attachment theory. *Psychotherapy Networker*. 35-39, 52.

Stanley, M. A., Wilson, N. L., Novy, D. M., Rhoades, H. M., Wagener, P. D., Greisinger, A. J., & Kunik, M. E. (2009). Cognitive behavior therapy for generalized anxiety disorder among older adults in primary care: A randomized clinical trial. *Journal of the American Medical Association*, *301*, 1460-1467.

Stepp, S. D., Whalen, D. J., Pilkonis, P. A., Hipwell, A. E., & Levine, M. D. (2011). Children of mothers with borderline personality Disorder: Identifying parenting behaviors as potential targets for intervention. *Personal Disorder,* 3(1), 76-91.

Stein, D. J. (1995). Cognitive therapy of substance abuse. *Journal of Cognitive Psychotherapy,* 9(2), 120-135.

Stein, D. J., Hollander, E., Trungold, S., Cohen, L., DeCaria, C. M., Mullen, L., et al. (1995). Compulsive and impulsive symptoms in trichotillomania. *Psychopathology,* 28, 208-213.

Steinberg, M. (1993a). *The interviewers guide to the SCID-D*. Washington, DC: American Psychiatric Press.

Steinberg, M. (1993b). *The structured clinical interview for DSM-IV dissociative disorders (SCID-D)*. Washington, DC: American Psychiatric Press.

Steinberg, M., Rounsaville, B., & Cicchetti, D. (1991). Detection of dissociative disorders in psychiatric patients by a screening instrument and a structured diagnostic interview. *Journal of Psychiatry*, 148(8), 1051-1055.

Steinhausen, H. C. (2002). The outcome of anorexia nervosa in the 20th century. *American Journal of Psychiatry*, 159, 1284-1293.

Steketee, G., Frost, R., & Bogart, K. (1996). The Yale-Brown Obsessive Compulsive Scale: Interview versus self-report. *Behavior Research and Therapy*, 34, 675-684.

Stepanski, E., Rybarczyk, B., Lopez, M., & Stevens, S. (2003). Assessment and treatment of sleep disorders in older adults: A review for rehabilitation psychologists. *Rehabilitation Psychology*, 48(1), 23-36.

Stepp, S. D., Whalen, D. J., Pilkonis, P. A., & Hipwell, M. D. (2011). Children of mothers with borderline personality disorder: Identifying parenting behaviors as potential targets for intervention. *Personality Disorder*, 3(1), 76-91.

Stevens, P., & Smith, R. L. (2009). *Substance abuse counseling: Theory and practice.* New Jersey: Pearson.

Stolorow, R. D., Brandchaft, B., & Atwood, G. E. (1987). *Psychoanalytic treatment: An intersubjective approach.* Hillsdale, NY: The Analytic Press.

Stone, M. H. (2006). *Personality-disordered patients: Treatable and untreatable*. Arlington, VA: American Psychiatric Publishing.

**Stoudemire, G. A. (1988). Somatoform disorders, factitious disorders, and malingering. In J. A. Talbot, R. E. Hales, & S. C. Yudofsky, (Eds.), *Textbook of psychiatry* (pp. 533-556). Washington, DC: APA Press.

**Strain, J. J. (1995). Adjustment disorders. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed., pp. 1655-1665). Washington, DC: American Psychiatric Association Press.

Strang, J., Bradley, B., & Stockwell, T. (1989). Assessment of drug and alcohol use. In C. Thompson (Ed.), *The instruments of psychiatric research* (pp. 211-235). New York: Wiley.

Strasburg, L. H. (1986). The treatment of antisocial personality syndromes: The therapist's feelings. In J. R. Meloy, Ed. *The Mark of Cain: Psychoanalytic Insight and the Psychopath* (page 297-313), Hillsdale, NJ: Analytic Press.

Striegel-Moore, R. H., & Bulik, C. M. (2007). Risk factors for eating disorders. *American Psychologist*, 62(3), 181-195.

Sturpe, D. A., & Weissman, A. M. (2002). What are effective treatments of panic disorder? Clinical Inquiries: from the Family Practice Inquiries Network - Brief Article. *The Journal of Family Practice*, 51(9), 743.

Sue, D., Sue, D. W., & Sue, S. (2006). *Understanding abnormal behavior* (8th ed). Boston, MA: Houghton Mifflin.

Swanson, J. (1999). *Sleep disorders sourcebook*. Detroit, MI: Omnigraphics Inc.

Swartz, M., Blazer, D., George, L., & Landerman, R. (1986). Somatization disorder in a community population. *American Journal of Psychiatry*, 143, 1403-1408.

Swartz, M., Landerman, R., George, L. K., Escobar J., & Blazer, D. G. (1991). Somatization disorder. In L. N. Robins, & D. Regier (Eds.), *Psychiatric disorders in America* (pp. 220-257). New York: Free Press.

Synder, C. R. (2000). *Handbook of hope: Theory, measures, and application*. New York: Academic Press.

Szapocznik J., Arturo, R., Perez-Vidal, A., & Kurtines, W. (1986). Bicultural Effectiveness Training (BET): An experimental test of an intervention modality for families experiencing intergenerational/intercultural conflict. *Hispanic Journal of Behavioral Sciences*, 8(4), pp. 303–330.

Tang, T. Z., DeRubeis, R. J., Hollon, S. D., Amsterdam, J., & Shelton, R. (1999). Sudden gains in cognitive therapy in depression and depression relapse/recurrence. *Journal of Consulting and Clinical Psychology*, 75(3), 404-408.

Taylor, J. W. (1975). Depression in thyrotoxicosis. *American Journal of Psychiatry*, 132, 552-553.

Taylor, S., & Asmundson, G. J. G. (2004).Treating health anxiety: *A cognitive-behavioral approach*. New York: Guilford Press.

Taylor, S., & Hyler, S. E. (1993). Update on factitious disorder. *International Journal of Psychiatry in Medicine*, 23, 81-94.

Tellegen, C. L., & Sanders, M. R. (2014). A randomized controlled trail evaluating a brief parenting program with children with autism spectrum disorders. *Journal of Consulting and Clinical Psychology,* 82(6), 1193-1200.

Tenney, N. H., Schotte, C. K. W., Denys, D. A. J. LP., vanMegan, H. J. G. M., & Westenberg, H. G. M. (2003). Assessment of DSM-IV personality disorders in obsessive-compulsive disorder: Comparison of clinical diagnosis, self-report questionnaire, and semi-structured interview. *Journal of Personality Disorder,* 17(6), 550-561. doi: 10.1521/pedi.17.6550.25352

Thayer, J. E., Friedman, B. H., & Borkovec. T. D. (1996). Autonomic characteristics of generalized anxiety disorder and worry. *Society of Biological Psychiatry*, 39, 255-266.

The National Board for Certifying Counselors. (1997). *National Clinical Mental Health Counseling Self-Assessment Examination: Directions and explanations*. Greensboro, NC: NBCC, Inc.

Thelen, M. H., Farmer, S., Wonderlich, S., & Smith, R. (1991). A revising of the bulimia test: The BUILT-R. *Journal of Consulting and Clinical Psychology*, 3, 119-124.

**Thomas, J. L., Wilk, J. E., Riviere, L. A., McGurk, D., Castro, C. A., & Hoge, C. W. (2010). Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. *Archives of Psychiatry*, 67(6), 614-623.

Thompson, R. A. (1994). Emotion regulation: A theme in search of definition. In N. A. Fox (Ed.), *The development of emotion regulation and dysregulation: Biological and behavioral aspects. Monographs of the Society for Research in Child Development,* 59(2-3, Serial No. 240), 25-52.

**Thoren, P., Asberg, M., Cronholm, B., Jornestedt, L., & Traskman, L. (1980). Clomipramine treatment of obsessive-compulsive disorder: I. A controlled clinical trial. *Archives General Psychiatry*, 37, 1281.

Tolan, P. H., & Cohler, B. J. (1992). *Handbook of clinical research and practice with adolescents.* New York: Wiley.

Toler, A. (1968). The graphomotor techniques. *Journal of Projective Techniques and Personality Assessment*, 32, 222-228.

Toneatto, T., & Ladouceur, R. (2003). Treatment of pathological gambling: A critical review of the literature. *Psychology of Addictive Behaviors*, 17(4), 284-292.

Torgersen, S., & Alnaes, R. (1990). The relationship between the MCMI personality scales and DSM-III, Axis II. *Journal of Personality Assessment*, 55(3 & 4), 698-707.

Torgersen, S., Lygren, N., Oien, P. A., Skre, I., Onstad, S., Advardson, J., Tambs, K., & Kringlen, E. (2000). A twin study of personality disorders. *Compr Psychiatry,* 41(6), 416-425.

Trinder, L. & Reynolds, S. (2000). Evidence-based practice: A critical approach. Osneymead, OX: Blackwell Science.

Tuokko, H., Hadjistavrpoulos, T., Miller, .J. A., & Beattie, B. L. (1992). The Clock Test: A sensitive measure to differentiate normal elderly from those with Alzheimers disease. *Journal American Geriatric Society*, 40, 579-584.

Turkat, I. (1990). *The personality disorders: A psychological approach to clinical management*. New York: Peragmon.

Turlington, D., Dudley, R., Warman, D. M., & Beck, A. (2006). Cognitive-behavioral therapy for schizophrenia: A review. *Focus*, 4(2), 223-233.

Turner, S. M., Beidel, D. C., Cooley, M. R., Woody, S. R., & Messer, S. C. (1994). A multi component behavior treatment for social phobia: Social effectiveness therapy. *Behavior Research and Therapy*, 32, 391-390.

**Turner, S. M., Jacob, R. G., Beidal, D. C., & Himmelhoch, J. (1985). Fluoxetine treatment of OCD. *Journal of Clinical Psychopharmacology*, 5, 201.

Turner, S. M., Stanley, M. A., Beidel, D. C., & Bond, L. (1989). The Social Phobia and Anxiety Inventory: Construct validity. *Psypathology and Behavioral Assessment,* 11(3), 221-234.

Tuschen-Caffier, B., Pook, M., & Frank, M. (2001). Evaluation of manual-based cognitive-behavioral therapy for bulimia nervosa in a service setting. *Behavior Research and Therapy*, 39(3), 299-308.

Tuschen-Caffier, B., Voegele, C., Bracht, S., & Hilbert, A. (2003). Psychological responses to body shape exposure in patients with bulimia nervosa. *Behavior Research*, 41(5), 573-586.

Vaillant, G. E. & Drake, R. E. (1985). Maturity of ego defenses in relation to DSM-III Avis II personality disorder. *Arch General Psychiatry*, 42, 597-601.

Valldeoriola, F., Nobbe, F. A., & Tolosa, E. (1997). Treatment of behavioral disturbances in Parkinson's disease. *Journal of Neural Transmission*. Supplementum, 51, 175–204.

Vallestad, J., Nielsen, M. B., & Nielsen, G. H. (2012). Mindfulness-and-acceptance-based interventions for anxiety disorders: A systematic review and meta-analysis. *British Journal of Clinical Psychology*, 51(3), 239-260.

Van der Kolk, B. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Rev Psychiatry*, 1, 253-265.

Vanderlinden, J. (2008). Many roads lead to Rome: Why does cognitive behavioural therapy remain unsuccessful for many eating disorder patients. *European Eating Disorders Review,* 16(5), 329-333.

Vanderlinden, J., Andriensen, A., Vancampfort, D., Pieters, G., Probst, M., & Vanstelandt, K. (2012). Behavioral therapeutic programs for patients with obesity and binge eating disorders: Short-and-long term follow-up data of a prospective study. *Behavior Modification,* 36(5), 670-686.

Van Etten, M. L., & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. *Clinical Psychology & Psychotherapy,* 5, 126-144.

Van Lankveld, J. J. D. M. (1998). Bibliotherapy in the treatment of sexual dysfunctions: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 66(4), 702-708.

Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E. C., & Ralph, C. J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, 55, 771-778.

Verdellen, C. W.J., Hoogduin, C. A. L., Kato, B.S., Keijsers, G. P. J., Cath, D. C., & Hoijtink, H. B. (2008). Habituation of premonitory sensations during exposure and response prevention treatment in Tourette's syndrome. *Behavior Modification*, 32(2), 215-227.

Veronen, L. J., & Kilpatrick, D. G. (1983). Stress management for rape victims. In D. Meichenbaum & M. E. Jaremko (Eds.), *Stress reduction and prevention* (pp. 341-374). New York: Plenum Press.

Victorio-Estrada, A., & Mucha, R. F. (1997). The Inventory of Drinking Situations (IDS) in current drinkers with different degrees of alcohol problems. *Addictive Behaviors*, 22(4), 557-565.

Violani, C., Devoto, A., Lucidi, F., Lombardo, C., & Russo, P. M. (2004). Validity of a short insomnia questionnaire: The SDQ, *Brain Res Bull*, 63(5), 415-412). doi: 10.1016/j.brainresbull.2014,03.03

Vitiello, B., & Stoff, D. M. (1997). Subtypes of aggression and their relevance to child psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 307-315.

Vitousek, K. M., & Gray, J. A. (2005). Eating disorders. In G. O. Gabbard, J. S. Beck, & J. Holmes (Eds.) *Oxford textbook of psychotherapy* (pp. 177-202). Oxford, England: Oxford University Press.

Voinescu, B. I., Szentagotai, A., & David, D. (2012). Sleep disturbance, circadian preference and symptoms of adult attention deficit hyperactivity disorder (ADHD). *Journal of Neural Transmission*, 119, 1195-1204.

Wadsworth, J. S., & Harper, D. C. (2007). Adults with attention-deficit hyperactivity disorder: Assessment and treatment strategies. *Journal of Counseling & Development*, 85(1), 101-108.

Waldinger, R., & Gunderson, J. G. (1987). *Effective psychotherapy with borderline patients.* New York: Macmillan.

Waldron, H. B., & Turner, C. W. (2008). Evidence-based psychosocial treatment for adolescents substance abuse. *Journal of Clinical Child and Adolescents Psychology*, 37(1), 238-261.

Walker, E. A., & Stenchever, M. A. (1993). Sexual victimization and chronic pelvic pain. *Obstet Gynecol Clin North Am*, 20, 795-807.

Walker, M. B. (1992). *The psychology of gambling*. Oxford. England: Peragmon Press.

**Walker, P. A., Berger, J. C., Green, R., Laub, D. R., Reynolds, C. L., & Wollman, L. (1985). Standards of care: The hormonal and surgical sex reassignment of gender dysphoric person. *Archives of Sexual Behavior*, 14, 79-90.

Wallace, C. J., & Liberman, R. P. (1985). Social skills training for patients with schizophrenia: A controlled clinical trial. *Psychiatry Research*, 15, 239-247.

Wallace, C. J., Liberman, R. P., Tauber, R., & Wallace, J. (2000). The Independent Living Skills, Survey: A comprehensive measure of the community functioning of severely and persistently mentally ill individuals. *Schizophrenia Bulletin*, 26(3), 631-658.

Waller, G., Stringer, H., & Meyer, C. (2012). What cognitive behavioral techniques do therapists report using when delivering cognitive behavioral therapy for eating disorders. *Journal of Consulting and Clinical Psychology,* 80(1), 171-175.

Walsh, B. T., Wilson, G. T., Loeb, K. L., Devlin, M. J., Pike, K. M., Roose, S., Fleiss, J., & Watermaux, C. (1997). Medication and psychotherapy in the treatment of bulimia nervosa. *American Journal of Psychiatry*, 154(4), 523-531.

Ward, R. K. (2004). Assessment and management of personality disorders. *American Family Physician*. 70(8), 1505-1513.

Warner, J. O., & Hathaway, M. J. (1984). Allergic form of Meadow's syndrome (Munchausen by proxy). *Archives of Disease in Childhood*, 59, 151-156.

Warren, W. L. (1994). *Revised Hamilton Rating Scale (RHRSD).* Los Angeles: Western Psychological Services.

Watkins, C. E.., Jr., Campbell, V. L., & McGregor, P. (1988). Counseling psychologists' uses of the opinions about psychological tests: A contemporary perspective. *Counseling Psychologist*, 16, 76-86.

Watkins, N., & Sparling, E. (2014). The effectiveness of the snug vest on stereotypic behaviors in children diagnosed with autism spectrum disorder. *Behavior Modification*, 38(3), 412-427.

Watson, D., & Clark, L. A. (1991). *The Mood and Anxiety Symptom Questionnaire*. Iowa City: University of Iowa, Department of Psychology (unpublished manuscript).

Watson, D., & Clark, L. A. (1994). *The PANAS-X: Manual for the Positive and Negative Affect Schedule-Expanded form*. Ames, IA: The University of Iowa.

Watson, D., Clark, L. A., & Tellegan, A. (1988). Development and validation of brief measures of positive and negative affect: *The PANAS scales. Journal of Personality and Social Psychology*, 54(6), 1063-1070.

Watson, D., & Friend, R. (1969). Measurement of social-evaluation anxiety. *Journal of Consulting and Clinical Psychology*, 33, 448-457.

Watson, J. C., Gordon, L.B., Stermac, L., Kalogerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting Clinical Psychology*, 71, 773-781.

Watson, J. C., Juba, M., Manifold, V., Kucala, T., & Anderson, P. (1991). The PTSD Interview: Rationale, description, reliability and concurrent validity of a DSM-III based technique. *Journal of Clinical Psychology*, 47, 179-185.

Weatherly, J. N., Miller, J. C., & Terrell, H. K. (2011). Testing the construct validity of the Gambling Functional Assessment–Revised. *Behavior Modification,* 35(6), 553-569.

Weathers, F. W., Blake, D. D., Schurr, P. P., Kaioupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Check-List for DSM-5 (LEC-5).* National Center for PTSD.

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). *The PTSD Checklist: Reliability, validity, and diagnostic utility*. Paper presented at the 9th Annual Meeting of the International Society for traumatic stress studies (ISTSS), San Antonio, TX. doi. 10.102/DA

Wechsler, D. (1974). *Manual for the Wechsler Preschool and Primary Scale of Intelligence-Revised.* San Antonio: The Psychological Corporation.

Wechsler, D. (1991). *Manual for the Wechsler Intelligence Scale for Children-III.* San Antonio, TX: Psychological Corporation.

Wechsler, D. (1992). *Wechsler Individual Achievement Test manual. San Antonio*: TX. Psychological Corporation.

Wechsler, D. (2003). *Wechsler Intelligence Scale for Children-Fourth Edition. Administration and scoring manual.* San Antonio, TX: Harcourt Assessment, Inc.

Weijmar Schultz, W., Basson, R., Bink, Y., Biniky, Y., Eschenbach, D., Wesselmann, U., & van Lankveld, J. (2005). Women's sexual pain and its management. *Journal of Sexual Medicine*, 2(3), 301-316.

Weinberg, G. (1996). *The heart of psychotherapy: A journey into the mind and office of the therapist at work*. New York, NY: St. Martin Press.

Weiner, E., & McKay, D. (2013). A preliminary evaluation of repeated exposure for depersonalization and derealization. Behavior Modification, 37, 226-242.

Weismann, M. M. (1994). Panic disorder: Epidemiology and genetics. In B. E. Wolfe & J. D. Maser (Eds.), *Treatment of panic disorder: A consensus development conference* (pp. 31-39). Washington, DC: American Psychiatric Press.

Weiss, M. D., & Weiss, J. R. (2004). A guide to the treatment of adults with ADHD. *Journal of Clinical Psychiatry*, 65 (Suppl. 3), 27-37.

Weissman, M. M., Markowitz, J. C., Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. NY: Basic Books.

Weisz, J. R., & Hawley, K. M. (2001). *Procedural and coding manual for identification of evidence-based treatments*. Los Angeles: University of California.

Weitzman, E. D., Moline, M. L., Czeisler, C. A., & Zimmerman, J. C. (1982). Chronobiology of aging: Temperature, sleep-wake rhythms and entrainment. *Neurobiology of Aging*, 3, 299-309.

Wells, A., & Carter, K. (1999). *The obsessive compulsive beliefs questionnaire*. Unpublished scale. University of Manchester.

Wells, A., Gwilliam, P. D. H., & Cartwright-Hatton, S. (2001). *The though fusion instrument:* Unpublished scale, University of Manchester.

Wells, A., Stopa, L., & Clark, D. M. (1993). *The social cognitions questionnaire*. Unpublished, Oxford, U.K. Department of Psychiatry, University of Oxford, Warnerford Hospital.

Westen, D. (1997). Divergences between clinical and research methods for assessing personality disorders: Implications for research and the evolution of Axis II. *American Journal of Psychiatry*, 154, 895-903.

Westen, D., & Shedler, J. (2007). Personality diagnosis with the Shedler-Westen Assessment Procedure (SWAP): Integrating clinical and statistical measurement and prediction. *Journal of Abnormal Psychology*, 116(4), 810-822.

Westhuis, D., & Thyer, B. A. (1986). *Development and validation of the Clinical Anxiety Scale: A rapid assessment instrument for empirical practice,* unpublished manuscript. Athens, GA: School of Social Work.

Wexler, B. E., & Cicchetti, D. V. (1992). The outpatient treatment of depression: Implications of outcome research for clinical practice. *Journal of Nervous and Mental Disease*, 180(5), 277-286.

Wheeler, A. M. (2013). How to explain (and understand) HIPAA. *Counseling Today*, 56(1), 23.

White, C. M., Gunderson, J. G., Zanarini, M. C., & Hudson, J. I. (2003). Family studies of borderline personality disorder: A review. *Harvard Review of Psychiatry*, 11, 8019.

White, L. A., Fisher, W. A., Byrne, D., & Kingman, R. (1977, October*). Development and validation of a measure of effective orientation to erotic stimuli: The Sexual Opinion Survey*. Paper presented at the meeting of the Midwestern Psychological Association, Chicago.

Whitworth, J. D., Crownove, B. K., & Nichols, W. (2007). Which nondrug alternatives can help with insomnia? *The Journal of Family Practice*. 56(10), 836-840.

Widiger, T. A. (2003). Personality disorder and Axis I psychopathology: The problematic boundary of Axis I and Axis II. *Journal of Personality Disorders*, 17, 98-107.

Widiger, T. A., & Sanders, C. J. (1995). *Assessing personality disorders, in clinical personality assessment: Practical Approaches*. Edited by J.N. Butcher, NY: Oxford University Press.

Wilhelm, S., Buhlmann, U., Tolin, D. F., Meunier, S.A., Pearlson, G. D., Reese, H. E., Cannistraro, P., Jenike, M. A., & Rauch, S. L. (2008). Augmentation of behavior therapy with d-cycloserine for obsessive-compulsive disorder. *American Journal of Psychiatry*, 165, 335-341.

Williams, J. B. W., Link, M. J., Rosenthal, N. E., Amira, L., & Terman, M. (1988). *Structured Interview Guide for the Hamilton Depression Rating Scale, Seasonal Affective Disorders Version (SIGH-SAD*). New York, NY: New York State Psychiatric Institute.

Williams, M., Teasdale, J., Segal, Z., & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York, NY. Guilford.

Willock, B. (1987). The devalued (unloved, repugnant) self: A second facet of narcissistic vulnerability in the aggressive, conduct-disordered child. *Psychoanalytic Psychology*, 4, 219-240.

Wilson, T., Grilo, C. M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist*, 62(3), 199-216.

Wise, M. G. (1995). Delirium due to a general medical condition, delirium due to multiple etiologies, and delirium not otherwise specified. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders Vol. 1* (2nd ed., pp. 423-443). Washington, DC: American Psychiatric Press, Inc.

Witkiewitz, K., & Marlatt, G. A. (2004). Relapse prevention for alcohol and drug problems. *American Psychologist*, 59(4), 224-235.

Woo, S. M., & Keatinge, C. (2008). *Diagnosis and treatment of mental disorders across the life span*. Boston: Wiley

Woods, D. W., Piacentini, J. C., & Walkup, J. T. (Eds). (2007). *Treating Tourette syndrome and tic disorders: A guide for practitioners.* New York, NY: Guilford.

Woods, S. P., Lovejoy, D. W., & Ball, J. D. (2002). Neuropsychological characteristics of adults with ADHD: A comprehensive review of initial studies. *The Child Neuropsychologist*, I, 12-34.

Woody, S. R., Steketee, G., & Chambless, D. L. (1995). The usefulness of the Obsessive- Compulsive Scale of the Symptom Checklist-90-Revised. *Behavior Research and Therapy,* 33, 607-611.

World Health Organization. (1997). *World Health Organization: Composite International Diagnostic Interview (CIDI), version 2.1*. Geneva, Switzerland: Author.

Wuthrich, V. M., Johnco, C., & Knight, A. (2014). Comparison of the Penn State Worry Questionnaire (PSWQ) and abbreviated version (PSWQ-A) in a clinical and non-clinical population of older adults. *Journal of Anxiety Disorder*, 28(7), 657-663.

Yanovski, S. Z. (1993). Binge eating disorder: Current knowledge and future directions. *Obesity Research*, 1, 306-324.

Yates, A. (1995). Conduct disorder. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorder Vol. 1* (2nd ed., pp. 189-200). Washington, DC: American Psychiatric Press, Inc.

Yontef. G. (1995). Gestalt therapy. In A. Gurman & S. Messer (Eds.), *Essential psychotherapies: Theories and practice.* New York: Guilford Press.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach (revised edition*). Sarasota, FL: Professional Resource Press.

Young, J. E., & Brown, G. K. (2001). *Young schema questionnaire-short version.* New York, NY: Cognitive Therapy Center of New York.

**Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York, NY: Guilford.

Yu, J. W., Buka, S. L., Mitzmaruce, G. M., & McCormick, M. C. (2006). Treatment outcomes for substance abuse among adolescents with learning disorders. *Journal of Behavioral Health Services & Research*, 33(3), 275-286.

Zanarini, M. C. (2009). Psychotherapy of borderline personality disorder. *Acta Psychiatrica Scandinavica* 120(5), 373–377.

Zanarini, M. C., Gunderson, J. G., & Frankenburg, F. R., & Chauncey, D. L. (1989). The Revised Diagnostic Interview for Borderline: Discriminating Borderline personality disorder from other Axis II disorders. *Journal of Personality Disorders*, 3, 10-18.

**Zeiss, A., & Zeiss, R. A. (1999). Sexual dysfunction: Using an interdisciplinary team to combine cognitive-behavioral and medical approaches. In M. Duffy (Ed.), *Handbook of counseling and psychotherapy with older adults* (pp. 294-313). New York: John Wiley & Sons.

Zimmerman, M., & Sheeran, T., & Young, D. (2004). The Diagnostic Inventory for Depression: A self-report scale to diagnose DSM-IV major depressive disorder. *Journal of Clinical Psychology*, 60(1), 87-110.

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents.* New York: Guilford.

Zung, B. J. (1965). A Self-Rating Depression Scale. *Archives General Psychiatry,* 12(1), 63-70. doi:10.1001/archpsyc.1965.01720310065008

Zung, B. J., & Charalampous, K. D. (1975). Item analysis of the Alcoholism Screening Test. *Journal of Studies in Alcohol*, 36(1), 127-132.

REFERENCE II

The following reference is a list of selected classifications and disorders related to assessment/diagnosis, treatment, instrumentation, and monitoring. In some categories no articles may appear at this time.

Neurodevelopmental Disorders

Assessment:

King, J. H. (2014). Assessment and diagnosis of neurodevelopment disorders. *Counseling Today,* 57(6), 12-15.

Pollak, J., Levy, S., & Breitholt, T. (1999). Screening for medical and neurodevelopmental disorders for the professional counselor. *Journal of Counseling & Development*, 77, 350-358.

Attention-Deficit/Hyperactivity Disorder

Assessment:

Brown, M. B., (2000). Diagnosis and treatment of children and adolescents with attention-deficit/hyperactivity disorder. *Journal of Counseling & Development,* 78, 195-203.

Greenhill, L. L. (1998). Diagnosing attention-deficit/hyperactivity disorder in children. *Journal of Clinical* Psychiatry, 59, 31-41.

Harvey, E.A., Metcalfe, L.A., Herbert, S.D., & Fanton, J.H. (2011). The role of family experiences and ADHD in the early development of oppositional defiant disorder. Journal of Consulting and Clinical Psychology, 79(6), 784-795.

Sibley, M. H., Pelham, W., Jr., Mollina, B. S. G., Gnagy, E.M., Wasmonsky, J. G., Waschbusch, D. A., Derefinko, K. J., Wyumbs, B. T., Carefino, A. C., Babinski, D. E., & Kuriyan, A. B. (2012). When diagnosing ADHD in young adults emphasized informant reports, DSM items, and impairment. *Journal of Consulting and Clinical Psychology*, 80(6), 1052-1061.

Wadsworth, J. S., & Harper, D. (2007). Adults with attention-deficit/hyperactivity disorder: Assessment and treatment strategies. *Journal of Counseling & Development*, 85, 101-108.

Weiss, M., & Murray, C. (2003). Assessment and management of attention-deficit hyperactivity disorder in adults. *Canadian Medical Association Journal,* 168(6), 715-721.

Treatment:

Author. (2005). What is the most effective treatment for ADHD in children? *The Journal of Family Practice,* 54(2), 166-168.

Sinzig, J., Dopfner, M., & Lehmkuhl, G. (2007). Long-acting methylphenidate has an effect on aggressive behavior in children with attention-deficit/hyperactivity disorder. *Journal of Child and Adolescent Psychopharmacology,* 17(4), 421-432.

Tourette's Disorder

Assessment:

Himle, M. B., Caprioretti, M. R., Hayes, L. P., Ramanujam, K., Scahill, L., Sukhodolsky, D. G., Wilhelm, S., Dickersbach, T., Peterson, A. L., Specht, M. W., Walkup, J. T., Chang, S., & Piacentini, J. (2014). Variables associated with tic exacerbation in children with chronic tic disorders. *Behavior Modification,* 38(2), 163-183. Kenney, C., Kuo, S., & Shahed, J. J. (2008). Tourette's syndrome. *American Family Physician*, 77(5), 65-658, 659-600.

Kenny, C., Kuo, S., & Shahed, J. J. (2008). Tourette's syndrome. *American Family Physician*, 77(5), 651-658.

Treatment:

Verdellen, C.W.J., Hoogduin, C. A. L., Kto, B. S., Keijers, G. P. J., Cath, D. C., & Hoijtink, H. B. (2008). Habituation of premonitory sensations during exposure and response prevention treatment in Tourette's syndrome. *Behavior Modification*, 32(2), 215-227.

Autism Spectrum Disorder

Lord, C., Risi, S., Lambrecht, L., Cook, E. H., Jr., DiLavore, P. C., Pickles, A., Rutter, M. (2000). The autism diagnostic observation schedule: A standard measure of social and communication deficits associated with the spectrum of autism. *Journal of Autism Developmental Disorder,* 30(3), 205-223.

Lord, C., Rutter, M., & LeCouteur, A. (1994). Autism diagnostic interview-Revised: A revised version of a diagnostic interview for caregivers of individuals with possible pervasive developmental disorders. *Journal of Autism Developmental Disorder*, 24(5), 659-685.

Schopp, L., Johnstone, B., & Merrell, D. (2000). Telehealth and neuropsychological assessment: New opportunities for psychologists. *Professional Psychology: Research and Practice*, 31, 179-183.

Weissman, M. M., Markowitz, J. C., Klerman, King, J. K. (2013). Assessment and diagnosis of autism spectrum disorder. *Counseling Today*, 56(3), 18- 20.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treatment of mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Rhythmic Movement Disorder

Treatment:

Hoban, T. (2003). Rhythmic movement disorder in children. *CNS Spectrum,* 8(2), 135-138

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia

Assessment:

Carpenter, W. T. (2014). Porous diagnostic boundaries: A new emphasis for the bulletin. *Schizophrenia Bulletin,* 30(1), 1-2. doi:a0.1093/schbul/sbt14

Fenton, W. S., Mosher, L. R., & Matthews, S. M. (1981). Diagnosis of schizophrenia: A critical review of current diagnostic systems. *Schizophrenia Bulletin,*7(3), 452-456.

Treatment:

Tandon, R., & Jibson, M. D. (2001). Pharmacologic treatment of schizophrenia: What the future holds. *CNS Spectrum,* 6(2), 980-986.

Schizophrenia Spectrum Disorders

Assessment:

King, J. H. (2014). Assessment and diagnosis of schizophrenia spectrum disorders. *Counseling Today*, 56(9). 12-14.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Bipolar And Related Disorders

Bipolar Disorders

Assessment:

Baldassano, C. F. (2005). Assessment tools for screening and monitoring bipolar disorder. *Bipolar Disorders,* 7(Suppl. 1), 8-15.

Chung, H., Culpepper, L., DeWester, J. N., Grieco, R., Kaye, S., Lipkin, M. Rosen, S., & Ross, R. (2007). Recognizing and understanding bipolar disorder. *Journal of Family Practice*, 56. S5.

Chung, H., Culpepper, L., DeWester, J. N., Grieco, R., Kaye, S., Lipkin, M. Rosen, S., & Ross, R. (2007). Recognizing and understanding bipolar disorder at the interface of primary care and psychiatric medicine. Part 4: Treatment by phase: Pharmacologic management of bipolar disorder. *The Journal of Family Practice,* 56(11SUPPL), S19-S27.

Das, A. K., Olfson, M., Gameroff, M.J., Pilowsky, D. J., Blanco, C., Feder, A., Gross, R., Neria, Y., Lantigua,R., Shea, S., & Weissman, M. M. (2005). Screening for bipolar disorder in a primary care practice. *JAMA,* 293(8), 956-963.

King, J.H. (2014). Assessment and diagnosis of psychotic and bipolar-related disorders. *Counseling Today*, 56(11), 12-15.

Wilkinson, G.B., Taylor, P., & Holt, J. R. (2002). Bipolar disorder in adolescence: Diagnosis and treatment. *Journal of Mental Health Counseling*, 24(4), 348-357.

Treatment:

Basco, M. R., Merlock, M., & McDonald, N. (2003). Cognitive-behavioral strategies for the management of bipolar disorder. *Primary Psychiatry,* 10(5), 65-71.

Coryell, W. (2005). Rapid cycling bipolar disorder: Clinical characteristics and treatment options. *CNS Drugs*, 19(7), 557-569.

Fountoulaksi, K. N., Grunze, H., Panagiotidis, P., & Kaprinis, G. (2008). Treatment of bipolar depression: An update. *Journal of Affective Disorders*, 109, 21-34.

Rea, M. M., Thompson, M. C., Miklowitz, D., Goldstein, M. J. , Hwang, S., & Mintz, J. (2003). Family-focused treatment versus individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 71(3), 482-492.

Wilkinson, G. B., Taylor, P., & Holt, J. R. (2002). Bipolar disorder in adolescence: Diagnosis and treatment. *Journal of Mental Health Counseling*, 24(4), 348-357.

Monitoring:

Baldassano, C. F. (2005). Assessment tools for screening and monitoring bipolar disorder. *Bipolar Disorders,* 7(Suppl. 1), 8-15.

Depressive Disorders

Disruptive Mood Dysregulation Disorder

Diagnosis:

Axelson, D., Birmaher, B., Findling, R. L., Fristad, M. A., Kowatch, R. A., et al. (2011). Concerns regarding the inclusion of temper dysregulation disorder with dysphoria *in the diagnostic and statistical* manual of mental disorders, fifth edition. *Journal of clinical Psychiatry*, 72(9), 1257-1262.

Copeland, W. E., Angold, A., Costello, E. J., & Egger, H. (2013). Prevalence, comorbidity, and correlates of DSM-5 proposed disruptive mood dysregulation disorder. *American Journal of Psychiatry,* 170, 173-179.

Seligman, L., & Moore, B.M. (1995). Diagnosis of mood disorders. *Journal of Counseling and* Development, 74, 65-69.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive* systematic *guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Instruments:

Berking, M., & Znoj. H. (2008). Enwicklung und validierung eines fragebogens zur standdisierten selbsteinschatzung emotionaler kompetenzen (SEK-27) [Development and validation of the Emotion-Regulation Sills Questionnaire (ERSQ-277]. *Zeitschrift fur Psychiatrie, Psychologie und Psychotherapie*, 56, 141-153. doi: 10.1024/1661-4747.56.2.141

Radkovsk, A., McArdle, J. J., Bockting, C. L. H., & Berking, M. (2014). Successful emotion regulation skill application predicts subsequent reduction of symptom severity during treatment of major depressive disorder. *Journal of Consulting and Clinical Psychology*, 82(2), 248-262. (Emotions Regulations Skills Questionnaire) [Berking & Zoj, 2008].

Major Depressive Persistent Disorder and Cyclothynuc Disorder

Assessment:

Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus*, 8(1), 32-42. (EFT manualized effectiveness)

King, J. K. (*2014).* Assessment and diagnosis of psychotic and bipolar-related disorders. *Counseling Today,* 56(11), 12-15.

King, J. K. (2014). Assessment and diagnosis of depressive disorders and bereavement reactions. *Counseling Today*, 57(2), 12-15.

Seligman, L., & Moore, B. M. (1995). Diagnosis of mood disorders. *Journal of Counseling &* Development, 74, 65-69.

Instruments:

Hakstian, A. R., & McLean, P. D. (1989). Brief screen for depression. *Journal of Consulting and Clinical* Psychology, 1(2), 139-141.

Kurlowicz, L. & Greenberg, S. A. (2007). The Geriatric Depression Scale (GDS). *Geriatric Nursing,* 4. www.hartfordign.org, retrieved 8-21-2014.

Muller, B.E., & Erford, B.T. (2012). Choosing assessment instruments for depression outcome research with school-aged youth. *Journal of Counseling & Development,* 90(2), 208-220.

Radkovsk, A., McArdle, J. J., Bockting, C. L. H., & Berking, M. (2014). Successful emotion regulation skills application predicts subsequent reduction of symptom severity during treatment of major depressive disorder. *Journal of Consulting and Clinical Psychology*, 82(2), 248-262. (Emotions Regulations Skills Questionnaire) [Berking & Zoj, 2008].

Voelz, Z., & Joiner, T. E., Jr. (2002). The tripartite model of anxiety and depression: Implications for the assessment and treatment of depressed adults and adolescents. *Primary Psychiatry*, 9(6), 59-62.

Wilkinson, G. B., Taylor, P., & Holt, J. R. (2002). Bipolar disorder in adolescence: Diagnosis and treatment. *Journal of Mental Health Counseling,* 24(4), 348-357.

Treatment:

Barrett, J. E., Williams, J. W., Oxman, T. E., Frank, E., Katon, W., Sullivan, M., Hegel, M. T., Cornell, J. E., & Sengupta, A. S. (2001). Treatment of dysthymia and minor depression in primary care. *The Journal of* Family Practice, 50(5), 405-412.

Carney, C. E. (2013). Sleep therapy is expected to gain a wider role in depression treatment. New York Times, November 24, 2013; http: nytimes.com/ 2013 /11/24/

DeLima, M. S. & Hotopf, M. (2003). Benefits and risks of pharmacotherapy for dysthymia. *Drug Safety,* 26(1), 55-64. (Result: effective outcome evidence)

Gilliam, C. M., & Cottone, R. R. (2005). Couple or individual therapy for the treatment of depression?: An update of the empirical literature. *The American Journal of Family Therapy*, 33, 265-272.

Gintner, G. G. (1995). Differential diagnosis in older adults: Dementia, depression, and delirium. *Journal* of Counseling *& Development,* 73, 346-351.

Goldman, R. N., Greenberg, L.S., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research*, 16, 536-546. (effectiveness study for EFT)

Greenberg, L. & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research,* 8, 210-224. (*effectiveness study for EFT)

Harpin, R. E., Lieberman, R. P., Marks, I., & et al. (1982). Cognitive-behavior therapy for chronically depressed patients: A controlled pilot study. *Journal of Nervous Mental Disorders*, 170, 295-301.

Kanter, J. W., Kohlenberg, R. J. & Loftus, E. F. (2002). Demand characteristics, treatment rationales, and cognitive therapy for depression. *Prevention and Treatment,* 5, Article 41.

Kanter, J. W., Rusch, L. C., Landes, S. L., Holman, G. I., Whiteside, U., & Sedivy, S. K. (2009). The use and nature of present-focused interventions in cognitive and behavioral therapies for depression. *Psychotherapy: Research, Theory, Practice, Training,* 46, 220-232.

Markowitz, J. C. (1966). Psychotherapy for dysthymic disorder. In M. B. Keller, W. B. Sanders (Eds), *The psychiatric clinic of North America: Mood disorder,* 9(1). 133-147. (*clinical trials for effectiveness for CBT & Interpersonal therapy).

Paradise, L., & Kirby, P. (2005). The treatment and prevention of depression: Implications for counseling and counselor training. *Journal of Counseling & Development*, 83, 116-119.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Watson, J.C., Gordon, L.B., Stermac, L., Kalogerakos, F., & Steckley, P. (1998). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting Clinical Psychology,* 71, 773-781. *(effectiveness study)

Wilkinson, G. B., Taylor, P., & Holt, J. R. (2002). Bipolar disorder in adolescence: Diagnosis and treatment. *Journal of Mental Health* Counseling, 24(4), 348-357.

Monitoring:

Achenbach, T. M., & Rescoria, L. A. (2001). *Manual for the ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families**.**

Berking, M., & Znoj. H. (2008). Enwicklung und validierung eines fragebogens zur standdisierten selbsteinschatzung emotionaler kompetenzen (SEK-27) [Development and validation of the Emotion-Regulation Skills Questionnaire (ERSQ-277]. *Zeitschrift fur Psychiatrie, Psychologie und Psychotherapie*, 56, 141-153. doi: 10.1024/1661-4747.56.2.141

McHugh, K., & Behar, E. (2009). Readability of self-report measures of depression and anxiety. *Journal of Consulting and Clinical Psychology*, 77(6), 1100-1112.

Anxiety Disorders

Separation Anxiety Disorder

Treatment:

Cheer, S., & Figgitt, D. P. Spotlight on Fluvoxamine in anxiety disorders in children and adolescents. *Pediatric Drugs,* 3(10), 762-781.

Choates, M. L., Pincus, D. B., Eybert, S. M. & Barlow, D. H. (2005). Parent-child interaction therapy for treatment of separation anxiety disorder in young children: A pilot study. *Cognitive and Behavioral Practice,* 12(1), 126-135.

Dia, D. A. (2001). Cognitive-behavioral therapy with a six-year-old boy with separation anxiety disorder: A case study. *Health and Social Work*, 26(2), 125-128.

Schneider, S., Blatter-Meunier, J., Herren, C., In-Albon, T., Adornetto, C., Meyer, A., & Lavallec, K. (2013). The efficacy of a family-based cognitive-behavioral treatment for separation anxiety disorder in children aged -13: A randomized comparison with a general anxiety program. *Journal of Consulting* and Clinical Psychology, 81(5), 932-940.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Anxiety Disorders

Assessment:

Eack, S. M., Singer, J. B., & Greeno, C. G. (2006). Screening for anxiety and depression in community mental health: The Beck Anxiety and Depression Inventories. *Community Mental Health*, 44, 465-474.

Fong, M. L., & Silien, K. A. (1999). Assessment and diagnosis of DSM-IV anxiety disorders. *Journal* of *Counseling & Development,* 77, 209-217.

Frick, P. J., Silverthorn, P., & Evans, C. (1994). Assessment of childhood anxiety using structured interviews: Patterns of agreement among informants and association with maternal anxiety. *Psychological Assessment*, 6(4), 372-379.

King, J. K, (2014). Assessment and diagnosis of anxiety, somatic symptom and related disorders. *Counseling Today*, 56(12), 12-15.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Instruments:

Eack, S. M., Singer, J. B., & Greeno, C. G. (2006). Screening for anxiety and depression in community mental health: The Beck Anxiety and Depression Inventories. *Community Mental Health*, 44, 465- 474.

Jones, K. D. (2012). Dimensional and cross-cutting assessment in the DSM-5. *Journal of Counseling and* Development, 90(4), 481-487.

Treatment:

Ayers, C. R., Sorrell, J. T., Thorp, S. R., & Wetherell, J. L. (2007). Evidence-based psychological treatments for late-life anxiety. *Psychology and Aging,* 22(1), 8-17.

Clark, D. M., Ehlers, A., Hackman, A., McManus, F., Fennell, M., Grey, N., Waddington, W., & Wild, J. (2006). Cognitive therapy versus and applied relaxation in social phobia: A randomized controlled trial. *Journal of Counseling and Clinical Psychology*, 74(3), 568-578.

Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus,* 8(1), 32-42. (*EFT shows promise as a treatment for anxiety)

Gryczkowski, M. R., Tiede, M. S., Dammann, J. E., Jacobsen, A. B., Hale, L. R., & Whiteside, S. P. H. (2013). The timing of exposure in clinic-based treatment for childhood anxiety disorders. *Behavior Modification,* 37(1), 113-127.

Herbeert, J. D., Gaudiano, B. A., Moitra, E., Myers, V. H., Dalrymple, K., & Brandsma, L. L. (2009). Cognitive behavior therapy for generalized social anxiety disorder in adolescents: A randomized controlled trial. *Journal of Anxiety Disorders,* 23, 167-177.

Miller, L. D., Short, C., Garland, E. J., & Clark, S. (2010). The ABCs of CBT (Cognitive Behavior Therapy): Evidence-based approaches to child anxiety in public school settings. *Journal of Counseling and Development*, 88, 432-439.

Persons, J. B**.** (2001). Understanding the exposure principle and using it to treat anxiety. *Psychiatric Annals,* 31(8), 473, 475-476.

Thompson, J. M. (2002). Psychodynamic insight-oriented treatment of anxiety. *Primary Psychiatry,* 9(7), 43-46.

Ward, H. E., Shapira, N. A., & Goodman, W. K. (2002). Nonpharmacological somatic treatments of anxiety disorder. *Primary Psychiatry,* 9(7), 55-58.

Zimand, E., Anderson, P., Gershon, J., Graap, K., Hodges, L. & Rothbaum, B. (2002). Virtual reality therapy: Innovative treatment for anxiety disorders. *Primary Psychiatry,* 9(7), 51-54.

Panic Disorder

Treatment:

Addis, M. E., Hatgis, C., Cardemil, E., Jacob, K., Krasnow, A., & Mansfield, A. (2006). Effectiveness of cognitive-behavioral treatment for panic disorder versus treatment as usual in a manage care setting: 2-year follow-up. *Journal of Counseling and Clinical Psychology,* 74(2), 377-385.

Beamish, P. M., Granello, P. F., Granello, D. H., McSteen, P. B., Bender, B. A., & Hermon, D. (196). Outcome studies in the treatment of panic disorder: A review. *Journal of Counseling & Development,* 74, 460-467.[Outcome studies for diagnosis/assessment and treatment)

Clark, D.M., Salkovskis, P.M., Hackmann, A., Wells, A., Ludgate, J., & Gelder, M. (1999). Brief cognitive therapy for panic disorder: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 67(4), 583-589.

Gould, R. A., Otto, M. W., & Pollack, M. H. (1995). A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review*, *15*, 819-844.
Leavitt, L.T., Hoffman, E. C., Grisham, J. R., & Barlow, D. H. (2010). Empirically supported treatments for panic disorder. *Psychiatric Annals,* 31(8), 478-487.

Marchland, L., Marchland, A., Pierre Landry, P., Legate, A., & Labrecque, J. (2013). Efficacy of two cognitive-behavioral treatment modalities for panic disorder with nocturnal panic attacks. *Behavior Modification*, 35(7), 680-704.

Generalzied Anxiety Disorder

Treatment:

Brown, A. P., Marquis, A., & Guiffrida, D. A. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling & Development*, 91(1), 96-104.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685-716 Dol:10.1146/annurev. psch.52.1.685. (several clinical trials effectiveness for CBT)

Grover, R. L., Hughes, A. A., Bergman, R. L., & Kingery, J. N. (2006). Treatment modifications based on childhood anxiety diagnosis: Demonstrating the flexibility in manualized treatment. *Journal of* Cognitive Psychotherapy: An International Quarterly, 20(3), 275-285.

Newman, M.G., Castonguay, L. G., Borkovec, T.D., Fisher, A.J., Boswell, J. F., Szkodny, L.E., & Nordbert, S. S. (2011). A randomized controlled trial of cognitive-behavioral therapy for generalized anxiety disorder with integrated techniques from emotion-focused interpersonal therapies. *Journal of Consulting and Clinical Psychology*, 79(2), 171-181.

Roemer, L., Orsillo, S.M., & Salters-Pedneault, K. (2008). Efficacy of an acceptance-based behavior therapy for generalized anxiety disorder: Evaluation in a randomized trial. *Journal of Consulting and Clinical Psychology,* 76(6), 1083-1089. (ACT shows promise for GAD).

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Siqueland, L., Rynn, M. & Diamond, G. S. (2005). Cognitive behavioral and attachment based family therapy for anxious adolescents: Phase I and II studies. *Journal of Anxiety Disorders*, 19, 361-381.

Social Anxiety Disorder

Treatment:

Albano, A. M. (2003). Treatment of social anxiety disorder. In R. Reinecke, F. Datillo, & A. Freeman (Eds.), *Casebook of cognitive behavioral therapy with children and adolescents* (2nd ed., pp. 128-161.

Beidel, D. D., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology*, 68, 1072-1080.

Cheer, S., & Figgitt, D. P. Spotlight on Fluvoxamine in anxiety disorders in children and adolescents. *Pediatric Drugs,* 3(10), 762-781.

Curtis, R.C., Kimball, A., & Stroup, E. I. (2004). Understanding and treating social phobia. *Journal of Counseling & Development,* 82, 3-9.

Herbeert, J. D., Gaudiano, B. A., Moitra, E., Myers, V. H., Dalrymple, K., & Brandsma, L. L. (2009). Cognitive behavior therapy for generalized social anxiety disorder in adolescents: A randomized controlled trial. *Journal of Anxiety Disorders,* 23, 167-177.

Huppen, J. D., Strunk, D. R., Ledley, D. R., Davidson, J. R. T., & Foa, E. B. (2008). Generalized social anxiety disorder and avoidant personality disorder: Structural analysis and treatment outcome. Depression and Anxiety, 25, 441-448.

Rowa, K., & Anthony, M. M. (2005). Psychological treatments for social phobia. *Canadian Journal of Psychiatry,* 50(6), 308-316.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Monitoring:

Mezo, P. G., McCabe, R. E., Antony, M. M., & Burns, K. (2005). Psychometric validation of a monitoring-blunting measure for social anxiety disorder: The Coping Styles Questionnaire for Social Situations (CSQSS). *Depression and Anxiety*, 22(1), 20-27.

Synder, M. (1974). Self-monitoring of expressive behavior. *Journal of Personality and Social Psychology* (Vol. 12). New York: Academic Press.

Obsessive-Compulsive and Related Disorders

Treatment:

Cheer, S., & Figgitt, D. P. Spotlight on Fluvoxamine in anxiety disorders in children and adolescents. *Pediatric Drugs,* 3(10), 762-781.

Hill, N. R., & Beamish, P. M. (2007). Treatment outcomes for obsessive-compulsive disorder: A critical review. *Journal of Counseling & Development*, 85, 504-510.

King, J. K. (2014). Assessment and diagnosis of obsessive-compulsive and related disorders. *Counseling Today*, 57(4), 12-15.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Monitoring

Simpson, H. B., Maher, M. J., Wang, Y., Bao, Y., Foa, E. B., & Franklin, M. (2011). Patient adherence predicts outcome from cognitive behavior therapy in obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology*, 79(2), 247-252.

Body Dysmorphic Disorder

Assessment

King, J. K. (2014). Assessment and diagnosis of obsessive-compulsive and related disorders. *Counseling Today*, 57(4), 12-15.

Knobloch, P. (2013). Body dysmorphic disorder and teens. *Counseling Today*, (56), 6, 12-13.

Phillips, K. A. (2000). Body dysmorphic disorder: Diagnostic controversies and treatment challenges. *Bulletin of the Menniger Clinic,* 64(11), 18-35.

Treatment:

Delinsky, S. S., & Wilson, G. T. (2006). Mirror exposure for the treatment of body image disturbance. *International Journal of Eating Disorders*, 39(2), 108-116.

Phillips, K. A. (2004). Treating body dysmorphic disorder using medication. *Psychiatric Annals,* 34(12), 945-953.

Phillips, K. A., & Dufresne, R. (2000). Body dysmorphic disorder: A guide for dermatologists and cosmetic surgeons. *American Journal of Clinical Dermatologist,* 1(4), 235-242.

Seligman, L., & Reichenberg, L. W. (2012*). Selecting effective treatment: A comprehensive* systematic *guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Excoriation Disorder (Skin-Picking Disorder)

Assessment:

King, J.K. (2013). Assessment and diagnosis of PTSD and skin-picking disorder. *Counseling Today*, (56)4, 20-22.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Trichotillomania

Assessment:

White Kress, V. E., Kelly, B. L., & McCormick. (2004). Trichotillomania: Diagnosis and treatment, *Journal* of *Counseling & Development,* 82(2), 185-190.

Treatment:

McDonald (2013). Trichotillomania: Identification and treatment. *Journal of Counseling &* Development, 90(4), 421-426.

White Kress, V. E., Kelly, B. L., & McCormick. (2004). Trichotillomania: Diagnosis and treatment. *Journal of Counseling & Development,* 82(2), 185-190. *[*Antidepressants with serotonergic properties most used (Diefenbach et al., 2000)]

Monitoring:

(Azrin, Nunn and Franz (1980) research with trichotillomania clients had a 97% reduction in hair pulling for 4 weeks following the training and 87% after 22 months of therapy.)

Azrin, N. H., Nunn, R. G., & France, S. E. (1980). Treatment of hair pulling (trichotillomania): A comparative study of habit reversal and negative practice training. *Journal of Behavior Therapy and Experimental Psychiatry,* 11, 13-20.

Diefenbach, G. J., Reitman, D., & Williamson, D. S. (2000). Trichotillomania: A challenge to research and practice. *Clinical Psychology Review*, 20, 289-309

Enos, S., & Plante, T. (2001). Trichotillomania: An overview and guide to understanding. *Journal of Psychosocial Nursing & Mental Health Services*, 39, 10-16. (Habit reversal technique-HRT.

Trauma-and Stressor-Related Disorders

Adjustment Disorder

Assessment

Greenberg, W. M., Rosenfeld, D.N., & Ortega, E.A. (1995). Adjustment disorder as an admission diagnosis. *American Journal of Psychiatry,* 152(3), 459-461.

Posttraumatic Stress Disorder

Assessment:

Beck, J. G., & Coffey, S. F. (2007). Assessment and treatment of posttraumatic stress disorder after a motor vehicle collision: Empirical findings and clinical observations. *Professional Psychology: Research and Practice,* 38(6), 629-639.

Blake, D. D. (1993). Psychological assessment and PTSD: Not just for researchers. *NCP Clinical Quarterly*, 3(1), 15-17.

King, J.K. (2013). Assessment and diagnosis of PTSD and skin-picking disorder. *Counseling Today*, (56)4, 20-22.

Treatment:

Chaill, S. P., Foa, E. B., Hembree, E. A., Marshall, R. D., & Nacash, N. (2006). Dissemination of exposure therapy in the treatment of posttraumatic stress disorder. *Journal of Traumatic Stress,* 19(5), 597-610.

Elhai, J. D., Gray, M. J., Kashdan, T. B., & Franklin, C. L. (2005). Which instruments are most commonly used to assess traumatic exposure and posttraumatic effects?: A survey of traumatic stress professionals. *Journal of Traumatic Stress,* 18(5), 541-545.

Falsetti, S. A. (2003). Cognitive-behavioral therapy in the treatment of posttraumatic stress disorder. *Primary Psychiatry*, 10(5), 78-82.

Korn, D. L. (2009). EMDR and the treatment of complex PTSD: A review. *Journal of EMDR Practice and Research*, 3(4), 264-278.

Makinson, R., & Young, J. S. (2012). Cognitive behavioral therapy and the treatment of posttraumatic stress disorder: Where counseling and neuroscience meet. *Journal of Counseling & Development*, 90(2), 131-140.

Ponniah, K., & Hollon, S. D. (2009). Empirically supported psychological treatment for adult acute stress disorder and posttraumatic stress disorder: A review. *Depression and Anxiety*, 26, 1086-1109.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Van Etten, M. L., & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. *Clinical Psychology & Psychotherapy,* 5, 126-144.

Acute Stress Disorder

Treatment:

Bryant, R. A., Moulds, M. L., Guthrie, R. M., & Nixon, R. D. V. (2005). The additive benefit of hypnosis and cognitive-behavioral therapy in treating acute stress disorder. Journal of *Counseling and Clinical Psychology,* 73(2), 334-340 [controlled study-CBT-hypnosis results reflected a greater reduction in re-experiencing symptoms of posttreatment than CBT]

Ponniah, K., & Hollon, S. D. (2009). Empirically supported psychological treatment for adult acute stress disorder and posttraumatic stress disorder: A review. *Depression and Anxiety*, 26, 1086-1109.

Dissociative Disorders

Dissociative Identity Disorder

Assessment:

Steinberg, M., Rounsaville, B., & Cicchetti, D. (1991). Detection of dissociative disorders in psychiatric patients by a screening instrument and a structured diagnostic interview. *American Journal of Psychiatry*, 148, 1050-1054.

Instrument:

Bauerband, L. A., & Galupo, P. (2014). The Gender Identity Reflection and Rumination Scale: Development and psychometric evaluation. *Journal of Counseling & Development*, 92(1), 219-231.

Ellison, J. W., & Ross, C. A. (1997). Two-year follow-up of inpatients with dissociative identity disorder. *American Journal of Psychiatry*, 154(832-839.

Somatic Symptom and Related Disorders

Somatic Symptom Disorder

Assessment:

King, J. K, (2014). Assessment and diagnosis of anxiety, somatic symptom and related disorders. *Counseling Today*, 56(12), 12-15.

Treatment:

Looper, K. J., & Kirmayer, J. (2002). Behavioral medicine approaches to somatoform disorders. *Journal of Counseling and Clinical Psychology,* 70(3), 810-827. * [efficacy studies for CBT support for hypochondriasis, body dysmorphic disorder, chronic fatigue syndrome, and group treatment for BDD.]

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Feeding and Eating Disorders

Assessment:

Anderson, D.A., Lundgren, J.D., Shapiro, J.R., & Paulosky, C.A. (2004). Assessment of eating disorders: Review and recommendations for clinical use. *Behavior Modification,* 28, 763-782.

Berg, K. C., & Peterson, C. B., & Frazier, P. (2012). Assessment and diagnosis of eating disorders: A guide for professionals. *Journal of Counseling & Development,* 90(3), 262-269.

Mitchell, J.E., & Peterson, C.B. (2005). Assessment of eating disorders. *New York, NY: Guilford Press.*

Pica Disorder

Assessment:

Rapp, J. T., Dozier, C. L., & Carr, J. E. (2001). Functional assessment and treatment of pica: A single-case experiment. *Behavioral Interventions,* 16, 111-125.

Instruments:

Eberly, C. C., & Eberly, B.W. (1985). A review of the Eating Disorder Inventory. *Journal of Counseling and Development*, 64, 285-288.

Reas, D. L., Whisenhunt, B. L., Netemeyer, R., Williamson, D. A. (2002). Development of the body checking questionnaire: A self-report measure of body checking behaviors. *International Journal of Eating Disorders*, 31(3), 324-333.

Treatment:

Bell, K. E., & Stein, D. M. (1992). Behavioral treatment of pica: A review of empirical studies. *International Journal of Eating Disorders*, 11, 377-389.

Burke, L., Smith, S. L. (1999). Treatment of pica: Considering least intrusive options when working with individuals who have a developmental handicap and live in a community setting. *Developmental Disabilities Bulletin,* 27, 30-46.

Federici, A., Wisniewski, L., & Ben-Porath, D. (2012). Description of an intense dialectical behavior therapy program for multidiagnostic clients with eating disorders. *Journal of Counseling & Development,* 90, 330-338.

Binge Eating Disorder

Assessment:

Tanofsky-Kraft, M., Goosens, L., Eddy, K.T., Ringham, R., Goldschmidt, A., Yanovski, S.Z., Braet, C., Marcus, M.D., Wilfley, E.E., & Olsen, C. (2007). A multisite investigation of binge eating behaviors in children and adolescents. *Journal of Consulting and Clinical Psychology*, 75(6), 901-913. (relationship between negative emotions and loss of control in eating, sensitive to negative feedback)

Treatment:

Grilo, C. M., Crosby, R.D., Wilson, G.T., & Masheb, R. M. (2012). 12-month follow-up of fluoxetine and 1108-1113.cognitive behavioral therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology*, 80(6), 1108-1113.

Grilo, C. M., & Masheb, R. M. (2012). Predictors and moderators of response to cognitive behavioral therapy and medication for the treatment of binge eating disorder. *Journal of Consulting and Clinical Psychology*, 80(5), 897-906.

Lenz, A. S., Taylor, R., Fleming, M., & Serman, N. (2014). Effectiveness of dialectical behavior therapy for treating eating disorders. *Journal of Counseling & Development,* 92(1), 26-35.

McLean, S. A., Paxton, S. J., & Wertheim, E. H. (2011). A body image and disordered eating intervention for women in midlife: A randomized controlled trial. *Journal of Consulting and Clinical Psychology,* 79(6), 751-758.

Safer, D.L., Lock, J., & Couturier, J.L. (2007). Dialectical behavior therapy modified for adolescent binge eating disorder: A case report. *Cognitive and Behavioral Practice,* 14, 157-167.

Tanofsky-Fraff, M., Goossens, L., Eddy, K. T., Ringham, R., Goldschmidt, A., Yanovski, S.Z., Braet, C., Marcus, M.D., Wilfley, D.E., Olsen, C., & Yanovski, J. A. (2007). A multisite investigation of binge eating behaviors in children and adolescents. *Journal of Consulting and Clinical Psychology*, 75(6), 901-913.

Telch, C., Agras, W., & Linehan, M. (2001). Dialectical behavior therapy for binge eating disorder. *Journal* of Counseling and Clinical Psychology, 61, 1051-1065.

Monitoring:

Allen, H.N., & Craighead, L. W. (1999). Appetite monitoring in the treating of binge eating disorder. *Behavior Therapy,* 30(2), 253-272.

Latner, J. D., & Wilson, G.T. (2002). Self-monitoring and the assessment of binge eating. *Behavior Therapy*, 33(3), 465-477

Bulimia Nervosa, Anoxrea Nervosa

Assessment:

Anderson, D. A., Lundgren, J. D., Shapiro, J. R., & Paulosky, C. A. (2004). Assessment of eating disorders: Review and recommendations for clinical use. *Behavior Modification*, 28, 763-782.

Berg, K. C., Peterson, C. B., & Frazier, P. (2012). Assessment and diagnosis of eating disorders: A guide for professional counselors. *Journal of Counseling & Development,* 90(3), 263-269.

King, J. K. (2014). Assessment and diagnosis of feeding, eating and elimination disorders. *Counseling Today,* 56(10), 12-15.

Miller, J. E., & Peterson, C. B. (2005). *Assessment of eating disorders.* New York, NY: Guilford Press.

Shekter-Wolfson, L., Woodside, L.F., & Lackstrom, J. (1997). Social work treatment of anorexia and bulimia: Guidelines for practice. *Research on Social Work Practice*, 7(1), 5-31.

Wonderlich, S. A., & Mitchell, J. E. (1997). Eating disorders and comorbidity: Empirical, conceptual, and clinical implications. *Psychopharmacology Bulletin*, 33, 381-390.

Instruments:

Fairburn, C. G., & Cooper, Z. (1993). The Eating Disorder Examination. In C. G. Fairburn & G. T. Wilson (Eds*.), Binge eating: Nature, assessment, and treatment* (pp. 317-360). New York, NY: Guilford Press**.**

Treatment:

Appolinario, J. C., & McElroy, S. (2004). Pharmacological approaches in the treatment of binge eating disorder. *Current Drug Targets*, 5, 301-307.

Berekowitz, M., & Eisler, I. (2007). A randomized controlled trail of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry*, 164, 591-598.

Delinsky, S. S., & Wilson, G. T. (2006). Mirror exposure for the treatment of body image disturbance. *International Journal of Eating Disorders*, 39(2), 108-116.

Gowers, S. G. (2006). Evidence-based research in CBT with adolescent eating disorders. *Child and* Adolescent Mental Health, 11(1), 9-12.

Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus,* 8(1), 32-42. *(EFT shows promise as a treatment for eating disorders)

Hurst, K., Read, S., & Wallis, A. (2012). Anorexia nervosa in adolescents and Maudsley-family based treatment. *Journal of Counseling & Development*, 90, 339-345. *(Maudsley family was manualized in 2001 and 5 randomized clinical controlled efficacy studies have been conducted and several uncontrolled studies)

Johnson, W. G., Tsoh, J. Y., & Varnado, P. J. (1996). Eating disorders: Efficacy of pharmacological and psychological interventions. *Clinical Psychology Review,* 16(6), 457-478.

Lenz, A. S., Taylor, R., Fleming, M., & Serman, N. (2014). Effectiveness of dialectical behavior therapy for treating eating disorders. *Journal of Counseling & Development,* 92(1), 26-35.

Mischoulo, D., Eddy, K., Keshaviah, A., Dinescu, D., Ross, S., Kass, A., ….Herzog, D. (2011. Depression and eating disorders: Treatment and course. *Journal of Affective Disorders*, 130, 470-477.

Sandberg, K., & Erford, B. T. (2013). Choosing assessment instruments for Bulimia practice and outcome research. *Journal of Counseling & Development,* 91(3), 367-379.

Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., Winn, S., Robinson, P., Murphy, R., Keville, S., Johnson-Sabine, E., Jenkins, M., Frost, S., Dodge, L., (CBT guided self-care had slight advantage over family therapy)

Schwitzer, A. M. (2012). Diagnosing, conceptualizing, and treating eating disorders not otherwise specified: A compromise practice model. *Journal of Counseling & Development,* 90, 281-289.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Shallcross, L. (2013). Body language. *Counseling Today*, 56(1), 28-40.

Wilson, G.T., Grilo, C.M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist*, 67(3), 199-216.

Elimination Disorders

Enuresis Disorder

Assessment:

Shapira, B.E., & Dahlen, P. (210). Therapeutic treatment protocol for enuresis using an enuresis alarm. *Journal of Counseling & Development*, 89, 246-252. (Shapira and Dalen recommended the diagnostic interview for assessment attending to family genetic data, medical causes (bladder), followed by the client's willingness to participate in the treatment-alarm)

Treatment:

Shapira, B.E., & Dahlen, P. (210). Therapeutic treatment protocol for enuresis using an enuresis alarm. *Journal of Counseling & Development*, 89, 246-252.

Sleep-Wake Disorders

Assessment:

King, J. H. (2014). Assessment and diagnosis of sleep-wake disorders. *Counseling Today*, 56(7). 12-15.

Mastin, D. F., Bryson, J., & Corwyn, R. (2006). Assessment of sleep hygiene using the Sleep Hygiene Index. Journal *of Behavioral Medicine*, 29(3), 223-227.

Milner, C. E., & Belicki, K. (2010). Assessment and treatment of insomnia in adults: A guide for clinicians. *Journal of Counseling and Development*, 88(2), 236-244.

Seligman, L., & Hardenburg, S. A. (2000). Assessment and treatment of paraphilia. Journal of Counseling & Development, 78, 113.107-

Voinescu, B. I., Szentagotai, A., & David, D. (2012). Sleep disturbance, circadian preference *an*d symptoms of adult attention deficit hyperactivity disorder (ADHD). *Journal of Neural Trasm*, 119, 1195-1204.

Instruments:

Johns, M. W. (1991). A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep,* 14, 540-545.

Treatment:

Carney, B. (2013). Sleep therapy is expected to gain a wider role in depression treatment. *New Times,* November 24, 2013; http: nytimes.com/ 2013 /11/24/

Elliott, A. C. (2001). Primary care assessment and management of sleep disorders. *Journal of the* American Academy of Nurse Practitioners, 13(9), 409-417.

McCurry, S. M., Logsdon, R. G., Teri, L., & Vitiello, M. V. (2007). Evidence—based psychological treatments for insomnia in older adults. *Psychology and Aging,* 22(1), 18-27.

Rowe, S. L., Jordan, J., McIntosh, V. V. W., Carter, F. A., Frampton, C., Bulik, C. M., Joyce, P. R., & Franz, F. (2010). Does avoidant personality disorder impact on the outcome of treatment for bulimia nervosa*? International Journal of Eating Disorder,* 43, 420-427.

Seligman, L., & Reichenberg, L. W. (2012). Selecting effective treatment: A comprehensive systematic *guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Insomnia Disorder

Assessment:

Carney, C. E., Ulmer, C., Edinger, J. D., Krystal, A.D. & Knauss, F. (2009). Assessing depression symptoms in those with insomnia: An examination of the Beck Depression Inventory Second Edition (BDI-II). *Journal of Psychiatric Research,* 43(5), 576-582.

Milner, C.E., & Belicki, K. (2010). Assessment and treatment for insomnia in adults: A guide for clinicians. *Journal of Counseling and Development*, 88, 236-244.

Riemann, D., Fischer, J., Mayer, G., & Peter, H. J. (2003). The guidelines for 'non-restorative sleep': Relevance for the diagnosis and therapy of insomnia. *Somnologie, 7(2), 66-76.*

Treatment:

Edinger, J. D., & Carney, C. E. (2013). *Overcoming insomnia: A cognitive-behavioral approach, therapist guide (2nd ed.).* New York, NY: Oxford University Press.

Garland, S. N., Carlson, L. E., Stephens, A. J., Antle, M. C., Samuels, C., & Campbell, T. S. (2014). Mindfulness-based stress reduction compared to cognitive behavioral therapy for the treatment of insomnia. *Journal of Clinical Psychology*, 32(5), 449-459.

Harvey, A. G., Belanger, L., Talbot, L., Eidelman, P., Beaulieu-Bonneau, S., Fortier-Brochu, E. F., Ivers, H., Lamy, M., Hein, K., Soehner, A., Me'rette, C., & Morin, C. M. (2014). Comparative efficacy of behavior therapy, cognitive therapy, and cognitive behavior therapy for chronic insomnia: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 82(4), 670-683.

Morin, C. M., Hauri, P. J., Espie, C. A., Spielman, A. J., Buysse, D. J., & Bootzin, P. R. (1999). Nonpharmalogical treatment of chronic insomnia. *An American Academy of Sleep Medicine Review*. 22(8), 1134-1156.

Vincent, N. L., & Samatha-Finnegan, H. (2008). Barriers to engagement in sleep restriction and stimulus control in chronic insomnia. *Journal of Consulting and Clinical Psychology,* 76(5), 820-828.

Instrumentation:

Duke Structured Interview for Sleep Disorders (DSISD), Structured Interview for Psychiatric Disorders, Patient Version (SCID-P), Insomnia Symptom Questionnaire (ISQ; Spielman, Saskin, & Thorpy, 1987), *Sleep Hygiene Index* (Mastin, Bryson, & Corwyn, 2006)

Mastin, D. F., Bryson, J., & Corwyn, R. (2006). Assessment of sleep hygiene using the Sleep Hygiene Index. *Journal of Behavioral Medicine,* 29(3), 223-227.

Monitoring:

Carney, C. E., Buysse, D. J., Ancoli-Israel, E. , Edinger, J. D., Krystal, A. D., Lichstein, K. L., & Morin, C. M. (2012). The consensus sleep diary: Standardizing prospective sleep-monitoring. *Sleep*, 35(2), 287-302.

Sexual Dysfunctions

Sexual Disorders

Assessment:

Frank, J. E., Mistretta, P., & Will, J. (2008). Diagnosis and treatment of female sexual dysfunction. *American Family Physician*, 77(5), 636-645.

Goodman, A. (1993). Diagnosis and treatment of sexual addiction. *Journal of Sex & Marital Therapy,* 19(3), 225-251.

Greiner, K. A., & Weigel, J. W. (1996). Erectile dysfunction. *American Family Physician,* 54(5), 1675-1682. [Article includes: physiology, assessment, and treatment]

King, J. H. (2014). Assessment and diagnosis of sexual and gender-related disorders. *Counseling Today*, 56(8), 12-15.

Seligman, L., & Hardenburg, (2000). Assessment and treatment of paraphilias. *Journal of Counseling* Development, 78, 107-113.

Instruments:

Author (1995). *Assessment for Sexual Interest.* Atlanta, GA: Able Screening Inc.

Chambless, D., & Lifshitz, J. (1984). Self-reported sexual anxiety and arousal: The expanded Sexual Arousability Inventory. *Journal of Sex Research,* 20, 241-254.

Treatment:

Moulden, H. M., & Marshall, W. L. (2005). Hope in the treatment of sexual offenders: The potential application of hope theory. *Psychology, Crime, & Law,* 11(3), 329-342.

Priest, R., & Smith, A. (1992). Counseling adult sex offenders: Unique challenges and treatment paradigms. *Journal of Counseling & Development*, 71, 27-32.

Segraves, R. T., & Althof, S. (1998). Psychotherapy of sexual dysfunctions. In P. Nathan & J. Gorman (Eds.), *A guide to treatments that work* (pp. 447-471). New York: Oxford University Press.

Seligman, L., & Reichenberg, L. W. (2012). Selecting effective treatment: A comprehensive systematic *guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Gender Dysphoria

Gender Dysphoria Disorder

Assessment:

King, J. H. (2014). Assessment and diagnosis of sexual and gender-related disorders. *Counseling Today*, 56(8), 12-15.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Disruptive Impulse-Control and Conduct Disorder

Assessment:

King, J. H. (2014). Assessment and diagnosis of disruptive, impulse-control and conduct disorder. *Counseling Today*, 57(30), 12-15.

Conduct Disorder

Assessment:

Searight, H. R., Rottnek, F., & Abby, S. L. (2001). Conduct disorder: Diagnosis and treatment in primary care. *American Family Physician*, 63(8), 1579-1588.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1998). Assessment and diagnosis of conduct disorder. *Journal of Counseling & Development*, 76, 1899-197.

Treatment:

Mpofu, E. (2002). Psychopharmacology in the treatment of conduct disorder children and adolescents: Rationale, prospects, and ethics. *South African Journal of Psychology*, 32(4), 9-21.

Oppositinal Defiant Disorder

Assessment:

Harvey, E.A., Metcalfe, L.A., Herbert, S.D., & Fanton, J.H. (2011). The role of family experiences and ADHD in the early development of oppositional defiant disorder. *Journal of Consulting and Clinical Psychology*, 79(6), 784-795.

Instruments

Erford, B. T., Paul, L. E., Oncken, C., Kress, V. E., & Erford, R. (2014). Counseling outcomes for youth with oppositional behavior: A meta-analysis. *Journal of Counseling & Development,* 92, 13-24.

Treatment

Erford, B.T., Paul, L. E., Oncken, C., Kress, V. E. & Erford, M. R. (2014). Counseling outcomes for youth with oppositional behavior: A meta-analysis. *Journal of Counseling & Development,* 92(1), 13-24.

Intermittent Explosive Disorder

Assessment:

Olvera, R. L. (2002). Intermittent explosive disorder: Epidemiology, diagnosis, and management. *CN Drugs*, 16(8), 517-526.

Treatment:

McCloskey, M. S., Noblett, K. L., Deffenbacher, J. L., Gollan, J. K., & Coccaro, E. F. (2008). Cognitive-behavioral therapy for intermittent explosive disorder: A pilot randomized trial. *Journal of Consulting and Clinical Psychology*, 76(5), 876-886.

Kleptomania

Treatment:

Dannon, P.N. (2002). Kleptomania: An impulse control disorder. *International Journal of Psychiatry in Clinical Practice*, 6, 3-7**.**

Substance-Related and Addictive Disorders

Assessment:

Evans, W. (1998). Assessing and diagnosis of the substance use disorders (SUDS). *Journal of Counseling & Development,* 76(3), 325-334.

Weigel, D.J., Donovan, K.A., Krug, K.S., & Dixon, W.A. (2007). Prescription opioid abuse and dependence: Assessment strategies for counselors. *Journal of Counseling & Development*, 85, 211-215.

Treatment:

Kleber, H. D. (2003). Pharmacologic treatments for heroin and cocaine dependence. *The American Journal on Addictions*, 12, S5-S18.

Maxwell, S., & Shinderman, M. s. (2000). Use of naltrexone in the treatment of alcohol use disorders in patients with concomitant major mental illness. *Journal of Addictive Diseases*, 19(3), 61-69.

Rivto, P., Lewis, M. D., Irvine, J., Brown, L., Matthew, A., & Shaw, B. F. (2003). The application of cognitive-behavioral therapy in the treatment of substance abuse. *Primary Psychiatry,* 10(5), 72-77.

Schulz, J. E. & Parran, T., Jr. (1988). Principles of identification and intervention (screening, assessment, intervention, monitoring, and follow-up care). *American Society of Addiction Medicine* (chapter 1). 249-304.

Sofuoglu, M., & Kosten, T. (2005). Novel approaches to the treatment of cocaine addiction. *CNS Drugs*, 19(1), 13-25.

Stein, D. J. (1995). Cognitive therapy of substance abuse. *Journal of Cognitive Psychotherapy*, 9(2), 120-135.

Instrument:

McLellan, A. T., Luborsky, L., Woody, G. E., & O'Brien, C. P. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. *The Journal of Nervous and* Mental Diseases, 16, 26-33.

Monitoring:

Leibert, T. W. (2006). Making change visible: The possibilities in assessing mental health counseling outcomes. *Journal of Counseling & Development,* 84 (2), 108-113.

Neurocognitive Disorders

Neurocognitive Disorders

Assessment:

King, J. K. (2013). Assessment and diagnosis of neurocognitive disorders. *Counseling Today,* 56(6), 20-22.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Alzheimer Disorder:

Assessment:

Villareal, D., & Morris, J. (1999). The diagnosis of Alzheimer's disease. *Journal of Alzheimer's disease,* 2, 249-263.

Instruments:

Bland, R. C., & Newman, S. C. (2001). Mild dementia or cognitive impairment: The Modified Mini-Mental State Examination (3MS) as a screen for dementia. *Canadian Journal of Psychiatry*, 46, 506-510.

Dementia Disorder

Assessment

Gintner, G. G. (1995). Differential diagnosis in older adults: Dementia, depression, and delirium. Journal of Counseling & Development, 73, 346-351.

Instruments:

Alexopoulos, G., Abrams, R. C., Young, R. C., & Shamoian, C. A. (1988). Cornell Scale for depression in dementia. *Biological Psychiatry,* 23, 271-284.

Bland, R.C., & Newman, C. (2001). Mild dementia or cognitive impairment: The Modified Mini-Mental Examination (3MS) as a screen for dementia. *Canadian Journal of Psychiatry,* 46(6), 506-510.

Logsdon, R.G., McCurry, S.M., & Teri, L. (2007). Evidence-based psychological treatments for disruptive behaviors in individuals with dementia. *Psychology and Aging*, 22(1), 28-36.

Yesavage, J. A., Brink, T. L., Rose, T. L., Lum, O., Huang, V., Adey, M., & Leirer, V. O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Psychiatric Research,* 17(1), 37-49.

Treatment:

Logsdon, R. G., McCurry, S. M., & Teri, L. (2007). Evidence-based psychological treatments for disruptive behaviors in individuals with dementia. *Psychology and Aging,* 22(1), 28-36.

Personality Disorders

Assessment:

Fong, M. (1995). Assessment and DSM-IV diagnosis of personality disorders: A primer for counselors. *Journal of Counseling & Development,* 73, 35-639.

Glickauf-Hughes, C., & Mehlman, E. (1995). Narcissistic issues in therapists: Diagnostic and treatment considerations. *Psychotherapy*, 32(2), 213-221.

Graham, J. R. (2006). MMPI-2: *Assessing personality and psychopathology* (4th ed.). NY: Oxford University Press.

Hope, D. A., Herbert, J. D., & White, C. (1995). Diagnostic subtype, avoidant personality disorder, and efficacy of cognitive-behavioral group therapy for social phobia. *Cognitive Therapy and Research,* 19(4), 399- 417.

Perry, J. C., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy personality disorders. American Journal of Psychiatry, 156(9), 1312-13221.

Ward, R. (2004). Assessment and management of personality disorders. *American Family Physician,* 70(8), 1505-1513.

Instruments:

Leising, D., Rehbein, D., & Eckardt. (2009). The Inventory of Interpersonal Problems (IIP-64) as screening measure for avoidant personality disorder. *European Journal of Psychological Assessment*, 25(1), 16-22.

Treatment:

Hofmann, S. G. (2007). Treating avoidant personality disorder: The case of Paul. Journal of Cognitive Psychotherapy: An International Quarterly, 21(4), 346-352.

Huppen, J. D., Strunk, D. R., Ledley, D. R., Davidson, J. R. T., & Foa, E. B. (2008). Generalized social anxiety disorder and avoidant personality disorder: Structural analysis and Treatment outcome. *Depression and Anxiety*, 25, 441-448.

Kiehn, B., & Swales, M. (2010). *An overview of dialectical behavior therapy in the treatment of borderline personality disorder*. http://priory.com/dbt.htm.

Kliem, S., Kroger, C., & Kosflder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects models. *Journal of Consulting and Clinical Psychology*, 78(6), 931- 951.

Links, P. S. (2002). The role of couple therapy in the treatment of narcissistic personality disorder. *American Journal of Psychotherapy*, 56(4), 522-539.

Livesley, W. J. (2005). Principles and strategies for treating personality disorder. *Canadian Journal of Psychiatry*, 50(8), 442-450.

Rowe, S. L., Jordan, J., McIntosh, V. V. W., Carter, F. A., Frampton, C., Bulik, C. M., Joyce, P. R., & Frsnz, F (2010). Does avoidant personality disorder impact on the outcome of treatment for bulimia nervosa*? International Journal of Eating Disorder,* 43, 420-427.

Borderline Personality Disorder

Treatment:

Brown, A. P., Marquis, A., & Guiffrida, D. A. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling & Development,* 91(1), 96-104.

Kliem, S., Droger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting* and *Clinical Psychology*, 78(6), 936-951.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *Lancet*, 34, 453-461.

Oldham, J. M. (2006). Borderline personality and suicidality. *American Journal of Psychiatry,* 63, 20-26.

Ost, L. G. (2008). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy,* 46, 296-321.

Paraphilic Disorders

Relational Clinical Attention

Treatment:

Elliott, R., Greenberg, L., & Leiter, G. (2004). Research on experiential psychotherapy, in Begin and Garfield, *Handbook of psychotherapy and behavior change*. New York, John Wiley & Sons.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schlinder, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Science Practice,* 6, 67-79. [effectiveness study for relational-individual]

Couples Counseling

Treatment:

Angus, L. (2012). Toward an integrative understanding of narrative and emotion processes in emotion-focused therapy of depression: Implications for theory, research and practice. *Psychotherapy Research,* 22(4), 367-380.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schlinder, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Science Practice,* 6, 67-79. [effectiveness study)

Bereavement

Assessment:

Fox, J., & Jones, K. D. (2013). DSM-5 and bereavement: The loss of normal grief. *Journal of Counseling &* Development, 91(1), 113-119.

King, J. K. (2014). Assessment and diagnosis of depressive disorders and bereavement reactions. *Counseling Today*, 57(2), 12-15.

Suicide

Kirkwood, A., & Bennett, L. 2014). The shift from "No harm contracts" to safety plans" for suicide prevention and treatment: A review of the literature. Idaho State University Institute of Rural Health. Retrieved http://wwwo.isu.edu/irh/projects/better)todays/B2T2Virtual Packet/Suicide Prevention/Safety, 4-26-214.

Main, T. (2012). The top 10 reasons against the use of no-suicide contracts. *Genesee Health Systems*. retrieved 8-26-2014 www.gencmh.org/News/Qaulity matters/tabid/315 Article 129

McMyler, C., & Pryjmachuk, S. (2008). Do 'no suicide' contracts work? Journal of *Psychiatric MentaHealth Nursing*, 15(6), 512-522. *(lack of quantitative evidence and ethical issues regarding coercion on part of therapist and service user's issues with 'control')

Outcome Research Articles

Author. (2006). Evidence-based practice in psychology. *American Psychologist,* 61(4), 271-285.

Baker, S., (2012). A new view of evidence-based practice. *Counseling Today*, 42-43.

Clancy, C. M., & Eisenberg, J. M. (1998). Outcomes research: Measuring the end results of health care. *Science Compass,* 282, 245-246.

Deacon, B. J., & Abramowitz, J. S. (2004). A pilot study of two-day cognitive-behavioral therapy for panic disorder. *Behaviour Research and Therapy*, 44, 807-817.

Drake, R. E., Goldman, H. H., Leff, S., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W. C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services,* 52(2), 179-182. 1176-1179.

Goldman, R. N., Greenberg, L.S., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of Depression. *Psychotherapy Research*, 16, 536-546. (effectiveness study for EFT)

Greenberg, L. & Watson, J. (1998). Experiential therapy of depression: Differential effects of client centered relationship conditions and process experiential interventions. *Psychotherapy Research,* 8, 210-224. (effectiveness study)

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z. & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist,* 51(10), 1059-1064.

Johnson, W. G., Tsoh, J. Y., & Varnado, P. J. (1996). Eating disorders: Efficacy of pharmacological and psychological interventions. *Clinical Psychology Review,* 16(6), 457-478.

Krumboltz, H. M. (2009). Cardiovascular quality ad outcomes: Outcomes research. *AHA Journals,* 2, 1-3. http://ciroutcomes, ahajournals.org/contennt2/1/1.

Lambert, M. J., & Cattani-Thompson, K. (1996). Current findings regarding the effectiveness of counseling: Implications for practice. *Journal of Counseling & Development,* 74, 601-607.

Lambert, M. J., & Shimokawa, J. (2011). Collecting client feedback. *Psychotherapy,* 48(1), 72-70.

Leibert, T. W. (2006). Making change visible: The possibilities in assessing mental health counseling outcomes. *Journal of Counseling & Development,* 84, 108-113.

Meyers, J. E., & Harper, M. C. (2004). Evidence-based practice with older adults. *Journal of Counseling & Development*, 82(2), 202-218. (Interventions for sleep disturbances, anxiety disorders, depression dementia, and substance abuse,)

Roysircar, G. (2009). Evidence-based practice and its implications for culturally sensitive treatment. *Multicultural Counseling and Development*, 37, 66-81.

Sexton, T. L. (1999). Evidence-based counseling: Implications for counseling practice, preparation, and professionalism. *Eric Digest,* EDO-CG-99-9.

Spinnazola, J., Blaustein, M., & van der Kolk, B. A. (2005). Posttraumatic stress disorder treatment outcome research: The study of unrepresentative samples. *Journal of Traumatic Stress,* 18, 425- 436.

Stewart, R. E., & Chambless, D. L. (2009). Cognitive-Behavioral therapy for adult anxiety disorders in clinical practice: A meta-analysis of effectiveness studies. *Journal of Consulting and Clinical Psychology,* 77(4), 595-606. (CBT effective for: panic disorder, social anxiety, obsessive-compulsive generalized anxiety, and Posttraumatic stress disorders (Deacon & Abramowitz, 2004)

Uppgaard, R. O. (1996). Outcome- based research has an important place I the scientific community. *British Medical Journal*, 312, 71-72.

VandenBos, G. R. (1996). Outcome assessment of psychotherapy. *American Psychologist,* 51(10), 1005-1006.

Watson, J.C., Gordon, L.B., Stermac, L., Kalogerakos, F., & Steckley, P. (1998). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting Clinical Psychology,* 71, 773-781. (effectiveness study)

Weisz, J. R., & Hawley, K. M. (2001). *Procedural and coding manual for identification of evidence-based treatments*. Los Angeles: University of California.

Whiston, S. C., & Sexton, T. L. (1993). An overview of psychotherapy outcome research: Implication for practice. *Professional Psychology: Research and Practice*, 24(1), 43-51.

4. APPENDICES

Evidence-Based Treatments for Children & Adolescents (Selected Disorders)

Two different treatment classifications may be noted in the following efficacious treatment criteria for respective disorders. These descriptions are modified to provide an over-view of the specific requirements to be met for three efficacious ratings.

1. Chambless et al. (1996, 1998) are as follows:

Well-established interventions (WE) include:

(a) superior to pill placebo or alternative treatment, or (b) equivalent to an already-established treatment. Two good research group designs in two independent research settings by an independent investigatory team and is statistically superior to pill or psychological placebo or to another treatment. The intervention is to use a manualized manual or equivalent, conducted with a group treated for a specific problem, employ a valid and reliable assessment measure with appropriate data analyses.

Probably efficacious (PE) interventions demonstrate either:

(a) more effective than no treatment control group in at least two well-conducted group design studies or (b) is superior to pill placebo or alternative treatment in two group-design studies and is statistically superior to a wait-list group.

Possibly efficacious interventions include:

(a) are superior to no treatment and waitlist control group in at least one study, and (b) possibly conducted by one team thus pending replication (Chambless & Ollendick, 2001).

Experimental treatment:

2. Nathan and Gorman (2002) is as follows:

Type 1 studies: (most rigorous scientific evaluations using randomized design, clinical trials, comparison groups, blind assessment, inclusion and exclusion criteria, state-of-the-art diagnosis, adequate sample sizes to power the analyzes, clearly described statistical methods

Type 2 studies: Clinical trials, comparison groups to test intervention, some flaws because some aspect of Type I criteria is omitted or missing. An example might the lack of randomization

Type 3 studies: Studies have significant methodological flaws, these may include pre-post uncontrolled studies and retrospective designs. The studies may be open trials and considered pilot studies

Type 4: Secondary analysis articles or reviews (meta-analysis)

Type 5: Do not include secondary data analysis

Type 6 studies: Case studies, essays, and opinion papers

In the following disorders Chambless, et al. (1996) and Nathan and Gorman (2002) classifications were a part of each efficacious article summary.

Autism

Evidence-based treatment:

Rogers and Vismara (2008) conducted an evidence-based review of autism treatments. Twenty-two randomized controlled design studies classified according to Chambless, et al. (1996) and Nathan and Gorman (2002) efficacious definitions were identified. There were 4 Type I, 6 Type 2, 11 Type 3 and 1 Type six studies published during the years 1998 through 2006. The treatments that met criteria for efficacious programs include:

Well-established:

Lovaas model-Early Intensive behavioral intervention (EIBI; Lovaas 1981, 1987, 2002). This therapy program was approved by the United States General Surgeon's office in 1999. The therapy intervention is applied behavioral analysis (ABA).

Possibly efficacious

None

Probable efficacious

Focused Parent Training (FPT): Caregiver-based intervention (Special child care worker assigned, 15 hour classes over 12 week communication development. The focus is compliance, mutual enjoyment, joint attention and language (Jocelyn, Casiro, Beattie, Cox, & Kneisz, 1998)

Relationship Development Intervention (RDI): Parent-training intervention (PTI): Home-based, parent-delivered developmental social communication intervention; Drew, Baird, Baron-Cohen, Cox, Solonims, Wheelwright, et al., 2002)

Parent-implemented Training (PIT): Social communication intervention (community care, speech and social skills training, manualized parent-delivered program language intervention; Aldred, Green, & Adams, 2004)

Tellegen and Sanders (2014) conducted a single randomized control trial efficacy treatment study. The authors reported efficacious outcome for Primary Care Stepping Stones Triple P. Triple P is a brief four sessions devoted to reduce child problems and improve parent styles, parenting satisfaction, and parental adjustment.

Tellegen, C. L., & Sanders, M. R. (2014). A randomized controlled trail evaluating a brief parenting program with children with autism spectrum disorders. *Journal of Consulting and Clinical Psychology,* 82(6), 1193-1200.

Instruments:

Instrument measures in the 22 efficacious treatments included:

1. Autism Diagnostic Interview (ADI; Lord, Rutter, & LeCouteur, 1994)
2. Autism Observation Schedule (ADOS; Lord et al., 2000)
3. The Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1984)
4. The MacArthur Communicative Developmental Inventory (Fenson et al., 1993)

Attention Deficit/Hyperactivity Disorder (Child & Adolescent)

Pelham and Fabiano (2008) conducted an evidence-based ADHD study using published empirical studies for the years 1997 to 2006. The authors reported that behavioral parent training (BPT) and behavioral classroom management (BCM) met well-established criteria. Of the 46 studies under review 2 were BPT (mainly group based treatments), 22 BCM studies that utilized contingency management procedures, and 22 were peer interventions and relationships (BPI). Behavioral peer interventions (BPI) focused on peer interactions and relationships such as social skills training, group-based, and office-based approaches had minimal effects. In summary the results of this efficacious study included:

Well-established:

Behavioral Parent Training (BPT)

Behavioral Classroom Management (BCM)

Intensive program-based peer interventions (BPI)

In summary, Pelham and Fabiano reported different guideline recommendations for psychopharmacological intervention (stimulants). The AMA indicated 'may include' pharmacotherapy, AAP 'should recommend' medication, and AACAP treatment 'may consist' of pharmacological intervention.

Phobic and Anxiety Disorder

Evidence-based analysis regarding anxiety treatment for children and adolescents was conducted by Silverman, Pina, and Viswesvaran (2008). Thirty-two peer reviewed anxiety studies were analyzed to determine if efficacious criteria were met for one of the six types (well-established, probably-efficacious treatments, possibly-efficacious treatments, and experimental treatments). Most of the 32 studies were classified as Type 1. Eight studies met Type II 2 criteria and three studies met criteria for Type 3. Findings indicated that none of the 32 studies met criteria for well-established. Individual cognitive behavior therapy (ICBT), group cognitive behavior therapy (GCBT), GCBT with parents, GCBT for social phobia (SOP), and SET-C for SOP met criteria for probably efficacious (Silverman, Pina, & Viswesvaran, 2008).

Well established (WE):

None

Possibly efficacious:

Individual cognitive behavior therapy (ICBT), group cognitive behavior therapy (GCBT), GCBT with parents, GCBT for social phobia (SOP)

Probably efficacious:

SET-C for SOP met probably efficacious

Instruments:

Silverman, Pina, and Viswesvaran, (2008) reported the most widely used youth self-rating scales 1, 2, and 3 below and for parents the Child Behavior Checklist.

1. Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1987)
2. Children's Depression Inventory (CDI; Kovacs, 1992)
3. Fear Survey Schedule for children-Revised (FSSC-R; Ollendick, 1983)
4. Child Behavior Checklist (CBCL; Achenbach, 1991), most widely used

Obsessive-Compulsive Disorders

Treatment:

(Lewin & Piacentini, 2010) Evidence-based treatment for OCD regarding children was evaluated by Barrett et al. (2008) for effectiveness. The authors analyzed 50 peer-reviewed OCD empirical studies. Of the 21 studies 2 met criteria for Type 1 effectiveness, 4 met criteria for Type 2 and the remaining were classified as Type 3, uncontrolled. Findings indicated that none of the 21 studies met criteria for well-established, exposure-based ICBT was probably efficacious and possibly efficacious for family focused GCBT and family-focused ICBT

Well-established (WE):

None

Probably efficacious (PE):

Individual exposure-based ICBT plus medication

Possibly efficacious:

Family-focused individual ICBT or family-focused GCBT

Instruments:

(used in studies-most frequent)

1. Children's Yale-Bown Obsessive Compulsive Scale (CY-BOCS; Schahill et al., 1997)

Feeding and Eating Disorders

Efficacious Treatment:
(child & adolescents)

Keel and Haedt (2008) conducted an eating problems and eating disorder efficacious study for the years 1985-2006. The efficacious study included Type I (2), Type II (10) for young adolescents (ages 11-20) and 49 empirical studies for adults aged 17-65. The majority of the studies related to bulimic nervosa (BN). In the adult studies CBT is the treatment of choice for older adolescents. CBT is the treatment of choice for

adolescents (ages 18 to 21). The Maudsley model of family therapy is the most widely used treatment for children and adolescents (emphasizing family organization and interaction, facilitating eating and weight gain (parables, paradoxes, personal authority, rationalizations, & psychodynamic interpretation), and homework

Well established (WE):

Family therapy

Probably efficacious:

None

Possibly efficacious:

Psychoanalytic therapy, Cash's Body Image Therapy, Family therapy for BN, CBT Guided Self-Care for Binge Eating in BN.

Instruments:

The efficacious studies were not about instruments; therefore, not necessarily considered the best. They are listed in terms of frequency of use in the studies.

1. Eating Attitudes Test (Garner & Garfinkel, 1979, Garner, et al., 1982)
2. Eating Disorder Inventory
3. Restraint Scale
4. Bulimic Investigatory Test Edinburgh

Conduct and Oppositional Disorders

Efficacious Treatment:

Eyberg, Nelson, and Boggs (2008) conducted an evidenced-based study for the years 1996 to 2007 regarding psychosocial treatment for children and adolescents with disruptive behavior (conduct and oppositional defiant disorders). The review included 20 Type I studies and 14 type II studies in addition to specific information regarding sample type, child race, sex, and age.

Well-established efficacious (WE):

Parent management training Oregon mode PMTO).

Probably efficacious (PE):

Anger control training, group assertive training, helping the noncompliant child (HNC), incredible years parent training (IY-PT), Incredible years child training (IY-CT), incredible years (IY), multidimensional treatment foster care (MTFC), multisystemic therapy (MST), parent-child interaction therapy (PCIT), positive parenting program, Triple P enhance treatment, problem-solving skills training (PSST), PSST + practice, PSST + parent (PSST + PMT), rational-emotive mental health program (REMH)

Instruments:

(used in studies)

1. Parent report was used in 22 studies
    a. Child Behavior Checklist (Achenbach, 1991)

b. Eyberg Child Behavior Inventory (Eyberg Pincus, 1997)

c. Revised Behavior Problem Checklist (Quay & Peterson, 1987)

2. Teacher report was used in 13 studies

a. Teacher Report Form (Achenbach, 1991)

b. Conners Teaching Rating Scale (Conners, Sitarenious, Parker, & Epsteing, 1998)

Depression

Efficacious Treatment:
(Children & Adolescents)

David-Ferdon and Kaslow (2008) conducted a review of empirical studies for efficacious treatment of depression. Studies represented the time period of 1988 to 2006. The efficacious evaluation was composed of (28) randomized controlled trial design studies. Two age groups were addressed, 12 and under (10 studies) and adolescent 13 and older (18 studies). The studies for the 12 and under group represented Type 2 efficacy. The adolescent group had 10 Type 1 and 18 Type 2 efficacious ratings.

Well-established:

Child group only and child group parent met criteria for well-established.

Probably efficacious:

CBT Penn state program, self-control therapy, coping with depressant adolescent, and interpersonal therapy-adolescent met probably efficacious.

Theoretical Orientation:

Well-established (WE):

Cognitive Behavioral Treatment (10 studies), Group, child only (6 studies), Child group plus parent component (2 studies),

Probably Efficacious (PE):

Behavior therapy

Penn Prevention Control Enhancement (4 studies), Self-control therapy (2 studies), behavior therapy (2 studies)

Experimental (interventions): Individual video self-monitoring (1 study), parent-child (1 study), Primary and secondary control enhancement training (1 study), Stress-Busters (1 study), family systems (1 study), child group plus parent intervention (1 study), systems integrative family therapy (1 study), group, child only, relaxation training (1 study), child group plus parent/teacher consultation, social skills training (1 study)

Type 3: Possibly Efficacious

None

Instruments:

1. Depression Inventory (CDI; Kovacs, 1992)-most often used

2. Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991)
3. Schedule for Affective Disorders and Schizophrenia for Children (K-SADS; Chambers, et al., 1985) most often used for diagnostic tool

Trauma (PTSD)

Evidence-based treatment for children and adolescents exposed to trauma was evaluated by Silverman et al. (2008) for effectiveness. The study analyzed published randomized controlled research for the years 1992-2006. The authors analyzed 23 peer-reviewed studies regarding sexual abuse (11 studies), physical abuse (3), community violence (1), major hurricane (1), marital violence (1), and vehicle accident (1). Seven of the studies were classified as Type 2 and 16 Type 1.

Well-established (WE):

Trauma-focused behavioral therapy (TF-CBT)

Probably efficacious (PE):

School-based group cognitive-behavioral, cognitive-behavioral intervention in schools

Possibly efficacious:

Resilient Peer Treatment (RPT), Family Therapy (FT), Client-Centered Therapy (CCT) Cognitive-Processing Therapy, Child-Parent psychotherapy (CPP), Cognitive-Behavioral Therapy for PTSD, Eye Movement Desensitization and Reprocessing (EMDR)

Substance (adolescent)

Efficacious Treatment:

(adolescents)

Evidence-based treatment for adolescent substance abuse was evaluated for effectiveness (Waldron and Turner, 2008). The authors analyzed 17 peer-reviewed empirical studies from 1998 to 2006. The 17 studies included 46 interventions and were analyzed for efficacious outcome. Fourteen of the studies were classified as well-established (Type 1) and three probably efficacious. Interventions included individual CBT (7 replication studies), group CBT (13 replications), family therapy (17 replications), and 9 minimal control condition studies. The results included:

Well-established (WE):

Multidimensional family (MDFT), functional family therapy (FFT), group CBT

Probably efficacious (PE):

Multisystematic therapy (MST), brief strategic family therapy (BSFT), Behavior family therapy (BFT)

Adult Efficacious Treatments

DeRubeis and Crits-Christoph (1998) conducted a review of effective treatments for 10 adult psychological disorders as defined by Chambless and Hollon's (1998) efficacy criteria. Studies published in 15 professional journals during the years 1993 to 1998 were included in the review. Even though there have been numerous effectiveness replication studies for many of these disorders the majority of the studies were published during the 1980's with the majority in the 1990's to 1996. In addition caution is to be exercised as each of the disorder evaluations were conducted with a limited number of randomized trials. This list is a work-in-progress and current meta-analysis reports will be included as they appear in the literature.

This review conducted during 1998 was based on the criteria included:

Efficacious:

Treatment has been found to be efficacious in at least two studies by two independent research teams

Possible efficacious:

Treatment in one study that is efficacious or if all of the research has been conducted by one team as possibly efficacious pending replication (Chambless & Hollon, 1998).

Major Depressive Disorder

Well-efficacious:

Cognitive therapy, cognitive-behavior therapy effective for relapse prevention, cognitive-behavioral with medication, and behavior therapy, interpersonal therapy, and psychodynamic interpersonal psychotherapy

Possibly efficacious:

Problem-solving therapy

Generalized Anxiety Disorder (GAD)

Nine clinical trial studies were reviewed for efficacious treatment for GAD and all but one study reported that cognitive therapy was more effective than pill placebo, wait-list, and nondirective therapy.

Well-efficacious:

Cognitive therapy, applied relaxation, and cognitive-behavioral therapy is a 'specific' treatment

Agoraphobic Disorder

Well-efficacious:

Exposure therapy

Social Phobia Disorder

Well-efficacious:

Exposure therapy alone, exposure plus cognitive restructuring (CBT)

Panic Disorder

Eleven clinical trial studies conducted during the years 1993 to 1998 were utilized for evaluating treatment efficacy. The 11 cognitive therapy trial studies were compared to different treatments. Some of these comparison treatments included a wait list, applied relaxation, brief supportive psychotherapy, exposure based treatment, and no treatment.

Well-efficacious:

Cognitive therapy (panic control therapy; PCT), Exposure therapy, applied relaxation

Obsessive-Compulsive Disorder

Well-efficacious:

Exposure and response prevention (ERP),

Possibly efficacious:

Cognitive therapy

Posttraumatic Stress Disorder

Well-efficacious:

Exposure (behavior therapy)

Possible efficacious:

Stress inoculation therapy, eye movement desensitization (EMDR)

Schizophrenia Disorder

Well-efficacious:

None

Possibly Efficacious:

Social skills training

Alcohol Abuse-Dependence

Well-efficacious:

None

Possibly efficacious:

Social skills training, cue exposure and "urge coping skills" therapy plus coping skills training and social skills training

Substance 'Use' (Abuse-Dependence)

Well-efficacious:

None

Possibly efficacious:

Supportive-expressive therapy for opiate dependence and cognitive therapy for opiate dependence, supportive-expressive (SE) plus drug counseling (DC), and cognitive therapy plus drug counseling.

Insomnia

Only two studies were located in the literature for effectiveness outcome for Insomnia. These efficacy studies were conducted by Morin, Cuthbert, and Schwartz (1994) and Murtagh and Greenwood (1995). The treatments were stimulus control and sleep restriction when compared to a placebo. Cognitive-behavioral was found to be mildly effective as an intervention for sleep maintenance (Montgomery & Dennis, 2003). Irwin, Cole, and Nicassio (2006) conducted a randomized clinical trials (RCT) efficacious study involving 23 of 51 intervention studies meeting criteria for at least one of five sleep outcomes, sleep quality, sleep latency, TST, sleep efficiency, and awakenings after sleep onset (WASO). The outcome data included:

Well-efficacious:

Behavioral interventions (Sleep quality, sleep latency, sleep efficiency, WASO)

Probably efficacious:

CBT, relaxation training (sleep efficiency), behavioral

Eating Disorders

Waller, Stringer, and Meyer (2012) conducted a study for the most commonly used techniques for eating disorders. The techniques were based on similar criteria as efficacious studies. The techniques and criteria include:

Widely supported:

Routine weighing, food diaries, cognitive restructuring, exposure, structured eating

Partially supported:

behavioral experiments, surveys

Unsupported:

Schema therapy, mindfulness

Marital or Couples

Distress and with adult mental health problems

Baucom, Shoham, Mueser, Daiuto, and Stickle (1998) conducted an intervention effectiveness study for marital distress and for adult diagnosable mental problems when accompanied by the spouse (one or the other spouse) in marital therapy. Twenty-two behavioral marital therapy (BMT) outcome studies were conducted.

Efficacious with special treatment:

Behavioral marital therapy (BMT), emotion-focused therapy (EFT)

Possibly efficacious:

Cognitive therapy, cognitive-behavioral therapy, insight-oriented therapy, systemic therapy, cognitive marital therapy (CMT), insight-oriented marital therapy (IOMT), cognitive therapy (CT) for couples, and couples' systemic therapy

Marital counseling with a partner with a diagnosable disorder:

The following treatments meeting efficacious criteria include partner-assisted or couples-based intervention when one partner has a diagnosable mental problems. These studies focused on the effectiveness of partner assisted or family-assisted.

Obsessive-Compulsive Disorder

Efficacious:

None

Possible efficacious:

Family-assisted exposure, partner assisted (PAE)

Agoraphobia

Efficacious:

None

Possibly efficacious:

CBT, partner assisted (PAE) plus couple communication, partner assisted

Depression BMT plus

Efficacious:

None

Possibly efficacious:

Behavioral marital therapy (BMT)

Sexual Dysfunctions

Efficacious:

None

Possibly efficacious:

Sexual Skills Training (SST; female orgasmic disorder), Masters and Johnson's Program (M & J; female orgasmic disorders), BMT plus M & J (mixed female sexual dysfunctions), Marital plus OCT for hypoactive sexual desire)

Alcohol 'Use' (Abuse & Dependence)

Included 30 studies in which two studies met criteria for the evaluation.

Well Efficacious:

None

Possibly efficacious:

Community Reinforcement Approach (CRA), Behavioral Marital Therapy (BMT)

Schizophrenia

Well Efficacious:

Behavioral family therapy, supportive family therapy

Possible efficacious:

Family systems therapy

Technique Definitions

Techniques

PART 1: Techniques and Application

Acting As IF

Application: (shyness, social skills)

To improve social interest Adlerian therapy might suggest the use of the 'acting as if' technique. This technique might be used to decrease symptoms, increase functioning, increase client's sense of humor and to change client perspective-taking (Erford, Eaves, Bryant, and Young, 2010). This technique is used to gauge if the client has the skills to act as if he/she could manage the interaction of counseling focus (goal). The client is to learn to 'catch oneself' (another Adlerian technique) repeating a dysfunctional behavior.

Aversion Therapy

This classical conditioning therapy is used to reduce the frequency of undesirable behavior. It is based upon the removal of a positive.

Behavioral Activation Application (depression)

Behavioral activation is an outgrowth of cognitive-behavioral therapy. It is considered a brief, short-term focus on assisting the client in overcoming the urge to escape or engage in avoidance behaviors such as drinking (alcohol). This technique has support as an adjunct for depression.

Behavioral Rehearsal

Application: **(**clients experiencing anger, frustration, anxiety, phobias, panic attacks, and depression)

Behavioral rehearsal is a form of role play. The client plays the role of him/herself and the counselor plays the role of the person with whom the anxiety is present or experienced. The client is encouraged to communicate his/her feelings about the anxiety-producing person or event/circumstances. The client continues to repeat the exercise until the communication is effectively managed.

Bibliotherapy

Application: (illness, death, self-destructive behaviors, family relationships, identity, violence and abuse, race and prejudice, sex and sexuality, gender specific anxieties, depression, gender, insight into self, attitudes) Bibliotherapy was coined by Samuel Crothers 1916 for the use of books in counseling (Erford, 2010). Glaser encouraged clients to read and that reading was an important component of reality therapy. The client will gain insight into a problem, learn new information, and increase self-esteem. There are four stages in the use of bibliotherapy identification, selection, presentation, and follow-up.

Blow up (Lazarus)

Another form of paradoxical intention (Frankl). Lazarus encouraged clients to exaggerate and elaborate their symptoms. The technique is helpful for those clients with obsessive thoughts. The client will dwell on

the topical symptom and take it to the most disastrous conclusion (similar to implosive therapy). The purpose is to make a disconnect between the problematic behavior and the discriminate stimulus.

Cognitive Restructuring

Application: (polarized thinking, extreme emotional reactions, anxiety disorders, panic disorder, self-esteem, stress, social phobia, OCD, substance disorders) Cognitive restructuring involves identifying inaccurate negative thoughts that contribute to the development of and continuation of self-defeating behaviors and is often an important part of the treatment for depression. Cognitive restructuring is a technique used during Albert Ellis, Aaron Beck, and Don Meichenbaum's behavioral and cognitive-behavioral therapies.

Behavioral Activation: When a client engages in enjoyable activities and develops or enhances problem-solving skills, that client exemplifies behavioral activation that can offset negative emotions, ruminations, and avoidant behaviors. The focus is on behavior activation without cognitive change, problem solving, long-term change, completion of goals, and from the urge to engage in avoidance behaviors.

Decoupling (DC)

The DC is a self-administered approach for nail biting. Nail biting was classified as an impulse control disorder not otherwise specified in the DSM-IV-TR. The DSM-5 does not list nail biting but the literature indicates there are a number of specific behaviors that are impulse related which have comorbidity such as trichotillomania. Decoupling is one of three approaches to treat nail biting: habit reversal (awareness training and competing response training), mild aversion therapy (bitter substance), and decoupling. DC strategy is to shift the nail biting and to mimic and eventually "sabotage" the behavior thus to shape and deviate the original movement rather than to freeze it (Moritz, Treszl, & Rufer, 2011).

Deep Breathing

Application: (anxiety disorders, anxiety, managing stress, GAD, panic attacks, agoraphobia, depression, irritability, muscle tension, headaches, fatigue, breath holding, shallow breathing, cold hands and feet, child birthing, sleep, pain, smokers quit, anger) This technique is to calm the body through breathing awareness and diaphragmatic breathing. There are several breathing techniques that focus on control of the physiological response of the body (pulse, blood pressure, lung usage/oxygen/carbon dioxide interchange, etc., neuroscience).

Empathy Chair (Gestalt)

Application: (interpersonal and intrapersonal issues, body image issues) (not recommended for clients with serious emotional distress-psychotic disorders) The client plays different roles and establishes a voice dialogue with one or more imagined individuals sitting in an empty chair. It is as though someone is sitting in the chair and the client talks to the chair. The intervention helps individuals move from talking about something toward experiencing the fullness of an immediate interaction and 'here-and-now' experience with an individual symbolized by an empty chair that includes sensation, affect, cognition, and movement. Implementation of this technique is a six step process leading to a deepening of the expression of an interactive, experience which can promote pathways to action.

Exception Technique

Application: (identifying strengths, resources client is using, behavioral problems,) When the times are the problem (issue) does not take place?

Extinction

Application: (perhaps tantrums) Extinction is based on punishment (withholding reinforcement) in order to reduce the frequency of a specific behavior. It is most effective when combined with counterconditioning (positive reinforcement).

Family Constellation

Alfred Adler's concept of family constellation involves the number and birth order, to include the personality characteristics of the members, in order to help determine the life style of the client within the context of his or her family. Bert Hellinger founded the family constellation in order to discover the client's unconscious connections with family ancestors and determine his or her entanglements with hidden family dynamics. The counselor, using this approach, can interviews the client to learn of significant family members and their roles, the presence of non-verbal communications, and the nature of the family fears and prohibitions in order to shed light on family dysfunctions.-

Family Mapping

A visual representation of a minimum three generations including adjectives descriptive of each member. The map is a view of relationships although additional data can be requested as to marriages, deaths, and occupations dependent upon the presenting client distress.

Flagging the Minefield

This technique may be similar to a substance term 'triggers' in which all members are aware of and encounter difficult symptoms for the diagnosis. The purpose of flagging the minefield is to reinforce what the client learned that provokes, or triggers the symptoms during the counseling hour and to implement alterations or changes in the natural setting (home, work, social, etc.). Flagging is a problem solving process in which the client learns or anticipates vulnerable times, behaviors, and situations for the problem. The client's adherence (compliance/noncompliance) to the strategy for change (goals/homework) may be a method to monitor for improvement and the counseling commitment to change.

Flooding

Application: (phobias) A respondent conditioning technique in which extinction is achieved by confronting the anxiety-producing stimulus. This technique is often used in phobia reduction or elimination.

Guided Imagery/Visual

Application: (phobias, training in relaxation, social skills, and stress management, anxiety, facilitate relaxation, sense of control, improve problem solving and decision-making, alleviate pain, and to develop new perspectives) This technique is used for many theories of change (cognitive, behavioral, transpersonal, Gestalt, and psychodynamic.) It is an adjunct to those theories. Visual imagery includes mental, positive imagery, and goal-rehearsal imagery or coping. Guided imagery is a subtype of visual imagery that assists the client to put emotional or interpersonal issues into words, development goals, rehearse new behaviors, and exert control over emotions or stressors. The counselor leads the client through a series of steps (visual) directed at the stimulus words.

Habit Reversal Training

Habit reversal training technique is used to help a client identify the situations, stresses, and other factors that trigger a bad habit such as excoriation disorder or skin picking. The therapist will help find other things for the client to do instead of skin picking, such as squeezing a rubber ball. This will help ease stress and occupy the client's hands.

Habituation

Application: (agoraphobic disorder) The client is to remain in the exposure situation long enough and should repeat the exposure frequently enough for the anxiety to diminish.

Head-on-Collision (Intensive)

When a therapist identifies a defense, the defense is immediately confronted.

Hunger Illusion

Application: (addiction) Dr. George Weinberg developed a three step counseling method to help clients identify the moment an automatic thought takes place as in a need to drink. The client often does not analyze why he/she is about to enter a drinking establishment. The client might be thinking a friend is in there or enter because a friend is about to enter. The second step is to stop and don't act and the third step is to recognize or become aware to what thoughts and feelings come up (Weinberg, 1996).

Hypnosis

Hypnosis is an altered state of human consciousness characterized by reduced peripheral awareness, enhanced capacity for suggestibility, and increased access to the hypnotized individual's past memories and unconscious thoughts and emotions. Hypnotherapy utilizes this modality to access memories, unconscious thoughts and emotions and facilitate the client's ability to form new responses, thoughts, behaviors, attitudes, or feelings. Several different forms of hypnotherapy include the following three types: traditional, Ericksonian, and cognitive/behavioral.

Imagery Therapy

Application: (Anxiety, PTSD) Imagery therapy is a time limited visual behavioral technique or therapy that is often useful to reduce the frequency and intensity of specific fears. The therapy is commonly referred to as imagery rehearsal therapy (IRT). The rehearsal aspect, which is a component of imagery therapy, uses a fear evoked from nightmares and rescripts to alter the ending conducted while the client is awake. Guided imagery is useful for stress reduction and stress management. The technique may include meditation, diaphragm deep breathing, muscle relaxation, or self-hypnosis.

In Vivo

Therapeutic procedures that take place in the environment, often practiced in the office to later be practiced or acted out in the environment (natural setting).

Interoceptive Exposure

Application: (panic disorder, PTSD) Interoceptive exercises are behavioral treatments designed to surface feelings that are evoked by bodily symptoms during a panic attack (somatic sensations). Common steps taken for panic attacks with interoceptive exposure for bodily symptoms include hyperventilation, breathing through a straw, exercising, spinning around in a chair, and breath-holding.

Mental Imagery

A relaxation method whereby the client imagines a safe pace through the use of imagery.

Meditation or Yoga

Meditation. Three forms of meditation are focused attention, mindfulness, and compassion. Focused attention is to concentrate on the in-and-out cycles of breathing. The mind tends to wander so focused attention is used to regain the focus. Mindfulness (open-monitoring) is observing sights, sounds, and other sensations including internal bodily sensations and thoughts. Compassion is having feelings of benevolence toward other people whether friend or enemy (Ricard, Lutz, & Davidson, 2014a, b). The goal of

meditation is to achieve a clear mind, emotional balance, a sense of mindfulness, and compassionate caring. Neuroscientists who are proponents of meditation believe that meditation facilitates a rewiring of the brain circuits, stimulate growth of the brain, and center the mind. -

Mindfulness-Based Stress Reduction (MBSR)

MBSR developed by Jon Kabat-Zinn is a technique or strategy that, when combined with meditation, is used to teach (instruct) clients 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 (1990) believed the mind can be rewired to allow the client to pause and reset and has been recommended for anxiety issues. The typical program is once a week for eight weeks of two-and-half hour meetings. The concept is based on the fact that the mind can adapt and rewire (neuroplasticity). The strategy is to reduce distress through meditation and mindfulness practice. Research tends to support that mindfulness practice does lower cortisol levels and blood pressure, and increases immune response. Mindfulness-based stress reduction and cognitive behavioral therapy have been found to be useful for insomnia (Garland, Carlson, Stephens, et al., 2014).

Miracle Question

Application: (couples, teen-agers at risk) Problem free image. The client is encouraged to express 'how the problem' might be different. Counselor and client may then strategize how to work from an idealized outcome back to the present. The contrast between what is and what the client really wants provides clarity to the task at hand (goal establishment).

Modeling

Application: (personal and social skills, cognitive problems, autism, intellectual disabilities, socially disturbed children, self-confidence) Modeling is a social learning technique (imitation, identification, observational learning) composed of overt, symbolic, and covert types. Cognitive modeling helps the client eliminate negative, self-defeating thoughts and behaviors by substituting them with positive statements or behaviors. Models or specific techniques utilized independent of a theory or in conjunction with a theory may be social skills training and communication skills training.

Paradoxical Intention

Application: (agoraphobia, insomnia, problems blushing (DeBord, 1989) This technique consists of deliberately practicing an undesirable habit or thought in order to identify and remove it. The counselor will prescribe disturbing and undesirable behaviors or symptoms from which the client wants to experience resolution or freedom (involuntary fear, pain, depression)-and encourage him or her to exaggerate those symptoms or behaviors. The technique may be symptom prescription, symptom scheduling, symptom restraining or symptom reframing. This technique, first described by Victor Frankl, is utilized in individual counseling (Erickson) and in family therapy (Jay Haley). The premise for using this technique is the disbelief that most problems are driven by emotional rather than logical thinking.

Premack Principle

Application: (management situations such as classroom, eating disorders-food refusal) This operant conditioning technique is based on the concept of positive reinforcement (higher probabilities behaviors will act as reinforcers for lower probability behaviors). An undesirable behavior will likely increase if followed by a high probability behavior (reward). The two probability behaviors are to be paired in time and space.

Primal Therapy

Application: (depression, phobias, panic and anxiety attacks) The primary emphasis of primal therapy is based on the recognition that within each person's life experiences there are various kinds and levels of emotional and physical pain which is imprinted and carried forward in the form of memories which tend to be repressed in individuals with physical or emotional symptoms. The therapy attempts to access those repressed memories (unconscious) and enable the client to re-experience them in the present. Primal therapy became very influential during the early 1970s after the publication of The Primal Scream, by Arthur Janov. Although it achieved a period of popularity and inspired many popular cultural icons, primal therapy has declined in popularity, partly because the outcomes haven't been successful enough to convince research-oriented psychotherapists of its effectiveness. However, Janov and many advocates continue to practice this therapy.

Progressive Muscle Relaxation Training

Application: (anxiety, stress, high blood pressure, headaches, asthma, insomnia) Progressive muscle relaxation, developed by Dr. Edmund Jacobson in the early 1920s (Jacobson, 1938), is a technique for controlling anxiety induced muscular tension by means of tensing and then relaxing a muscle or muscle groups. Jacobson's research found that there is a connection between excessive muscular tension and disorders of mind and body and that relaxation can oppose states of tension and provide resolution for or prevention of psychosomatic disorders. The client can sense the difference when a muscle is tensed and then relaxed. This resulting relaxation provides the client the feedback of being able to control the neuromusculature via brain activity. In training sessions the client reclines with eyes close and follows instructions to relax and release all distracting thoughts or behaviors.

Pushing the Button

Pushing the button is to move back and forth with negative to pleasant thought (Mosak-Adlerian). The client learns to create whatever feeling he or she wants by thinking about it. For example, the client can be encouraged to first initiate a pleasant memory with its attached positive emotions, then change to an unpleasant image and attached negative feelings, then back to the positive memory and emotion.

Reframing

Application: (understanding, accepting, or solving a problem, couples in conflict, client attitudes toward counseling, family therapy, reducing negative emotions, mild to moderate depression) Reframing gives a new definition to a situation so a new and different constructive change takes place. The purpose is to change the context of a dysfunctional conceptual or emotional viewpoint of a situation. The client is encouraged to see a new point of view different from the original point of view and to consider the alternative. The technique is a three step approach and is a paradoxical strategy.

Relaxation

Muscle relaxation (Edmund Jacobson)-relaxes muscle groups systematically and in a fixed order, small muscle group of the feet and working to the head or vice versa.

Role Playing

Application: (typically used with adolescents using reality, rational-emotive, cognitive, and social learning theories or treatments) Role playing is acting the part of someone else under different conditions. The technique is taught in seven stages and the client practices switching roles in a safe environment.

Role Reversal

Application: (conflict, split in the self) Role reversal is a Gestalt technique introduced, at times, when the counselor suspects the client is displaying a behavior that is a reversal of some underlying feeling. The client takes on a role of another person, or position of another, during which the anxiety is present in order to make contact (get in touch) with the feelings and thoughts associated with the interaction. When this technique is used by a counselor to resolve an interpersonal conflict or help a client better understand or empathize with another individual, the client can be asked to imagine having that individual's thoughts and feelings and take on the role of that person.

Scaling (Solution-focused technique)

Application: (motivation, hurting self or others, self-esteem) Scaling, a behavioral approach, is used to clarify or bring specificity to abstract concepts to achieve concreteness. It is also used as a self-report monitoring technique. Scaling uses a representative linear rating of 1-5 or 1-10 defined from least to most of a concept such as improvement. Variations in scaling may be used throughout the counseling process to assess a point-in-time for concepts such as catastrophic thinking, motivation to change, relationships, personal reactions, suicide ideation/attempt, and improvement.

Script Analysis

Eric Berne (interpersonal therapy) suggested that there were three unhealthy life scripts~~:~~ depression (no love scripts), madness (no mind script), and addiction (no joy script). From early childhood an individual's life script began to be formed based on transactions that took place between a parent and child. According to Berne's transactional analysis (TA) theory, life scripts were established either by means of strokes (rewards) or injunctions (should/oughts,etc.) Unhealthy transactions led to the formation of unhealthy life scripts and negative symptoms and behaviors. According to TA theory individuals suffering from adverse symptoms and behavioral difficulties because of unhealthy life scripts can learn to rescript their lives. A counselor utilizing TA theory can analyze a client's life a script by assessing for one of the four basic 'OK' positions established by transactions based on mother-father-child-interactions. Of significance, according to TA theory, is that only one of these four 'OK positions' is positive: 'I'm OK and you're OK. The other three positions are all negative: 'I'm not OK, you're OK', 'I'm not OK, you're not OK', 'I'm OK, you're not OK'. The purpose for conducting a script analysis is to assist the client in recognizing that his or her present life script has been adversely affecting interpersonal relationships and has not been achieving the autonomy desired. This sets up a therapeutic plan in which the client can decide against the present script and ~~to~~ rewrite one to achieve autonomy.

Sculpturing

Virginia Satir, a family theorist, believed family members were physically molded and displayed particular characteristic roles that portrayed their view of the family constellation. The family is in a physical arrangement of its members (in space and time) and each member represents a person's symbolic view of the actual relationship with other family members. These relationships are known to the members in the family.

Sensate focusing

Application: (sexual disorder) Senate focusing techniques allows a couple to experience closeness and intimacy without intercourse. A sex therapist will guide the timing and technique for sensate focusing to develop an increasing awareness of the texture and qualities of the partner.

Short-term Dynamic Psychotherapy

Habib Davanioo was the founder of short-term dynamic psychotherapy (ISTDP). ISTDP is designed to be conducted as quickly as possible maintaining the core principles of psychodynamic psychotherapy (defense mechanisms, unconscious, transference, etc.) and to hone in on the sequence of feelings. The therapist attempts to overcome resistance as quickly as possible and to focus on the impulse-laden feelings outside of consciousness or awareness.

Sleep Restriction

Application: (sleep disorders) Sleep restriction is recommended to re-establish a destabilized or irregular sleep-wake rhythm for insomnia. The goal is to increase 'sleep pressure' starting with a specified number of hours considered to be the needed sleep time for a client. If that number is 6 hours the client is instructed to go to bed only from 1:00 to 7:00 AM. If the client complies the bedtime will increase 30 minutes weekly. Compliance is the major issue for this method especially for the elderly (Stepp, et al., 2011).

Social Rhythm

Social rhythm therapy is often combined with interpersonal therapy to form interpersonal and social rhythm therapy (IPSRT; Frank, 2007). Social rhythm is based on the factors of the circadian clock that is interrupted numerous times affecting sleep-wake, appetite, energy, and alertness. Frank suggested that clients predisposed to circadian rhythm disruptions may likely be vulnerable to mood disorders especially bipolar disorder I and II. The client has difficulty adjusting to the somatic and cognitive states of those disruptions. IPSRT is a four-phase treatment and the goal is to stabilize the client's social routines and improve his or her interpersonal relationships. Improvements are to be noted in terms of reducing denial and increasing acceptance, and in reducing the number and severity of stressors (Frank).

Social Skills Training

(SST)–Social skills training, was developed by Michel Hersen for depressed women (Hersen, Bellack, Himmelhoch, & Thase, 1984). The use of modeling, behavioral rehearsal, corrective feedback, social reinforcement, and homework assignments are introduced to teach effective social behavior. Social phobia may be represented as a deficiency in verbal (e.g., appropriate speech content) and nonverbal (e.g., eye contact, posture, and gestures; Heimberg & Juster, 1995).

Spitting in the Client's Soup (Adler)

Application: (no empirical evidence for effectiveness) Spitting in the client's soup is a paradoxical technique whereby the counselor helps the client recognize that certain adverse behaviors about which he or she received secondary gain, are actually destructive. This Adlerian technique requires the counselor to assess the ways a client can benefit if he or she is willing to change rather than maintain the disturbing behavior. The technique of spitting in the client's soup points out the ways the client gains from the symptom by using a word or question that changes (reduces symptoms) the meaning of a dysfunctional behavior (change goal).

Storytelling (mutual)

Application: (children between ages of 5 and 11, ADHD) Several treatment approaches utilize storytelling (broader definition of storytelling) such as emotion-focused family therapy, play therapy, and pro-longed exposure therapies. The point of interest in using mutual storytelling is that clients have been unable to analyze their own life stories. Emotion-focused family therapy helps the client or family during counseling hours to recognize repetitive non-verbal and verbal reports of the same old stories, empty stories, broken stories, untold stories, unexpected outcome stories and healing stories. These stories had not been analyzed by the client until they present in therapy. If this technique is used with a child the first step is to

have the child create a self-fictional story with a beginning, middle, and end with interesting characters. The counselor formulates his/her own story variation. The analysis includes asking the child to name the story, provide a moral to the story, and a title to the story.

Stimulus Control

This therapy involves making changes to a client's environment to help curb skin picking. For example, he/she might try wearing gloves or Band-Aids to help prevent feeling the skin and getting the urge to pick. Or he/she might cover mirrors if seeing facial blemishes or pimples brings on picking behavior. The level of denial, manipulation and deception is to be taken into consideration when developing a treatment program for the factitious client who often has a personality disorder in conjunction with the factitious disorder. A treatment framework is recommended that includes avoiding unnecessary hospitalization. While no specific treatment is known it is recommended that the therapist be empathic and gently confrontive yet supportive, provide validation, and reduce or avoid regressive dependency. Individual therapy is recommended if the client is old enough and has the ability to have insight, while family therapy is helpful for some to regain some degree of autonomy (Eisendrath, 1995).

Stress Inoculation Training (SIT)

Application: (speech anxiety, test anxiety, phobias, anger, assertion training, social incompetence, depression, social withdrawal in children) SIT is a combination of cognitive restructuring with training in verbal self-instruction and behavioral self-management techniques for mild stressors that will allow a client to handle larger stressors. The client is encouraged to apply these skills to a series of increasingly stressful situations as therapy progresses.

Systematic Desensitization

Application: (specific phobias; in vivo or imaginal, OCD, sexual disorders, anxiety disorders) The client repeatedly recalls, imagines, or experiences anxiety provoking events and will use a relaxation technique to suppress the anxiety. A client gradually overcomes maladaptive anxiety elicited by an approaching feared situation or object. Wolpe believed that two competing situations cannot occur simultaneously. One cannot fear and be calm at the same time. The process is to strengthen the desirable one. This is accomplished through systematic desensitization using a relaxation technique that is paired with an increasing fear hierarchy. This technique may be known as reciprocal inhibition, counterconditioning, or classical conditioning (Head & Gross, 2008).

Time Out

Application: A client is totally unable to cope with the situation, tantrums, alcoholic consumption, thumb sucking, aggression, intellectual disability disorder, self-injurious behaviors, noncompliant children, self-control issues, low functioning children with Autistic Disorder. Time out is an operant technique based on punishment of undesirable behavior. Assuming that the undesirable behavior has been 'learned' the counselor applies a format whereby it can be 'unlearned.' The counselor instructs the removal of the negative behavioral reinforcement for a period of time until corrective actions have been taken. These steps can be in successive approximations to the goal or for full recovery. The three types of time out include seclusionary, exclusionary, and non-seclusionary.

Token Economy

Application: (changes group behaviors, disruptive behaviors, ADHD, serious emotional problems, increase participation, school phobia, tantrums, thumb-sucking, encopresis, fighting, autism, feeding and eating disorders, schizophrenia, addictions) Token economy is an operant technique based on the consequences of a behavior. This is a positive reinforcement situation where the client receives a token for desirable

behaviors. Once a sufficient amount of tokens are accumulated the client can trade them for a larger tangible reinforcement on the want list. This reinforces delayed gratification and a cost accounting. This form of reinforcement is best suited for residential centers or closed hospital wards.

Thought Stopping

Application: **(**addiction, skin picking, alcohol or substance use disorders, gambling, OCD, phobias, hypochondriasis, failure, sexual inadequacy, common fears, negative thoughts, smoking, hallucinations) The process is to interrupt the unwanted thoughts or behaviors causing the distress. The introduction of the word 'stop' (distractor) is to serve as a punishment decreasing the likelihood of the thought to continue (incompatible to what the client wants) followed by a substitute thought or behavior. Several individuals are credited with the technique to include Alexander Bain, James Taylor, and Joseph Wolpe (Erford, 2010).

Voice Dialogue

A dialogue between different 'selves' of the person that are at odds

Techniques (Interventions)

Adjustment Disorder

Coping skills training, crisis-intervention, psychoeducation, stress inoculation, solution-focused therapy, problem-focused therapy, DBT

Agoraphobic Disorder

Panic control therapy, exposure therapy, flooding, systematic desensitization, imaginal

Alcohol Use/Related

Cognitive-behavioral, cognitive, cue exposure, urge coping, self-control training, brief motivational, stress management, supportive-expressive therapy, exposure prevention, homework, cognitive restructuring, maladaptive thinking, relapse prevention, problem solving, social skills training, ITP

Anorexia Nervosa

Maudsley model, family organization and interaction, facitate eating and weight gain, parables, paradoxes, personal authority, rationalizations, psychodynamic interpretation, homework

Attention Deficit/Hyperactivity

Behavior parent training, contingency management (teacher reward, point systems, time-out), family therapy, social skills training, anger management, communication skills, recognition of nonverbal, time management, BPT, behavior classroom management (BCM), summer-based treatment programs

Autism Spectrum

Social development, focusing skills, sensitivity to cues, modeling communicative skills, predictable play (Some techniques may not be appropriate for one of the four disorders combined under autism spectrum disorder)

Bipolar Disorder (Adult)

Medication (first-line), family psychoeducation, family-focused psychoeducation, IPSRT w/social rhythm, circadian rhythm, family-focused therapy

Body Dysmorphic Disorder

Verbal expression, stress management

Bulimia Nervosa

CBT, routine eating, structured eating, monitoring of food intake, exposed-based methods, weighing, cognitive restructuring, food diaries

Conduct Disorder

Social skills training, relaxation exercises, impulse control, negative talk, family therapy, active attention skills, active ignoring skills, parent training (setting limits, physical affecting, attention, planned ignoring)

Depression

Bibliotherapy, CT in group format, ITP, problem-solving

Delirium

Support for caregivers, relaxation training, coping skills

Eating Disorders

Mindfulness and acceptance, cognitive-behavioral, routine weighing, food diaries, exposure, structured eating, behavioral experiments

Facitious Disorder

Reduction in self-injurious behaviors, coping skills

Generalized Anxiety (GAD)

Cognitive restructuring, relaxation training, emotion regulation, exposure techniques, problem-solving, muscle relaxation, guided imagery, diaphragmatic breathing, expressive therapy, systematic desensitization, CBT, ACT, Cognitive

Insomnia

CBT, sleep hygiene, sleep diary, relaxation exercises, muscle relaxation, autogenic training, sleep scheduling, sleep restriction, paradoxical intention, thought-stopping, and problem-solving

Intermittent Explosive

Stress management, impulse control, distraction, relaxation training, systematic desensitization, habit reversal, problem-solving, real-life conflict situations

Major Depressive

Cognitive, CBT, Interpersonal psychotherapy, mindfulness-based cognitive therapy, BCT, exercise therapy, light therapy, medication

Marital Distress

Problem solving (BMT), contracting, communication training skills

Obsessive-Compulsive

CBT, ACT, exposure, cognitive restructuring, mindfulness, response prevention (ERT), acceptance, defusion, self as context, present moment awareness, committed action, habituation, parent intervention, relaxation training

Oppositional Defiant

Social skills training, problem-solving, active attention skills, active ignoring skills, parent training (setting limits, physical affection, attention, planned ignoring)

Panic Disorder

Panic control therapy, psychoeducation, relaxation training, cognitive restructuring, cognitive reappraisal, controlled breathing, diaphragmatic breathing skills, in-vivo exposure, imaginal exposure (IE), symptom-induction exercises, exposure therapy, interoceptive exposure, mindfulness, brief supportive therapy, ACT

Paraphilia Disorder

Stress reduction, aversion therapy, covert sensitization, thought stopping, extinction, cognitive restructuring, contingency management, aversive conditioning

Personality Disorder

Psychoeducation, cognitive-behavioral, DBT, schema therapy, attachment therapy, mentalization

Phobic & Anxiety

In-vivo, imaginal, behavioral exposure, bibliotherapy, ACT

Posttraumatic Stress Disorder

Psychoeducation, prolonged exposure therapy, imaginal exposure, stress reduction, exposure therapy, stress inoculation, adaptive coping, DBT, ACT, EMDR, stress reduction

Schizophrenia

Cognitive-behavioral social skills, problem-solving skills, social skills training, family psychoeducation

Separation Anxiety

Anger management, parent management, and problem-solving

Sexual Disorders

Psychoeducation, couples counseling, progressive relaxation, sensate focusing, systematic desensitization, stimulus-control and scheduling, cognitive restructuring, communication skill training

Social Anxiety Disorder

Exposure alone, cognitive restructuring, exposure combined with cognitive restructuring, social skills training, attentional focus training, homework, applied relaxation, anxiety management, mindfulness, flooding, in-vivo, imaginal, psychoeducation, exposure to feared situations, anxiety coping skills, problem solving [cognitive-behavioral models, cognitive group therapy, social-effectiveness therapy (SET), interpersonal psychotherapy (IPT)]

Somatic Symptom

Relaxation exercises, sleep hygiene

Part II: Techniques Noted in Treatment Research

Cognitive-Behavioral (CBT)

In-vivo, cognitive restructuring, breathing-retraining, interoceptive exposure, muscle relaxation, thought stopping, behavior reversal, contingency management, paradoxical intention, reframing

Acceptance Commitment (ACT)

ACT, psychoeducation, mindfulness, cognitive defusion, cognitive distancing, self-talk, acceptance, defusion, self as context, present moment awareness, values, committed action

Attachment Therapy

Psychoeducation, family connections (FC), parent-infant relationship, scheduling (predictability in routine) and monitoring, emotion regulation, mindfulness-based parenting

Dialectical Behavior Therapy (DBT)

Mindfulness and acceptance, interpersonal effectiveness, distress tolerance, focusing, emotion regulation

Interpersonal Therapy (IPT)

Social skills training, assertiveness training, role playing, decision analysis, contract setting, modeling

Social Effectiveness Therapy (SET)

Psychoeducation, exposure to feared situations, anxiety coping skills, relaxation techniques, cognitive restructuring, problem solving and homework

Therapy Terms

The following terms were recommended for select disorders in the Supplement. The definitions for the different terms are brief and may require further research.

Acceptance and Commitment Therapy (ACT)—ACT is a psychological intervention that uses acceptance and mindfulness strategies mixed with commitment and behavior-change approaches to increase psychological flexibility. ACT targets experiential avoidance, poor experiential awareness, and lack of motivation, symptoms which are prominent in eating disordered clients as well as extreme ambivalence about their need for treatment (Fairburn, 2008). ‐ The goal of ACT is to increase psychological flexibility through acceptance of unavoidable distress, creating a mindful outlook to counteract excessive confusion with cognitions, and to clarify personal values linked to behavioral goals. Metaphors and stores are interventions or techniques utilized to increase flexibility and internal stress. ACT utilizes six core processes to address excessive reliance on experiential control and the belief that emotions are harmful by increasing psychological flexibility and openness with unwanted thoughts and feelings that are resistant and difficult to amend. These six core processes include: (1) acceptance, (2) defusion, (3) self as context, (4) present moment awareness, (5) values, and (6) committed action (Bluett, Homan, Morrison, 2014; Levin, & Twohig, 2014). Preliminary research evidence has found ACT effective for a variety of problems including chronic pain, addictions, smoking cessation, depression, anxiety, psychosis, workplace stress, diabetes management, weight management, epilepsy control, self-harm, body dissatisfaction, eating disorders, burn out, and several other areas. (Hayes, S. State of the ACT Evidence, ContextualPsychology.org). Bluett, Homan, Morrison, et al. (2014) reported an analyzed review of 100 randomized control studies and found that ACT has been an effective treatment for anxiety and depression. CBT is considered the first line treatment for anxiety disorders although ACT, a third wave behavior therapy, has literature support for GAD, PTSD, social phobia/anxiety, panic disorder, specific phobias, and OCD. Vallestad, Nielsen, and Nielsen (2012) reviewed 19 studies for combined treatments of mindfulness and ACT for anxiety disorders.

Acceptance Based Depression and Psychosis Therapy (ADAPT)—ADAPT shows promise in treating depression with psychotic features. This intervention targets acceptance, mindfulness, and values and results with a limited sample revealed significant improvements and in psychosocial functioning (Gaudiano, Nowlan, Brown, Epstein-Lubow, & Miller, 2012).

Acceptance Enhanced Behavior Therapy-referenced as a treatment but considered a mindfulness technique.

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, and 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.

Behavioral Activation (BA)-targets a client's behavioral avoidance patterns through a functional analysis that is examining antecedents and consequences of behavior and the development of a goal-oriented plan for changing behavioral deficits using a stepwise process. (Martell, Addis, & Jacobson, 2001).

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 posttraumatic stress disorder or both as one or more comorbid disorders.

Copying Cat–a manualized approach that recommends 16 to 20 sessions, the first half of which focuses on psychoeducation, emotional awareness, relaxation and cognitive restructuring, whereas the latter half focuses on facing fears through exposures (Kendall, 2000). Child behavior therapy program ("copying cat") was designed to target anxiety disorders in general among children but especially SAD (Flannery-Schroeder & Kendall, 2000). Strategies or techniques for the treatment include psychoeducation, exposure to feared stimuli or situations, anxiety coping skills, and homework assignments.

Decoupling (DC)-the DC is a self-administered approach for nail biting. Nail biting was classified as an impulse control disorder not otherwise specified disorder in the DSM-IV-TR. The DSM-5 does not list nail biting but the literature indicated there is a number of specific behaviors that are impulse related which have comorbidity such as trichotillomania. Decoupling is one of three approaches to treat nail biting; habit reversal (awareness training and competing response training), mild aversion therapy (bitter substance), and decoupling. DC strategy is to shift the nail biting and to mimic and eventually "sabotage" the behavior thus to shape and deviate the original movement rather than to freeze it (Moritz, Treslz, & Rufer, 2011).

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 that 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) and Kanter et al. (2009) demand characteristics sometimes 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, adjustment disorder with depressed mood, persistent depressive disorder, prolonged grief disorder, 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.

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 humans can acquire emaciation 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.

Episode-See APA, 2013, p. 820

Erotomania–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. Weiner and McKay (2013) report the methods of exposure involve imaginal and in vivo procedures. In vivo is based on a procedure of sensations with real-world stimuli, and imaginal exposure uses guided imagery to evoke sensory realism in situations based on reality. Found throughout the literature are terms now referred to as exposure therapy such as implosion, implosive therapy, flooding, expose, graded exposure, and real-life exposure (Schare & Wyatt, 2013).

Factitious–the intentional production of physical or psychological signs or symptoms. Persistent problems related to illness perceptions and identity (APA, 2013, p. 310).

Fetishism–involves the use of non-living objects. The person usually masturbates while holding, rubbing, or smelling the object

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.

Group-Cognitive-Behavioral Therapy (G-CBT or CBGT)-Heimberg and Becker (2002) indicated that G-CBT involves the application of psychoeducation, breathing retraining, cognitive restructuring, simulated and in vivo exposure to social stimuli, and social skills training for social phobia. CBGT is one of two treatment cognitive-behavior programs for children and adolescents experiencing social anxiety disorder (Herbert & Forman, 2011, 2012).

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–excessive production of thyroid hormones due to overactive thyroid gland activity that 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 caused by genetic abnormalities, chronic disorders, and life-style induced somatic changes, infectious processes, or inflammatory diseases. Organs that may be affected include such as liver (hepatitis), kidneys (hypertensive nephropathy), blood (thalassemia), pancreas (diabetes), cardiovascular (arteriosclerotic disease), and gastrointestinal system (celiac disease).

Metabolic Syndrome - a disorder diagnosed by the presence of three out of five of the following medical conditions: abdominal obesity, elevated blood pressure, elevated fasting blood sugar, high serum triglycerides, and abnormally low high-density cholesterol (HDL) levels. Certain psychoactive medications, primarily selected anti-psychotics, have been found to trigger this disorder due to symptoms such as weight increase, insulin resistance, dyslipidemia, impaired glucose tolerance, type II diabetes and hypertension. Dyslipidemia and increased insulin resistance can be collateral or a direct consequence of psychoactive drug actions. Studies have shown the prevalence in the USA to be an estimated 34% of the adult population, and the prevalence increases with age. Other risk factors include obesity, race, pre-existing diabetes, cardiovascular disease, family history of diabetes, nonalcoholic fatty liver disease, and polycystic ovary syndrome.

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 that 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. There may sometimes be a cross-over or correlation between neurological disorders treated by a neurologist and psychiatric or mental health disorders treated by psychiatrists or other mental health professionals. Symptoms and disorders which may fall into these two camps can include brain tumors, Dementia, Amnesia, Multiple Sclerosis, Asperger's Syndrome, ADHD, chronic pain, movement disorders, complex partial seizures, fibromyalgia, Huntington's disease, Lyme Disease, encephalo-meningitis, neuroleptic malignant syndrome, Parkinson's Disease and nighttime problems (Lees, 1988), Pick's Disease, REM sleep disorder, sleep apnea, syncope, and tardive dyskinesia (Aarsland, Larsen, & Cummins, 1999).

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.

Pedophilic–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. Positive psychotic symptoms are primarily hallucinations and delusions which are found to be 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.

Psychiatric Evaluation–A psychiatric evaluation is often requested without necessarily resulting in medications being prescribed. This evaluation is performed by a psychiatrist (with 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.

Psychoeducational Supportive Therapy (PST)-discussion around topics.

Psychological Flexibility-acceptance and commitment therapy (ACT) emphasizes personal values and psychological flexibility. ACT incorporate mindfulness, acceptance and cognitive defusion (flexibility). Psychological flexibility is the ability to make contact with one's experience in the present moment that will include personal values and goals (Hayes, Strosahl, & Williams, 2011). This approach is aimed at managing internal conflict.

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. Medications often first choice treatment for various disorders (Bender, 1999; Bender, 2008).

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.

Sensory Integration Therapy (SIT)—A new innovation to the SIT is the snug vest (inflated vest worn by the client) intended to reduce repetitive behaviors. Clients diagnosed with autism spectrum display stereotypy behaviors such as repetitive, invariant, and contextually inappropriate maladaptive operants most often maintained by automatic reinforcement contingencies (Cunningham & Schreibman, 2008; Watkins & Sparling, 2014).

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.

Sleep Restriction-Sleep restriction is recommended to re-establish a destabilized or irregular sleep-wake rhythm for insomnia. The goal is to increase 'sleep pressure' starting with a specified number of hours considered to be the needed sleep time for a client. If that number is 6 hours the client is instructed to go to bed only from 1:00 to 7:00 AM. If the client complies the bedtime will increase 30 minutes weekly. Compliance is the major issue for this method especially for the elderly (Stepp, Whalen, Pilkonis, et al., 2011)

Social-effectiveness Therapy (SET-C)-SET-C is recommended for children and adolescents experiencing social anxiety disorder. The program format is to be administered during 24 sessions over a 12-week period of time. Each week one session is devoted to exposure and the second session to social skills training.

Social Skills Training (SST)–Social skills training, was developed by Michel Hersen for depressed women (Hersen, Bellack, Himmelhoch, & Thase, 1984). 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 nonverbal (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 client's 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 include:

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.

Wait or Waiting List-the group that is randomly assigned to receive the intervention later becomes the comparison research controls. The wait list does receives the treatment or intervention after the study is completed. The wait list is a preference to a study with no control group (Brown, Heimbert, & Juster, 1995). Brown, Wyman, Guo, and Pena (2006) reported a class of wait lists defined as one in which the subjects are randomly assigned to different groups and all groups receive the intervention but the intervention is timed for the different groups. The advantage of this method is that none of the participants have to wait a period of time to receive the intervention.

Withdrawal–temporary psychological and physiological disturbances resulting from the body's attempt to readjust to the absence of a drug.