DR. ARTHUR'S STUDY OVERVIEW

for the

NCMHCE

NATIONAL CLINICAL MENTAL HEALTH COUNSELING EXAMINATION

Case Study Exam Study Guide

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Dr. Arthur's Study Overview for the NCMHCE

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UNIT I: INTRODUCTION TO THE NCMHCE

In 2022, the National Board for Certified Counselors (NBCC) changed the format of the National Clinical Mental Health Counseling Examination (NCMHCE) to one structured around 11 case studies (narratives). The content for the case studies includes the six domains and 173 content items (NBCC, 2022, 2019) and course content representing the CACREP objectives for the eight required courses (professional counseling orientation and ethical practice, social and cultural diversity, human growth and development, career development, counseling and human helping, group counseling and group work, assessment and testing, and research and program evaluation). The DSM-5 or DSM-5-TR is the primary resource.

This unit includes a description of the testing format for the NCMHCE, and suggestions for preparing for the examination. The preparation material and case studies are based on the content of the DSM-5-TR, 2014 ACA Code of Ethics, the NBCC six domains (173 sub-domains), CACREP objectives for the eight core courses and the 2022 publication for the National Clinical Mental Health Counseling Examination (NCMHCE). NBCC published only one case study example online. Perhaps, additional material will be available in the future.

Each of the 11 case studies details client information, demographics, diagnosis, and interview categories describing the client's background, mental status, and presenting problem information. The categories of client information may vary for different case studies or narratives. The single example provided by NBCC includes presenting information, mental status exam, and family history but other case studies on the exam may identify other clinical categories such as the client's current living conditions, work history, substance use and addiction, relationships, and socialization history. The client information categories are outlined in the clinical and biopsychosocial interviews.

There are three parts for each case study that contain a range of 9-15 questions based on the provided information, documented client and counselor interactions, and the necessity to manage and execute clinical procedures.

Each of the three parts contains three to five questions with four choices and one correct answer. Each question will provide a domain, sub-domain, and a cognitive level.

The domain content for each case study is based on one NBCC example. The five domains for question formatting are: professional practice and ethics-24 content items, intake, assessment, and diagnosis-21 content item, treatment planning-16 items, counseling skills and interventions-49 content items and core counselor attributes-13 items.

PART ONE: The questions pertain to the introductory material presented at intake as though a prior assessment session developed a chart of client information. The narrative is assigned to the examinee to provide responses (answers) to represent an understanding of the intake information.

Domain 3-areas of clinical focus. It contains 50 content items that are provided and integrated within the narrative much like a running chart of information gained throughout the sessions that

indicate where the symptoms are being expressed. Domain 3 is not a separate score for the examination but a critical area for treatment and assessment.

PART TWO (A clinical session): The case study informs the examinee of the therapy session number, such as the first session, which may be one or two weeks after the intake session (part 1). The session number is followed by additional client-counselor information and/or communication that will be involved in the questions for that part. This information may involve the client's sharing past thoughts/feelings during the intervening week about the first session of therapy. It may relate to homework compliance or involve changes in the client's motivation, thoughts about a disorder stigma, or a disruption in the communication.

PART THREE (another clinical session): The case study informs the examinee of the session number which is followed by information pertinent for the remaining questions. Based on the single case study presented by NBCC, 3-5 questions may represent domain 4 (treatment planning), domain 5 (counseling skills and interventions), and domain 6 (counselor attributes). Typical counseling programing is not usually spaced out in two-week intervals for sessions. When one or more weeks separate therapy sessions, multiple opportunities exist for intervening variables to improve or derail client progress.

The 13 multiple choice questions appear to be based on counselor-client interactions involving alliance, motivation, stages of change, environmental observations, and events occurring during and between therapy sessions. The format of the 13 questions appears to be focused on different attitude traits or states, cognition levels, affect deficits or strengths, and behaviors related to client diagnoses and counselor responses that occur before, during, and after or prior to each set of questions and sessions. Interactions are likely to become communication responses involved in the counselor-client alliance. Topical areas may be client ruptures, compliance issues, resistance, disorder stigma, trust, misunderstanding, disagreements, conflicts in relationships and when client progress goes off track. The case studies and questions are based on expectations for an entry level counselor to apply knowledge regarding the six domains.

The examinee will be provided the diagnosis and information pertaining to a limited number of interview strategies (clinical, psychosocial biopsychosocial, mental status, cultural formulation interview (CFI), and motivational interviews). Scoring will be based on the 130-150 questions derived from each form of the NCMHCE 100 scoring questions to determine a pass score (NBCC, 2022). The remaining 30-50 questions will be used by NBCC to help create future examinations.

The percent of items per domain for the examination are: Professional Practice and Ethics 10-20%, Intake, Assessment, and Diagnosis 20-30%, Treatment Planning 10-20%, Counseling Skills and Interventions 25-35%, and 10-20% for Core Counseling Attributes (NBCC, 2022).

Based on the range of percentages for scoreable items for each domain throughout the 3 parts for each case study, it is estimated that professional practice and ethics have 24 content items, or 2 questions, intake, assessment, and diagnosis have 21 content items or 4 questions, treatment planning have 16 content items or 2 questions, counseling skills and interventions have 49 content items or 4 questions, and core counseling attributes have 21 content items and 2 questions. The sum of questions here is 14, close to the advertised 13 questions.

Case Study Definition

Kaluzevicitue and Moreton (2023) reported that case studies function as a beginning phase of research that represents a connection between theory and clinical practice. A case study can be viewed as anecdotal reports rather than evidence. Retroductive reasoning (retroduction) is a move backward in understanding the client's presenting statements tracing the causal mechanisms of a complex case. Retroductive reasoning describes the causal powers that produce, generate, create, determine or enable things to happen. For the NCMHCE, for part one, the examinee traces the causal factors leading to the client's presenting complaints.

A case study includes a client's background information, a description of the presenting problem, and a diagnosis. The presenting problem describes the symptoms involving physical, emotional, or sensory symptoms reported by the client. Diagnostic or screening instruments are reported with scores and supporting documentation. The diagnosis is provided based on symptomology for the DSM-5-TR. Probing for details, the case study examines the who, what, how, where and when of presenting information (5 WH's).

Within these probes, factors such as motivation, levels of engagement, strengths and needs, attachment factors, observational data, behaviors, skills, and attitudes of the client are assessed through testing, observations, and client reporting (formal and informal means).

Preparation for Case Studies

A starting point in preparation for the NBCC case studies is to have an understanding of the development and course (trajectory) for each disorder (See Unit IV). The DSM-5-TR (APA, 2022) provides information for each disorder in the development and course, diagnostic features and associated features, culture, risk behaviors and functional consequences. Units II-IV provides specific and in some cases detailed information for these areas.

Counselor-Client Dynamics, Interactions, and Derailments

Within a case study, the questions highlight client-counselor communication and interaction during two sessions. Some of these questions may focus on client statements while others may focus on the counselor observations, impact on the process, client changes, and clinical services. Each counselor response should be based on the presenting information within the client chart (intake), information provided by NBCC at the start of each session, knowledge of client and counselor dynamics, and how best to prepare for and communicate with the client.

It might be helpful to consider the NBCC online example scenario of 13 questions involving a 35-year-old female assessed with major depressive disorder. Part one asks questions about how best to develop and prepare for the relationship (alliance, Domain 1P, 5E). The second question focuses on how to manage shared confidentiality (ethics) with the client (Domain 1F). The third question queries information included in the intake that aides in the diagnosis (Domain 2N). The fourth question is a request for how severity is determined (Domain 2J). The fifth question in part one relates to selecting a long-term goal (Domain 4B). Part two, question six is a request for how the counselor can assist the client to reduce her anxiety (Domain 5F). This is not a question for an intervention rather, how would the counselor engage the client. Question seven is about a

cognitive understanding of a client behavior (Domain 5J). Question eight requests what additional information is needed for exploration (Domains 4L, 4M). Question nine is a question about a counselor attribute (Domain 6J). Part three, question ten is a request for a counselor skill to demonstrate empathy (Domain 6H). Question eleven is a question for cognitive deficit or error (Domain 5F). Question twelve is a communication interchange with the client (Domain 5N). Question thirteen is a request for a comorbid disorder (Domain 2G). A general theme throughout the 13 questions is communication and the application of specific skills (techniques) on an interaction level in which client understanding and involvement takes place. See Unit IV for trajectory, derailment, monitoring, and therapy.

Below is another case study to use to prepare for the social anxiety disorder

The NBCC instructions provide the diagnosis and some client information. In addition, the NBCC information indicates that the focus area for the symptom expressions (Domain 3) will be provided and integrated into the intake information. Sub-domain examples are 3P (sleep issues), 3 AF (rumination), 3X (family: physical/emotional issues related to trauma), 3AT (family abuse), 3AX (emotional dysregulation), and 3AC (rumination and/or intrusive thoughts).

Suggestions: Content Topics for Social Anxiety

Recommended preparation for the examination should include knowledge of the six-domains and content (173 items) to answer questions for each of the three parts of each case study. A second source is the DSM-5 or TR for the sub-listings identified as: diagnostic features, associated features, development, risk factors, culture-related issues, suicidal behaviors, differential diagnosis, and comorbidity (APA, 2022).

Items 1-11 are considerations for clinical preparations for case studies disorders and for this example, social anxiety disorder.

1. Diagnosis: Social Anxiety Disorder (SAD)
2. Core feature(s) for SAD: look for one or two core symptom features provided in Part 1: Presenting Problem: Symptoms shared are worry, fear, avoidance, attentional bias, drift, evaluation/scrutiny.
3. Clinical focus (Domain 3): look for where the symptoms are being expressed (home, school, community). The presenting problem and clinical categories include this information (presenting problem, mental status, family history, etc.) and are provided in the client intake information.
4. Dimensional assessment: requires a count for severity, frequency, and duration (listed in criteria DSM-5-TR), when the presenting problem started and how often.
5. Problem solving skills (client cognition): look to see if and how the client attempted to solve the presenting problem before coming to therapy (problem solving skills or lack of problem-solving skills).
6. Critical intervention focus: consider for social anxiety disorder what interventions might be paired for what symptoms and are present such as psychoeducation, in vivo exposure to

feared situations, anxiety coping skills (relaxation, cognitive restructuring, problem-solving), and homework assignments.

7. Risk-factors (red flags) for different disorders: consider the DSM-5-TR and literature support as sources for suicide, risk factors, defense mechanisms, distortions, treatment resistant, malingering, distortions, etc. Consider terms related to behaviors associated with risk such as behavioral inhibition, fear of negative evaluation, negative social experiences, and suicide ideation.
8. Trauma-related disorders (DSM-5-TR): major depressive disorder, PTSD are important for childhood development (maltreatment, trauma, attachment styles).
9. Pre-disposition for disorders: including social anxiety client will avoid or withdraw from certain social interactions (the clinical category within the clinical interview), the counselor would query social involvement, or if a major depression, a request for family information for genetic predisposition, alcohol use disorder, anxiety disorders (withdrawal/ socialization).
10. Differential diagnosis: for social anxiety disorder is normative shyness (APA, 2022, p. 293).
11. Red flag disorders: safety/suicide ideation, attempts, self-harm (major depression), defense mechanism for disorder use (alcohol use disorder/denial), treatment resistance (ODD), client beliefs within disorders (Schizophrenia/stigma; cultural beliefs/pica), suicide ideation, anxiety symptoms are severe, habit-forming drugs (Schub & March, 2018)
12. Communication: issues for the counselor and client that may be problematic for the alliance, ruptures, resistance, malingering, trust, stigma, dependence, and defense mechanisms.

Case Study Example

PART ONE

Intake

Client: Male

Age: 11

Sex: Male

Gender: Male

Ethnicity: Caucasian

Relationship Status: Child, no siblings

Counseling Setting: Community mental health

Types of Counseling: Individual

Presenting Problem: Worry, fear, emotions, scrutiny concerns, sleep

Diagnosis: Social Anxiety Disorder

Presenting Problem:

A school counselor recommended an 11-year-old boy, accompanied by his mother, to seek counseling because of the client's inability to relate to peers (non-participation), withdrawing into himself and not working up to his academic potential. He does not do well with oral reports as he has hyperventilated twice in front of the class. The teachers consider him to be reserved and shy. His mother reported that her son does not think before he acts and was physically abused by his father. His father has repeatedly told the client he does not learn from his mistakes and that his behavior is typical of relatives on his mother's side of the family.

Mental Status:

The client presented with a degree of hesitation, emotional dysregulation, and communication deficits. A drift symptom was observed when requested to draw a picture of his family. Eye contact was limited and reflected a degree of shyness. Self-esteem needs further attention due to his inability to provide age-appropriate skills to describe what he does well, current interests/hobbies, and purpose of the referral for counseling. He reported that he does not orally answer questions in class because he gets nervous, sweats a lot, and often has a dry mouth. He worries over the little things in his daily activities.

Family History:

The mother said her son is a worrier and lacks confidence because he tends to go inward when anyone corrects him. He was a wanted child at birth but does have a history of maltreatment by his father. He does not approach adults as he is insecure, experiences sleep issues, and as a toddler enjoyed the presence of his mother. His favorite activity is playing with his

dog. “We got him the dog because we thought he needed a companion. He talks to the dog, and we feel certain the dog knows more of his personal thoughts than we do. He does not participate with other children unless we force him which we do not. He does not engage in after-school fun type activities.” His father is a long-distance semi-truck driver, and the father-son relationship is distant. He stays apart from male figures and prefers the company of his mother.

Answers for correct and incorrect choices are located after the 13th question. A brief reason will be provided for each of the incorrect choices.

Domain 1 Professional Practice and Ethics
Sub-Domain 1.P. Monitor the therapeutic relationship and build trust as needed

1. What information in the intake session would the counselor consider a possible barrier in creating an atmosphere of engagement and trust with the client?
   A. communication is often delivered with hesitation suggesting ambivalence
   B. client tends to go inward and is reserved
   C. lack of understanding why he was referred for counseling
   D. hesitations in approaching adults and a history of abuse

Answer:

Domain 2 Intake, Assessment, and Diagnosis
Sub-Domain 2.N. Use formal and informal observations

2. The intake information identified sleep as an issue and the client worries about the next day in school. What symptom does the counselor look for with the knowledge the symptom is one of bidirectional association that increases and maintains difficulty with sleep and worry?
   A. alexithymia
   B. anhedonia
   C. intolerance of uncertainty
   D. rumination

Answer:

Domain 2 Intake, Assessment, and Diagnosis
Sub-Domain 2.O. Assess for trauma

3. In reviewing the intake data, what information should the counselor prioritize to gain a better understanding of the client’s accumulated symptoms and diagnosis?
   A. physical and mental abuse

B. discrepancy in mental ability and school performance

C. possible attachment style between the client and mother

D. the symptom of drift and response inhibition

Answer

Domain 2 Intake, Assessment, and Diagnosis
Sub-Domain 2J. Assess the presenting problem and level of distress

4. What information in the assessment leads the counselor to consider a socialization deficit?

   A. lacks involvements in peer relationships

   B. as a toddler he preferred to be near his mother

   C. physical markers are subpar

   D. was not exposed to parentification skills

Answer:

Domain 4 Treatment Planning
Sub-Domain 4.M. Educate the client to the importance of compliance

5. During the counselor's explanation for a treatment modality, the importance of therapy attendance and practicing the recommended interventions were emphasized. What concept was being referenced?

   A. compliance

   B. setting goals

   C. relapse

   D. cooperation

Answer:

PART TWO

First session, one week after the intake session

The client started to hyperventilate when the counselor looked at him and asked him to relate why he is coming to counseling. The client reported that he knows he has difficulties going to sleep and remaining asleep. His mind shifts to repeating thoughts and feelings about his worry about speaking in class or in front of the class. He is bothered because he knows he is anxious causing him to perspire, and his voice cracks making it hard to speak. He is worried that he will not get over this feeling.

Domain 6 Core Counseling Attributes
Sub-Domain 6.A. Awareness of self and impact on clients

6. What might be a soothing counselor response to aid the client to relax and develop a sense of the counselor's empathy?
   A. "I know it is difficult when things are not explained to you in a thorough way."
   B. "Try to relax as you do need a perfect answer to that question."
   C. "Most all people experience difficulties talking about themselves. We can talk about whatever you would like."
   D. "It is not easy to meet someone and begin to talk about yourself. I understand you have a pet. As a child I always wanted a pet pig I could keep in the house. In what way is your dog a confidant for you?"

Answer:

Domain 6 Core Counseling Attributes
Sub-Domain 6.H. Empathic responding

7. The client said to the counselor, "My mother says I am shy. Maybe you feel the same way about people who are shy and have anxiety around people like I do." How would you reflect on the meaning of the client's remarks about how you, the counselor, feel about people who are shy?
   A. "Not all people hold the same thoughts and feelings."
   B. "You are wondering if I might be judging you because you may be thinking I am like others you have met."
   C. "You can rest assured that is not my intent."
   D. "It is natural for you to wonder about how people see you, especially a stranger like myself."

Answer:

Domain 1 Professional Practice and Ethics
Sub-Domain 1A Assess your competency to work with a specific client

8. What is a typical response for a client with social anxiety disorder when the communication becomes silent or the client does not answer questions because of physiological sensations of anxiety, perspiring, and often a dry mouth?
   A. externalizes symptoms for causes for his bodily reactions
   B. treats the communication like a school room examination
   C. would prefer taking a written examination rather than an oral examination or request
   D. takes an inward attentional shift

Answer:

PART THREE

Second session, 2 weeks after the intake session

The client walked into the counselor's office with an appearance of self-control and said he and his mother had gone to the family physician who prescribed a low dose beta blocker. The client reported he does not think pills will help him over his fear and worry, and it is wrong to take pills. He said he read on Google that beta blockers are for high blood pressure, heart failure, and irregular heartbeat and would add weight. This bothers him but the doctor did not say any of those things. He would still like to be home schooled because so many of his classmates are mean.

Domain 5 Treatment Planning
Sub-Domain 5.A. Align intervention with client's developmental level

9. The term to describe symptoms when a child has an affect deficit in managing the intensity and duration of negative emotions, displays withdrawal behaviors, and experiences physiological reactions that promote his distress is referred to as:
   A. an obsession.
   B. blunting.
   C. emotional dysregulation.
   D. decentering.

Answer

Domain 5 Counseling Skills and Interventions
Sub-Domain 5.O. Help facilitate client's motivation to make the changes they desire

10. The counselor wanted to reinforce the client's searching out information that is important for resolving the presenting problem. What can the counselor say to reinforce client's problem solving?
    A. "It is nice to see you sharing what you found on the Internet."
    B. "Not many children your age would even think of checking out the doctor's recommendation."
    C. "This is a good sign of your seriousness to overcome the problems you have been encountering. It will be good to see how this works."
    D. "It takes some time for the medicine to become helpful. Are you encouraged that it will?"

Answer:

Domain 5 Counseling Skills and Interventions
Sub-Domain 5.F. Apply theory-based counseling interventions

11. What intervention is recommended to treat the client's rumination and obsessive thoughts?
    A. functional analysis and imagery
    B. reciprocal inhibition
    C. defusion
    D. mindfulness

Answer:

Domain 5. Counseling Skills and Interventions
Sub-Domain 5. Z. Provide psychoeducation for the client

12. The counselor wanted to reassure the client that the physician's assessment and prescription for anxiety should be given a chance to work. To start the learning process, the counselor can offer a first line assistance with:
    A. psychoeducation.
    B. crisis intervention.
    C. involving a big sister for support.
    D. reviewing the treatment plan for adjustments.

Answer:

Domain 5 Counseling Skills and Intervention
Sub-Domain 5.AG Facilitate resolution of interpersonal conflict

13. At the conclusion of session two, what might the counselor ask to further motivate the client to continue counseling?
    A. the miracle question
    B. What level of anxiety has he experienced over the past 4 weeks?
    C. What would he like to accomplish in the next session of therapy?
    D. Has anything changed since coming to counseling?

Answer:

DISCUSSION BOX: Conduct Disorder

ANSWERS FOR QUESTIONS 1-13

PART 1: PREPARING FOR THE CLIENT

Question 1.

✔ Discussion: Answer d. hesitation in approaching adults and a history of abuse. It was reported the client experienced maltreatment by his father, lacked confidence, withdraws into himself, is shy, insecure, and reluctant to talk to adult. This focal point for this question is the definition and meaning of trust and trustworthiness in creating client engagement. Clients with social anxiety disorder use experiential avoidance coping strategies to respond to threats that surface shame and embarrassment (Tursi, Sellers, & Marquie, 2021). Trust is an important component of effective counseling relationships and may be based on a client's personal experiences and cultural group history. Trust exists between two individuals when one believes the other person is honest, sincere and feels safe while interacting with the other person who will not deliberately harm them (Bray, 2022; Skocic, Jackson, & Hulbert, 2015). Social anxiety clients tend to use perseverative cognition, social inhibition, blunting, and monitoring to avoid situational settings in which threat is a possibility (Metzo et al. 2005; Bailley et al., 2019). The core attributes of the counselor involving awareness of self and impact on clients result in the counselor using empathic responding, a non-judgmental stance, foundational listening, attending, and reflecting skills to respond (Domains 6a, h, j, k, M.).

✘ Answer a. The client did present with hesitation but suggesting ambivalence is the driver for a lack of trust in the counselor-client relationship may be a supposition.

✘ Answer b. The client going inward when he senses threat was not substantiated during the intake. Further assessing might warrant 'threat' as the reason for the going inward or withdrawing from others.

✘ Answer c. Lack of understanding why he was referred for counseling can be cleared up when the counselor communicates the ethical obligations of explaining the processes, procedures, risks, and benefits plus the client's rights and responsibilities.

Question 2.

✔ Discussion: Answer d. rumination. Rumination is repetitive self-focused thinking about the implications, causes, and meanings of one's negative feelings. It affects mood, problem-solving, and cognitive functioning. Rumination may be caused by inhibition impairments but also can be a type of coping (affective & cognitive rumination). Alexithymia may contribute to treatment resistance of psychological symptoms (Edwards, 2022).

✘ Answer a. Alexithymia refers to difficulties in identifying and describing feelings, differentiating between bodily sensations and feelings, and considered to be a cognitive style of concrete thinking.

✘ Answer b. refers to a lack of pleasure in response to rewarding stimuli and is a core feature of depression and prominent in bipolar (Fang et al., 2021).

✘ Answer c. Intolerance of uncertainty (IU) refers to a client's "dispositional incapacity to endure the aversive response triggered by the perceived absence of salient, key, or sufficient information, and sustained by the associated perception of uncertainty (Carleton, 2016, p. 31)"

Question 3

✔ Discussion: Answer a. physical and mental abuse. Even though the client is not working up to his ability, the presenting issue focused on his inability to relate to his peers, withdraws, is shy and received maltreatment by his father.

✘ Answer b. The client's mental ability and school performance are on par, that was not the presenting issue.

✘ Answer c. Attachment style is important to assess but was not defined in the presenting information

✘ Answer d. Attention and response inhibition was not a focus of the client's deficits.

Question 4

✔ Discussion. Answer a. The client does not involve himself with classmates (peers), is shy, and reluctant to approach adults.

✘ Answer b. The client's experiences as a child were not presented other than the maltreatment.

✘ Answer c. Physical markers were not assessed.

✘ Answer d. Parentification skills might be lacking but not observed during the assessment.

Question 5

✔ Discussion: Answer a. Compliance is a component of the treatment plan and emphasized during the ethical application of explaining the counseling process, procedures, risks, and benefits.

✘ Answer b. Setting goals is a component in establishing a treatment protocol and theory of orientation.

✘ Answer c. Relapse has not been presented as a risk for this disorder.

✘ Answer d. Cooperation is a factor in compliance which focuses on motivation and commitment to resolve the problem and a desire to reduce distress.

PART TWO

Question 6

✔ Discussion: Answer d. Empathize with the client about the task at hand and shift to a topic he uses daily. "What" questions derive information.

✘ Answer a. Focus on explanation is avoiding the physiological sign of hyperventilation and avoidance.

✘ Answer b. Telling the client to relax is most likely going to increase the anxiety.

✘ Answer c. The first part relating the concern to other people is an avoidance of the tension this client is experiencing

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Question 7

✔ Discussion: Answer b. Empathy and using non-judgmental foundational listening, attending, and reflecting skills allow for the client to develop a sense of being heard.

✘ Answer a. Referring to all people is not address this person.

✘ Answer c. Referencing the counselor's intent is not an opening when it is coming from the "I" position.

✘ Answer d. Removing the 'you' from the first of this response would be helpful as the client may focus on the 'you' and become more of a 'on the spot' tension builder. The counselor's reference to himself as a stranger is increasing what might be a difficulty in relaxation.

Question 8

✔ Discussion: Answer d. When the client senses threat (answering questions), physiological sensations appear causing the client to have distorted cognitions and may demonstrate an attentional bias for the social threat. As a result, the client takes an inward focus (Rowa & Anthony, 2005). This attentional shift is similar to emotional blunting.

✘ Answer a. Clients with social anxiety tend to internalize anxiety, see themselves as unable to achieve the necessary life skills.

✘ Answer b. Questioning in the classroom raises the tension level if the client are expected to answer questions.

✘ Answer c. Answering written questions removes the client from verbal interactions in a classroom setting

PART THREE

Question 9

✔ Discussion: Answer c. Emotional dysregulation is a numbing of both positive and negative emotions. There is a reduction in the broad range of emotions such as love, fear, anger, and affection (Ma, Min, & Wang, 2021).

✘ Answer a. Obsessions are urges or images that are intrusive and unwanted increasing distress.

✘ Answer b. Blunting refers to emotional indifference, a reduction emotional sensitivity, and a diminution in emotional responsiveness

✘ Answer d. Decentering is when the client (social anxiety disorder) recalls past social events in which they perceived themselves as failing and tends to strengthen their belief they have an inability to meet social situations.

Question 10

✔ Discussion: Answer c. "This is a good sign of your seriousness to overcome the problems you have been encountering. It will be good to see how this works." This response is a positive reinforcement in recognizing the client's improvements, motivation and commitment.

✘ Answer a. The first part of this response is an attempt to reinforce client participation in problem solving but somewhat empty of empathy

✘ Answer b. Referring to other children is an indirect way to reinforce the client's monitoring.

✘ Answer d. Discounting the importance is not advised and to follow that with an influencing statement about alternatives may be discouraging to the client.

Question 11

✔ Discussion: Answer a. functional analysis is a detailed analysis of a behavior to identify contingencies that sustain the behavior. Imagery refers to language that stimulates the individual's senses. In evoking the senses through touch, taste, sound, smell, and sight, the client derives a deeper understanding of their experience, connects with the meaning.

✘ Answer a. Reciprocal inhibition refers to the failure of cognitive control (compulsions/ obsessions, habits, etc.). The intervention is a stop-signal task to measure the action cancellation (action restraint).

✘ Answer c. Defusion helps the client to change how they relate to their inner experiences as to what they are, rather than what they present themselves to be. They defuse from obsessional stimuli when they use exposure in practice.

✘ Answer d. Mindfulness teaches the client for acceptance of internal experiences, decreases in depressive and anxiety symptoms, increased ability to be nonjudgmental and nonreactive, discourages suppression and avoidance of thoughts that lead to increased habituation and less reliance on compulsions (Key, Rowa, Bieling, McCabe, & Pawluk, 2017).

Question 12

✔ Discussion: Answer a. Psychoeducation is a first line approach in responding to the client's concern about medication. This can be supported through the counselor's experience or providing educational documents to support the client's concern.

✘ Answer Crisis intervention is effective at the time of the incident or event that has upset the client.

✘ Answer c. A recommendation for a big sister or brother is more effective toward the closure of the counseling program with continued positive interactions in the community.

✘ Answer d. Revising the treatment plan would not be necessary if the client is monitoring for compliance. If medication is or becomes an issue, the counselor is to recommend the client return to the prescribing physician or psychiatrist for consultation.

Question 13

✔ Discussion: Answer a. miracle question. The miracle question could have been asked in session one, but session two is not too late. Interpersonal relations may surface as a priority since he does not join groups, lacks friendships, and tends to seek isolation.

✘ Answer b. This response could be used for monitoring change.

✘ Answer c. This is a reasonable response because this is only session two and therapy is very likely to be over a lengthier period of time.

✘ Answer d. This probe is a monitoring effort as well.

Scoring

NBCC indicates that each of the 11-case studies will have 9-15 questions (10 will count for a final score). The entire 11 case studies will yield a total of 130-150 questions. Ten of 11 case studies will count for 100 questions that will count towards your score. The remaining questions are trial questions for future use. Your score report received after the exam will list a raw number of your correct answers compared against the maximum score for each domain (NBCC, 2023). Below is a possible example using the 5 scoreable domains and spread of percent of items for each domain. For this illustration, one point per question will yield a total of 100 points. This is an example report for any form that NBCC has developed.

Domain	Your	Max Score	Percent Range
Professional Practice and Ethics	11	16	(10-20)%
Intake, Assessment, Diagnosis	19	25	(20-30)%
Treatment Planning	13	16	(10-20)%
Counseling Skills/Interventions	21	27	(25-35)%
Counselor Attributes	14	16	(10-20)%
Total	78 or 78%	100	

The number of questions per domain fall within the spread percentages that NBCC has published in developing each case study (NBCC, 2023). Each form of the case studies is likely to have a different number and percentage for each form, but all will fall within the published range of percentages for that domain.

When considering the number of items in the six domains (173 items), there are multiple types of questions that can be formulated. It is known for this format that each question will be headed with a domain and sub-domain that will be the focus of that question.

The following Unit is a suggested list of terms, tools, and DSM-5-TR disorder information that may be helpful. The material may be utilized in the question sentences or format requesting one answer. Understanding the definitions and functions of these terms would be helpful.

UNIT II: RESOURCES AND TERMS

It is unknown the amount and type of specific information that will be required to respond to the multiple-choice questions and three parts in each NBCC case study. The NBCC single example does not require a diagnostic assessment (is provided), instrument selection, or global treatments. There is no indication of the length of time clinical procedures will span (number of sessions). There is a lack of specificity for what counselor-client tasks and duties will be required. Based on the online example, the case studies in this new exam may provide less-than-ideal passages of time between sessions.

Should the counselor's duties and tasks in the new format require the same knowledge bank for the six domain clinical procedures, the counselor-client interactional assessments and counselor resources and communication may be another preparation requirement. The below list is not extensive, or depth exhaustive, and additional resources might be needed. It might be good advice to add to this start up list.

The following terms are common in the literature for different disorders. Conducting a similar exercise for 20-25 disorders would be a helpful starting point.

Requests may be enveloped into questions that may include:

1. plans before the first or following session
2. plans between the sessions
3. genetic predispositions: bipolar I (high genetic determination), major depression
4. suicide risk: bipolar disorders, depression, PTSD
5. stigma: stigma for autonomy (bipolar disorder, OCD, schizophrenia)
6. revising or modifying a treatment plan
7. collateral services
8. disorders in which clients tend to be treatment resistant
9. disorders in which counselor-client alliance issues are based on trust
10. disorders in which compliance is problematic

TERMS

Terms are listed for different headings involving assessment, therapeutic alliance and issues, client behaviors, clinical symptoms, counselor techniques and client deficits, and monitoring. Terms may fit into different categories.

ASSESSMENT

Acculturation: refers to the process of adopting the cultural norms of the majority culture, including adjusting to a new language, customs, and rituals (Helms & Cook, 1999).

At-risk mental states: Disorders such as schizophrenia, psychosis, dementia and Alzheimer's disease, brief psychotic disorders may need assessing for capacity to understand informed consent procedures.

Bipolar screening instruments: Zimmerman (2014) listed the most widely used instruments for bipolar disorders. Bipolar Spectrum Scale (bipolar I), Mood Swings Questionnaire/Survey (distinguish bipolar I and bipolar II), The Hypomanic Checklist (hypomanic features and bipolar II), and Mood Disorders Questionnaire (life time history of mania or hypomania).

Character strengths and traits: The purpose in assessing for strengths is often a result of clients who present with vulnerabilities. Disorders with symptoms of anxieties, existential despair, pain, and misery are often a result of a build-up of tension between inner strength (resiliency) and vulnerability. The counselor's intervention is to decrease or eliminate the tension to increase the potential for client change and growth. Strengths can be understood to mean the capacity to cope with difficulties, maintain functioning, bounce back, and use external challenges as a stimulus for growth (McQuaide & Ehrenreich, 1997). The authors reported that strength perspectives have been used with a wide variety of client situations (severely mentally ill, addiction, clients with disabilities, children, elderly, and the homeless). Strength perspective has served in another capacity, empowerment. Identifying strengths has been used to solve immediate problems as well as future problems. Strengths are identified in five categories: cognitive and appraisal skills, defenses and coping mechanisms, temperamental and dispositional factors, interpersonal skills and supports, and external factors.

Character traits: 24-character traits involve reflection wisdom, courage, social and community strengths, and protective strengths. The counselor assesses for strengths that are exhibited in the different character traits.

Client competence (Comprehensive Assessment of At-Risk Mental States-CAARMS): The 2015 CAARMS is a brief interview version to assess for competence. This is important in the mental health assessment to assure the client has the capacity to understand informed consent procedures and consent to treatment. Consider disorders where this may be problematic (brief psychotic disorder, schizophrenia, memory issues, and psychoses).

Cultural idioms: cultural concepts such as idioms are ways of communicating emotional distress specific to personal or social ways of expressing somatic, emotional, and social meaning. A specific phrase may signify the distress such as 'heat in the heart'.The DSM-5-TR provides several examples of cultural concepts of distress based on folk lore throughout the world. Examples include Ataque de nervios, Dha syndrome, Hikomori, Khyal cap, Kufungisisa, Maladi drab, Nervios, Shenjing shuairuo, Susto, and Taijin kyofusho (APA, 2022).

Dark triad (unhealthy lifestyle): This dark triad concept focuses on the health potential of a person. Health behaviors reflect self-esteem, self-efficacy, optimism, sense of coherence, and mental resilience (Debska et al., 2021). Dark triad consists of three personality traits: narcissism (grandiosity, entitlement, dominance, and superiority), Machiavellians

(manipulation, self-service, amorality, and deceit), and psychopathy (impulsivity, thrill seeking, low empathy, and anxiety). Individuals put their personal good ahead of the public interest.

Impairment: is the severity of the client's subjective distress and reduced functioning. Clients manifesting impairment in 2 or more areas of functioning are likely to benefit from treatment that is lengthier and from psychoactive medication. Clients who have little social support from other people are likely to benefit from lengthier therapy and development of social support outside of therapy.

Deficit syndrome: is a syndrome requiring at least two out of six negative symptoms, restricted affect, diminished emotional range, poverty of speech, curbing of interest, diminished sense of purpose, and two or more those in the last 12 months for schizophrenia (Kirkpatrick & Gadleerisi, 2008).

Internal Reactivity Index (IRI) IRI assesses for perspective taking, fantasy, empathic concern, and personal distress. This is a measure of individual differences in empathic tendencies and responsiveness to others (Ingoglia, Coco, & Albiero, 2016).

Malingering: refers to a falsification of information (physical or mental). A client may fake responses to enhance external benefits. Some instruments such as the MMPI have specific scales to measure this tendency. The focus word for malingering would be avoidance. For example, a client with an eating disorder might use denial and minimization (Berg, Peterson, & Frazier, 2012).

Response distortion: Deception and manipulation are considered core psychopathic traits. Over-reporting is known as malingering or faking bad, an intentional exaggeration of psychopathically traits/symptoms.

Severity Levels (mild, moderate, severe): The levels of severity are an outcome of the dimensional assessment DSM-5 addition. Example: Oppositional Defiant Disorder–MILD symptoms confined to one setting, MODERATE some symptoms in at least two settings, and SEVERE some symptoms in three or more settings.**State and Trait:** State and trait for personality disorders involve meanings for ego dystonic/ego syntonic. A trait is a stable disposition over time, and a state is a behavior that is activated to respond to a particular behavior and the tendency to be responsive to others.

Strength: resiliency is the capacity to cope with difficulties, to maintain functioning in the face of stress, to bounce back in the face of significant trauma, to use external challenges as a stimulus for growth, and to use social supports as a source of resilience.

Tripartite Model: of anxiety and depression: refers to a model used to describe comorbidity between anxious and depressive symptoms and disorders. Watson and Clark (1991) proposed this model that divides symptoms into negative affect, positive affect, and physiological hyperarousal.
Negative affect refers to feeling upset/unpleasant, distress, fear, disgust, scorn, and hostility. Mood states for depression include sadness and loneliness, insomnia, restlessness, irritability, and poor concentration. Positive affect includes enthusiasm, energy level, mental alertness,

interest, joy, social dominance, adventurousness, and activeness. A low level of positive affect is anhedonia. Anhedonia is the loss of interest and an inability to experience pleasure when experiencing things that used to be pleasurable (characteristic of depression).

ALLIANCE

Alliance rupture refers to interactions that break down between the counselor and client. There can multiple reasons for poor communications. The counselor works best when an effort is made to rectify the rupture by using open communication (open dialogues, empathic attunement, reformulation). The communication styles influence the social and intimate relationships with others. When relationships are avoided or violated, clients experience disconnections. Cultural-relational theory advocates that clients who disconnect with others use avoidance strategies to manage disagreements, misunderstandings, and conflicts in relationships. The client may exhibit a sense of shame and humiliation. Behavioral responses include blaming, withdrawing, ignoring, minimizing, or attacking others to achieve some degree of emotional safety (Duffey & Trepal, 2016).

The Session Questionnaire has two versions for session feedback for the client and the counselor each with 15 items assessing for the therapeutic alliance, problem activation, and problem-solving (Grawe,1998).

Communication core conditions and 5 W's and 1H: Carl Rogers developed what he referred to as the fully functioning person. To function at one's best he focused on core conditions that included microskills, respect, genuiness, empathy, concreteness, immediacy, self-disclosure, and confrontation. The 6 Ws and 1 H are who, what, when, where, why and How. The useage of each word elicits from clients responses in the cognitive, affective, and behavioral domains. What derives information, Who requests involved person(s), Where elicits locations the symptoms are taking place (areas for clinical focus), When requests a time/timing of the disturbance (recent, past), and How elicits emotions.

Compliance: refers to issues involving medication, homework, therapy attendance, and personality dynamics. Simpson et al. (2011) reported on the importance of treatment adherence for treatment outcome. Homework compliance may be one observation for early adherence and integrity. Non-compliance is a signal that the counselor may need to revisit the commitment to adhere to the treatment program.

Cultural Formulation Interview (CFI) is a person-centered instrument for apprising the impact of cultural factors in psychological assessment. The factors of the CFI are important for assessing and in developing, maintaining a therapeutic alliance, enhancing client rapport, and important in treatment interventions to induce change. Strand and Baarnhielm (2022, p. 847) reported differences in gender, ethnicity, age, socioeconomic background, education level, language, sexual orientation, religious beliefs, occupation and disability that can contribute to misunderstandings, lack of insight by clinicians into the contexts and failure to establish rapport and trust. When these factors are not observed and considered, treatment adherence, negative outcomes, and prolonged distress often contribute to a negative trajectory for the disorder. The CFI has been shown to enhance rapport, emphasize the

interpersonal-social relationship, and offer signs to the client that their experiences and views are important. To understand the client's cultural heritage, the therapist conveys compassion and curiosity, rather than influence a client's misperception of a counselor's judging or classifying. Research indicates certain clients assessed with personality disorders, self-injurious behaviors, and eating disorders experience these barriers in developing an alliance.

Derailment: is referred as a sense of instability and self-direction over time and is accompanied by disruption of self-continuity evolving from a lack of identity commitment. Feelings become confused when clients become aware they are or may become a different person. During the counseling process old patterns of self-identity are replaced by new commitments and surface difficulties in reconciling the difference in adjusting to change (Ratner et al., 2021). The client's sensing derailment causes a low-level of well-being (Chishima & Nagamine, 2021).

Informed Consent: is composed of three elements that are meaningful for informed consent. They are information disclosure (full and relevant information), decisional capacity (encompasses understanding, appreciation, reasoning, and stable choice), and voluntary decision-free from coercion (Dunn, 2007).

Interview styles: Different interview styles fit different disorders and settings. The decisions are based on function/purpose and include those identified in Domain 2, intake, assessment, and diagnosis (2A-2D), clinical interview, biopsychosocial interview, mental status interview, motivational interview, cultural formulation interview, and solution-focused interview.

Motivational interviewing principles: focus on exploring and resolving ambivalence and processes within the individual that facilitate change. The counselor interacts with the client by expressing empathy, supporting self-efficacy, rolling with resistance, and developing discrepancies. Skills include OARS (open-ended questions, affirmations, reflections, summaries). Domains 6 G, H, K, and M include foundational listening, attending, and reflecting skills. The communication for change talk is to elicit a client's wants or desires (I want to change), the ability (I can change), solid reasoning (it is important to change), and a felt need (I need to change). Change talk is a good indication the client is embracing motivation and commitment in the therapeutic endeavor and becomes a vehicle in monitoring client change.

Ruptures in alliance: occur due to specific symptoms experienced for different disorders. Schizoid personality disorder clients symptoms of an inability to communicate their difficult feelings and inner worlds, distance themselves, and loneliness can cause ruptures (Thylstrup & Hesse, 2009).

Sawtooth pattern: relates to features of an alliance. A sawtooth pattern is one in which the alliance changes over time. This type of pattern is one in which there is within-session sudden increases followed by between sessions decreases which localizes sudden gains in the alliance. Overall, a sawtooth pattern is an unstable development (Kivity et al., 2020).

Solution-focused style emphasizes asking questions related to the client's counseling goals and the miracle question to use to assess for the client's picture of what change is to look like

and motivation to change (ask if any part of the miracle question is already taking place). Solution-focused therapy, a term for what would the client wishes change to look like is helpful for developing goals and securing client motivation. Solution interviewing focuses on what brought the client to therapy, how can the counselor help, employing the miracle question, probe for relationships with others, and use the exception question (are there any parts of the miracle question operating right now), scaling questions, and if there is anything else.

SYMPTOMS

Bidirectional symptoms refer to a relationship of symptoms. For example, generalized anxiety disorder clients experience sleep disturbance that exacerbates rumination and rumination affect sleep.

Emotional cascade: The emotional cascade model describes a cycle in which rumination increases the intensity of negative emotions and in turn prompts continued rumination (Selby et al., 2008).

Emotions: are defined along three dimensions, valence, arousal, and object focus. Valence and arousal are common to all emotions but do differ in contents, origins, and functions (Pekrum, et al., 2023).

Prodromal (schizophrenia spectrum): consists of low-grade symptoms assessed retrospectively that gradually emerge before the onset of psychosis and are considered for relapse. Examples of prodromal symptoms may include loss of interest in work, social activities, personal appearance (hygiene), generalized anxiety, and mild degrees of depression, all of which may precede psychotic symptoms. This phase is mostly limited to negative symptoms such as blunting, incongruity of emotional response, apathy, paucity of speech, and breaks in the client's train of thought (Keith & Matthews, 1991).

Residual symptoms: Residual symptoms follow directly from a psychotic episode (DSM-5-TR, Category A) and are collected prospectively (hallucinations/delusions). Cognitive impairment and depressive subsyndromal symptoms are the most widely studied for bipolar disorder (Samalin et al., 2016).

Social bonding: Klerman et al. (1994) identified four elements (representations) to address social bonding such as: 1. enhancing social skills, 2. decreasing interpersonal stress, 3. facilitating emotional processing, and 4. improving interpersonal skills that adapt well to integrative therapy (IPT).

Soft and hard neurological signs: This terminology identifies different neurological deficits often found with schizophrenia. Hard signs refer to impairment in basic motor, sensory, and reflex behaviors. Hard sign symptoms for schizophrenia include delusions, hallucinations, disorganized thinking, and negative symptoms. Soft signs are subtle deficits in sensory integration, motor coordination, and sequencing of complex motor acts (Bachmann, Degen, Geider, & Schroder, 2014).

Subthreshold: refers to a stimulus that is not of sufficient intensity to elicit a behavior or disorder. A psychotic disorder may have low intensity symptoms but do not meet the criteria to call it brief psychotic disorder. The same holds true for other disorders.

Sudden gains (SG) and Sudden losses (SL): refers to rapid symptom increases or decreases typically developing out of the preceding session and reported in the next session. Counselors should be trained for alert signals representing a critical event referred to as a critical session. Sizable gain research focus has been to determine what drives these gains or the causative or triggering factors. The SG/SLs reflect the instability and variance of symptom severity and it is important to be assessed at or from baseline assessments. Some identified factors have conflicting or contradictory findings. The two most common contributing factors are isolated and understanding in most research reporting cognitive changes (cognition-based) and for expressive-experiential modalities (emotion factors). Following factors suspected to contribute to SGs and are literature based: a) cognitive changes (O'Mahen et al., 2021; Andrews et al., 2020; Koffman, 2020; Marco et al., 2020; Bailey et al., 2019; Vincent & Norton, 2019; Thorisdotti et al., 2018; Wucherpfennig et al., 2017; and Tang & DeRubeis, 1999), b) cognitive behavior therapies (O'Mahen et al., 2021; Visla, Constantino, & Fluckiger, 2021; Andrews, Hayes, & Abel, 2020; Kivity, Strauss et al., 2020; Vincent & Norton, 2019; Mychailyszyn, Carper, & Gibby, 2018;Tang et al., 2005), c) experiential-expressive modality (Singh et al., 2021; Andrusyna et al., 2006), d) expression of adaptive emotions-self-compassion (Singh et al., 2021), e) meaning-making (Singh et al., 2021), f) hope (Erekson et al., 2020; Abel et al., 2016), g) alliance (Hillman et al., 2022; Kivity et al., 2020; Lutz et al., 2013), h) engagement (Vincent & Norton, 2019), and i) life events and sudden physiological-psychological changes prior to the SG (Andrusyna et al., 2006).

Not all therapy symptoms change on a linear perspective, some have ups and downs, some changes are within and between sessions. SGs are best understood by the counselor and client through therapeutic interchanges through a baseline assessment of symptom severity (Zilcha-Mano et al., 2019). Bohn, Aderka, Schreber, Stangier and Hofmann (2013) reported a three-phase process for therapeutic interchanges with the client. When SGs are observed or reported there are early warning signs (EW) in the form of fluctuations in emotions and represent a discontinuous change pattern. The first phase is discovery of the mechanisms. Review the treatment modality for specific mechanism that drive the SG changes (above factors). This is best accomplished when the therapist uses techniques that establish the foundation for the sudden changes. The second phase or stage is when the breakthrough occurs and sudden gains appear. In the third phase an upward spiral occurs and to preserve the change and to avoid reversal is to promote further change.

Symptom effects are assessed for levels and for client internal expressions (persistent depressive disorder, major depressive disorder, autism spectrum, decreased self-esteem, self-image). Internalizing clients tend to benefit from interpersonal and insight-oriented therapies in developing a coping set of skills. Externalizing clients tend to blame, take little responsibility for their actions, and avoid situation where they will be confronted (antisocial personality disorder, narcissistic personality disorder, oppositional defiant disorder, blame others). To

develop a coping style, externalizing clients tend to benefit from symptom-focused and skill-building therapies. Symptoms are assessed for frequency, duration, and severity. The positive and negative symptoms for schizophrenia are central to the diagnosis and treatment.

Symptom severity: Symptom severity involves dimensional assessment for frequency, duration, and severity. Symptoms for different disorders are observed under different conditions and settings. For adjustment disorder, acute stress disorder, and posttraumatic stress disorder the intensity of the stressors tend to be described as acute and chronic. Seven types of acute events include death of a loved one, divorce, moving, criminal act, accident, retirement, and termination of leisure. Nine types of chronic events include financial difficulties, family conflict, serious illness, conflict at a job, conflict with neighbors, too much/too little work, illness/care of a loved one, unemployment, and pressure to meet deadlines (Glaesmer et al., 2015; Einsle et al., 2010).

Timing disturbance: Timing disturbance is a key component for schizophrenia. Timing disturbance is the ability to process event duration and to integrate contextual information into a predictive framework plays a pervasive role in the continuity of consciousness (Ciullo et al., 2018). Reality is disturbed by alterations in the experience of time and is a temporal processing distortion. A distinction exists between perception of time and timing of perception. Perception of time refers to the subjective experience of the passage of time and duration of an event. Instead, timing of perception refers to the temporal resolution in processing events(Amado et al., 2022).

Trajectories: of mental disorders involve sequential and integrative relationships among genetic, neural, behavioral, and experiential/environmental factors leading to psychopathology or to recovery. Acute stress disorder that does not improve (untreated) over time (3 months) is predicted to become posttraumatic stress disorder (Visser et al., 2022; Ali, Pihl-Thingvad, & Elklit, 2021).

Unexplained symptoms: are medical complaints unexplained symptoms (MUS) when clinical findings provide evidence of incompatibility between the physical symptom and recognized neurological or medical conditions (Sansone & Sansone, 2010; Scamvougeras & Howard, 2020).

Vegetative symptoms: Vegetative symptoms are necessary to maintain life with a clinical mental disorder such as depression. Examples include change in sleep, changes in bodily functions, weight loss and loss of appetite, insomnia, fatigue and low energy, and inattention. The client may even lack self-awareness and cognitive functioning (Paradiso, Duff, Vaidya, Hoth, & Mold, 2010; Toenders et al., 2020). Vegetative changes such as anergia, hypersomnia, increased appetite, a craving for carbohydrates, and weight gain. These signs are often considered the core of the disorder (Enggasser & Young, 2007).

CLIENT BEHAVIOR (features in counselor presentations)

Adaptive behavior: definition (neurocognitive disorders) and definition/meanings for conceptual, social, and practical domains (intellectual development)

Alexithymia: refers to difficulties in identifying and describing feelings, differentiating between bodily sensations and feelings, and is considered to be a cognitive style of concrete thinking. Edwards (2022) reported that alexithymia may impede treatment progress. Alexithymia for treatment resistance involves a) difficulties applying appropriate labels to emotional experiences, b) difficulties communicating and expressing emotional experiences and needs to others, and c) cognitively rigid thinking style that attends to external information over internal information (p.1192). Alexithymia is a common symptom in somatoform disorder, panic disorder, obsessive-compulsive disorder, social phobia, and depression (Tapanci, Yildirim, & Boysan, 2018).

Anhedonia: refers to a lack of pleasure in response to rewarding stimuli and is a core feature of depression and prominent in bipolar disorders (Fang et al., 2021).

Attachment styles (relational view for influence in client disorders—ODD, CD): The writings of Jane Ainsworth and John Bowlby described different behavioral styles in the relationship development between the child and parent(s). Four attachments styles include anxious, avoidant, disorganized, and secure. Attachment styles are based on the parent-child relationship. When these reflect issues associated with all but the secure type, physical or emotional deprivations are prominent and associated with several disorders.

Attention: is the primary source of individual differences that determines the susceptibility to ruminate in response to negative affect. Those clients with narrow scope (major depression disorder) are thought to allocate more resources to the thought in the center of their attention than individuals with broad attentional scope. High ruminators for emotional states tend to process more narrowly for sad or depressed mood symptoms (Fang et al., 2018).

Attentional scope: refers the primary source of individual differences that determines a client's susceptibility to ruminate in response to negative affect. The focus a client attends is the center of their attention rather than a broad scope attentional focus. The narrow approach is known to exist for client's who ruminate and is especially important for depressive disorders. The client is likely to be high ruminator, therefore becomes even more narrowly focused on negative mood-relevant information (Fang, Sanchez-Lopez, & Koster, 2018).

Blunted affect: refers to emotional indifference, a reduction emotional sensitivity, and a diminution in emotional responsiveness. Emotional blunting is frequently reported when alexithymia is a core symptom. Cognitive appraisals tend to shape perceptions of unrelated situations and in guiding behaviors. Clients who blunt use selective attention to seek out information that is congruent with their beliefs and opinions and avoid exposure to information that is contrary to their beliefs. They will avoid dissonance and use psychological defenses of repression, suppression, and denial (Case, Andrews, Johnson, & Allard, 2005). Blunting refers to when individuals (clients) seek out distractions when confronted by a threatening situation (Mezo, McCabe, Antony, & Burns, 2005). Blunting can be an adaptive coping strategy for clients with social anxiety disorder. It can also increase the symptom and become worse. The Oxford Questionnaire (Ma, Cai, & Wang, 2021), Monitoring-Blunting

Questionnaire (MBQ) and Monitoring Blunting Social Situations (MBSS) assess for blunting (Killian et al., 2015).

Blunted affect, a negative symptom, is a prominent symptom of schizophrenia, depression, and PTSD. The client has trouble in expressing their emotions outward. There is diminished facial expression, expressive gestures, and vocal expressions in reaction to emotion provoking stimuli. It is likely the client's internal emotional experience does not mirror their reduced external expressions (Killian et al., 2015). Emotional blunting is when the client is not feeling their feelings very strongly, and are emotionally numb. Lambe, Craig, and Hollentein (2019) reported the link between depressive symptoms and blunted physiological stress reactivity. Blunting is also common to social anxiety disorder and depression and presents an assessment difficulty in attributing blunted affect in conducting a diagnostic classification for schizophrenia, depression, or a different disorder.

Emotional blunting can have different affect outcomes depending upon how the client perceives a negative event and can elicit a specific emotion. Winterich, Han, and Lerner (2010) reported that if a client appraised a negative event to be controlled by other individuals, the emotional outcome is likely to be anger. Although, if the event is controlled by the situation (environment), the emotion is likely to be sadness. This is referred to as an appraisal tendency (ATF). Emotional blunting with the passage of time can carry over into a subsequent emotion such as sadness blunted subsequent anger and anger blunted subsequent sadness (Winterich et al., 2010). Six cognitive dimensions define the appraisals underlying emotions: pleasantness, anticipated effort, certainty, attention activity, self-other responsibility/control, and situational control agency (Smith & Ellsworth, 1985)

Blunting and Monitoring: Blunting refers to the degree to which individuals seek out or avoids distractions when confronted by a threatening situation. A client will blunt when encountering a threatening situation. Monitoring is when the client seeks out information ahead of the time when a situation is likely to develop (Mezo et al., 2005).

Brooding and reflection: are two components of rumination. Brooding is a passive form of a self-critical form of rumination and both have been linked to depression and suicidality. Reflection, although a component of rumination, does appear to have elements of adaptive reasoning and may distance the person from negative emotions (Gooding, Taylor, & Tarrier, 2012).

Callous-unemotional (CU) refers to traits including lack of guilt, lack of empathy, and shallow affect (Hawes, Price, & Dadds, 2014). High levels of CU traits that are particularly sever and is an example of chronic trajectory for antisocial behavior. CU is associated with conduct disorder, and intermittent explosive disorder. The CU trait in client disorders is strong evidence for poor treatment outcomes.

Cognitive emotional regulation: is assessed to determine how an individual responds to emotionally arousing information and controls emotions during or after an adverse event. A client, during a request for self-appraisal, may tend to internalize or externalize the symptom tendency as ruminating, blaming or will reappraise and move forward in a positive direction

using resiliency strategies. Examples include: self-blame, other-blame, rumination, catastrophizing, putting into perspective, positive refocusing, positive reappraisal, acceptance, and refocusing

Distress tolerance: refers to the ability to accept, in a non-evaluative and nonjudgmental fashion, both oneself and the current situation. Distress tolerance focuses on tolerating and surviving crises and accepting life as it is in the moment. Skills taught are distracting, self-soothing, improving the moment, and thinking of pros and cons.

Emotional cascade model: refers to a cycle in which rumination increases the intensity of negative emotion and negative emotion prompts continue rumination and often reaches unbearable levels (Arbuthnott, Lewis, & Bailey, 2015).

Executive functioning: is composed of three components and is important in regulating emotions and inhibiting undesirable behaviors. The components are set shifting, monitoring and updating, and inhibition. Executive functions are mental control precesses that involve directing attention, patten recognition of priority, goal formulation, activity planning, plan implementation, self-regulation, inhibitory control, flexibility, and self-evaluation of the results from performed action (Jimenez, Jane-Ballabriga, Martin, & Brophy, 2018; Senn et al., 2004).

Impulsivity: Impulsivity involves four facets. One, a lack of premeditation (tendency to act without careful thought). Two, negative urgency(tendency to engage in impulsive behaviors in the content of intense negative emotions). Three, sensation seeking to seek excitement tendency. Four, a lack of perseverance; experiencing difficulty completing tasks and a tendency for boredom (Whiteside & Lynam, 2002). Negative urgency is considered the most distinct fact (Wahl et al., 2021).

Mentalization: Tauber et al. (2021) reported mentalization as the individual's imaginative ability to perceive oneself and understand oneself, and others' mental states and behaviors as the product of affective and cognitive mental states. Mentalization can mediate the relationship between childhood maltreatment and externalizing problems (such as in conduct disorder). It is a self-reflective an interpersonal component (Babi et al., 2015). Eye behavior is taught to clients who have deficits in limited prosocial emotions and reciprocal relations (sibling rivalry) and in emotional dysfunctionality.

Perseverative cognition: refers to continuous (repetitive) thinking about negative events in the past or future. Perseverative cognition is characterized by higher cognitive inflexibility (difficulties inhibiting thoughts and interference with ongoing activities), mood worsening, and autonomic nervosa system rigidity. Worry and rumination are habitually dysfunctional coping strategies for major depression and social anxiety disorder (Bailey, Shabhabi, Tarvainen, Shapiro, & Ottaviani, 2019).

Physiological hyperarousal is an increased activity in the sympathetic nervous system in response to threat. Anxiety disorder hyperarousal includes shortness of breath, feeling dizzy/ lightheaded, dry mouth, trembling, shaking, and sweaty palms (social anxiety disorder). The Positive and Negative Affect Schedule (PANAS) measures for positive and negative affect.

Psychological flexibility: Acceptance and commitment therapy (ACT) targets six core processes of change that involve acceptance, cognitive defusion, awareness of the present moment, self as context, values, and commitment to action (Twohig et al., 2015).

Relapse (disorders): Alcohol use disorder, bipolar I and II, obsessive-compulsive disorder, and major depressive disorder have established histories for relapse in which the client returns to pretreatment symptoms for the disorder (Feihuan et al., 2021; Pilgrim, Karakashian, & Hanson, 2021). Relapse prevention is included in treatment planning, and the protocol calls for safeguards that may include discontinuation of medication and prevent post-treatment failures to maintain healthy choices.

Resistant clients: the counselor should develop an awareness for which disorders that clients are likely to resist change and are literature supported. Antisocial personality disorder where clients do not respond well to therapy, they refuse treatment (McGonigal & Dixon-Gordon, 2020; Caple & Schub, 2018; Messina, Wish, Hoffman, & Nemes, 2002).

Response Distortion: Core psychopathic traits are deception and manipulation (Knack, Blais, Baglole, & Stevenson, 2021; Gortz et al., 2017). Response distortion can be displayed in a number of ways such as positive impression management (faking good), malingering (over-reporting or faking bad) involving exaggeration, and underreporting negative traits.

Response Inhibition: refers to the failure of cognitive control (compulsions/obsessions, habits, etc.). Response inhibition refers to individual differences in the ability to suspend a response during an active moment-to-moment behavior. The intervention is a stop-signal task to measure the action cancellation (action restraint). Cognitive behavioral therapy (CBT) is recommended when the client exhibits high emotional reactivity, poor insight, or difficulty comprehending the rationale of treatment (Jonsson, Kristensen, & Arendt, 2015).

Rumination: Rumination is repetitive self-focused thinking about the implications, causes, and meanings of one's negative feelings. It affects mood, problem-solving, and cognitive functioning. Rumination may be caused by inhibition impairments but also can be a type of coping (affective & cognitive rumination). The primary source of individual differences in rumination is the attentional scope of the client. A person with a high attentional scope tends to have limited control over negative thinking thus impaired disengagement of attention from negative information (Fang, Sanchez-Lopez, & Koster, 2018). Brooding and reflection are two components of rumination. Brooding is a passive, self-critical form of rumination and both has linked to depression and suicidality. Reflection, although a component of rumination, does appear to have elements of adaptive reasoning and may distance the person from negative emotions (Gooding, Taylor, & Tarrier, 2012).
Women ruminate and men tend to use avoidance. Rumination is a risk-facto. There are two-forms of rumination for children are sadness and aggression (Harmon, Stephens, Repper, Driscoll, & Kistner, 2019). Wahl et al. (2021) reported that rumination about obsessive symptoms and mood maintains obsessive-compulsive symptoms and depressed mood. Rumination is a tendency to passively perseverate on feelings of distress and their causes and

consequences which leads to more intense negative affect (Nolen-Hocksema, Wisco, & Lyubomirsky, 2008).

Anger rumination is based on the causes and consequences of anger. Emotional arousal and stress are increased (Offredi et al., 2016).

Self-control: refers to the "ability to override impulses to act as well as the ability to make oneself initiate or persist in boring, difficult, or disliked activity" (Carver, 2019, p 477). Emotions are related to their perceptions of personal control over, and value of, achievement-related activities and outcomes (Forsblom et al., 2021).

Sense of self (SOS): refers to awareness of one's physical body and mental state. It is an awareness of one's inside awareness with one's outside awareness. Moe and Docherty (2013), in describing SOS as a symptom for schizophrenia, focus on a disruption caused by two distortions of consciousness, hyperreflexivity (exaggerated self-consciousness) and diminished self-affection. SOS is a core feature for schizophrenia (Moe & Docherty, 2013).

Sluggish cognitive tempo (SCT): SCT refers to a cognitive impairment and deficits commonly associated with ADHD. It is composed of a group of symptoms that include daydreaming, feeling spacey, moving slowly, and processing information slowly (Kamradt, Eadeh, & Nikolas, 2022). Involved is a deficit in executive functioning for problems with organization and problem solving (Jarrett et al., 2017).

Social attribution: The social attribution model refers to any action that can be categorized as internal or external. Feelings and cognition mediate the relationship between mental health signals and people's response to these signals. Clients with mental health disorders externalize and internalize symptoms. Increased internalizing symptoms are prominent in depression and anxieties and include decreases in self-esteem, negative self-image, and poor academic performances (Camodeca & Goossens, 2005).

Social bonding: Klerman et al.(1994) identified four elements (representations) to address social bonding such as: 1. enhancing social skills, 2. decreasing interpersonal stress, 3. facilitating emotional processing, and 4. improving interpersonal skills that adapt well to integrative therapy (IPT).

Stigma: Mental health stigma has focused on medically explained and unexplained symptoms and has been assessed as internalized stigma. The DSM-5-TR somatic symptom disorder has medically explained and unexplained symptoms. Somatic symptom disorder clients experience internalized stigma and interventions should involve empathy.
Stigma exists for other mental health disorders such as OCD and schizophrenia spectrum (Espinosa, Valiant, Rigabert, & Song, 2016; McCarty, Guzick, Swan, & McNamara, 2017). Clients are targets of negative attitudes, social labels, social rejection, social distancing, pity, devaluation, separation, and being different (Aydogmus, 2020). A stigma can trigger an initial episode of psychosis, relapses, and even promote a more severe course (Hoftman, 2017). Corrigan, Rafacz, and Rusch (2011) and Angermeyer, Beck, and Matschinger (2006) reported that there are three core beliefs linked to mental health stigma: dangerousness, dependency, and controllability and pity, anger, and fear are three emotional reactions to a stigma.

Sub-threshold: refers to a stimulus that is not of sufficient intensity to elicit a behavior or disorder. A psychotic disorder may have low intensity symptoms but do not meet the criteria to call it brief psychotic disorder. The same holds true for other disorders.

Working memory (component of executive functioning) refers to the ability to memorize and then process information in the short term. It involves reasoning, decision-making and includes the ability to memorize, active processing of incoming visual-stimuli and auditory information that require focusing and attention for new and old learning. Working memory is a cognitive component that allows for the capacity to hold information temporarily. Working memory controls for the duration in temporal and color discrimination both of which reflect a timing disturbance for clients with schizophrenia (Ciullo, 2018). It is the basis for higher cognitive functioning for planning, problem solving, reasoning, and language (Oflaz et al., 2014). Working memory requires the ability to encode, tore, manipulate, and retrieve information.

Worry: Intolerance of uncertainty (IU), cognitive control, and attentional control (AC) are three main elements that contribute to worry. Cognitive control refers to the processes involved in regulating, coordinating, and sequencing thoughts and actions to accomplish a goal (Braver, 2012). AC is the ability to regulate control in the face of distractions and to disengage, shift, and focus attention on current goals (Saulnier et al., 2021)

TECHNIQUES/STRATEGIES

Attentional shift training: is a technique to reduce self-focused attention, increase attention flexibility and modified performance on an emotional attention set shifting task. It is frequently useful for cognitive and threat related issues such as adjustment disorder, acute stress disorder, and posttraumatic stress disorder. Cognitive attentional syndrome (CAS) leads to emotional disorder and is helpful for emotional regulation.

Attention Training (ATT) is a technique used in metacognitive therapy. The focus for change is to reduce self-focused attention, increase attention flexibility, and modify performance on emotional attention set shifting task. A threat related bias in cognitive functioning is a primary factor involved in the maintenance of anxiety and manifested in worry, rumination, and focusing on threat-related stimuli. Cognitive control is central to cognitive attentional syndrome and is linked to activate perseveration processing (Callinan, Johnson, & Wells, 2015). ATT reduces self-focused attention, increase attention flexibility, and modifies performance on emotional attention set sifting tasks (Callinan, Johnson, & Wells, 2015).

Bilateral stimulation: is a core treatment element for several disorders representing two symptoms associated with each other. EMDR treatment is an example and has four main effects using visual or auditory stimulation. The effects include relaxation (decreased physiological arousal), increased attentional inflexibility, distancing effect (problem seems smaller), and decreased worry (Kaminska et al., 2020; Amano & Toici, 2016).

Cognitive emotion regulation: is assessed to determine how an individual responds to emotionally arousing information and controls emotions during or after an adverse event. A

client, during a request for self-appraisal, may tend to internalize or externalize the symptom tendency as ruminating, blaming or will reappraise and move forward in a positive direction using resiliency strategies. Examples include: self-blame, other-blame, rumination, catastrophizing, putting into perspective, positive refocusing, positive reappraisal, acceptance, and refocusing.

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Cognitive Restructuring is a technique for developing a goal to replace stress-producing thoughts (cognitive distortions) with more balanced thoughts to help people change the way they think that do not produce stress.

Critical incident stress debriefing (CISB): involves a discussion of the client's thoughts and reactions that is non-evaluative and confidential in conjunction with psychoeducation about coping and stress skills (Mitchel & Everly, 2000). CISB can be the beginning of psychotherapy although is not to treat or prevent another disorder.

Decentering: Centering is the ability to observe one's thoughts and feelings as transient, objective events in the mind, as compared to true reflections of oneself (Shikatani, Anthony, Kuo, & Cassin, 2014). Decentering is when the client (social anxiety disorder) recalls past social events in which they perceived themselves as failing and tends to strengthen their belief they have an inability to meet social situations.

Decoupling: refers to a method to reduce impulse control disorders. For example, decoupling can be used to reduce body-focused behaviors such as trichotillomania, skin picking, lip-cheek biting, and nail biting. Hadash et al. (2016) and Olendski (2006) describe decoupling from a model of equanimity. The person can neither hold onto a pleasant experience nor push away from an unpleasant experience. During therapy, the counselor attempts to assist the client in accepting a pleasant experience, and not wanting to maintain the unpleasant experience. This technique is associated with acceptance and commitment therapy and mindfulness (Hadash et al.,2016).

Delay discounting: refers to a smaller preference for a reward versus larger delayed rewards. Treatment for ADHD is to promote, more often than control, smaller immediate rewards over larger delayed rewards (Beauchaine & Cicchetti, 2019; Beauchaine, Ben-David, & Sela, 2017). Children with ADHD prefer immediate over delayed rewards. Social rejection and stigmatization often become the outcomes.

Emotional dysregulation: refers to "change or regulating emotional cues, experiences, actions, verbal, and behavioral response, and is characterized by frequent negative emotional experiences, an inability to regulate intense physiological arousal, orienting attention away

from emotional stimuli, cognitive distortions, and difficulty with information processing" (Fettich, McCloskey, Look, & Coccaro, 2015, p. 25).

Inhibitory control training: is a technique or intervention in which clients with specific propensity (craving) cues learn to withhold an emotional or behavioral response (Bonham, Shanley, Waters, & Elvin, 2020; Howard, Johnson, & Pascual-Leone, 2014; Jones et al., 2016).

Interoceptive exposure: targets the interaction between the physical and the cognitive aspects of anxiety disorders (panic disorder) and is designed to reduce anxiety in response to physical sensations (Levitt et al., 2001).

Intolerance of uncertainty (IU): refers to a client's "dispositional incapacity to endure the aversive response triggered by the perceived absence of salient, key, or sufficient information, and sustained by the associated perception of uncertainty" (Carleton, 2016a, p. 31). Doubt is often the outcome of the anxieties surrounding the client's interactions in the environment. Doubt is a key core symptom for obsessive-compulsive disorder. Anxiety can be a source or the outcome of the doubt.

Johari Awareness model : examines dynamics of communication that becomes a picture for change. This is a change process to view the problem in another way. The model contains four quadrant, an open quadrant, blind quadrant, hidden quadrant, and unknown quadrant (Eisenberg & Patterson, 1079).

Meaning-making Model: refers to meaning in life as the experience of freedom, responsibility and self-determination and is associated with a positive view of life, the future and oneself. Martela and Stegar (2016) defined meaning in life as composed of three dimensions: 1) coherence, the cognitive component of meaning in life, the degree to which people feel that the world around them is structured, predictable and explainable; 2) purpose, the motivational dimension, is the way people experience their life as guided by life goals, and 3) significance, the affective component that refers to the sense of the inherent value of life and implies having a life worth living. This model suggests that people search for and assign meanings to their behavior, relationships, situations, values, goals, and events. After a stressful event, people search for meaning to understand the stressful event. If the person's senses are being violated or their understanding is different than their global meaning, the client will experience distress and will attempt to reduce the discrepancy between held beliefs and the situational stressor's impact. The person uses meaning-making processes to develop coping strategies and gain control resulting in adaptive coping (Marco, Alonso, & Barios, 2020).

Mentalization: Tauber et al. (2021) reported mentalization as the individual's imaginative ability to perceive one's own and others' behaviors as the product of affective and cognitive mental states. Mentalization can mediate the relationship between childhood maltreatment and externalizing problems (such as in conduct disorder). Eye behavior is taught to clients who have deficits in limited prosocial emotions and reciprocal relations (sibling rivalry) and in emotional dysfunctionality.

Metacognitions: refers to knowledge and beliefs about thinking and strategies used to regulate and control the thinking process. For obsessive-compulsive disorder (OCD), two

subcategories maintain the disorder. The first is metacognitive beliefs of the meaning and consequences of intrusive thoughts and feelings, and the second is beliefs about the necessity of performing a ritual (van der Heiden, Rossen, Dekker, Damstra, & Deen, 2016).

Mindfulness: refers to a state in which one becomes highly aware and focused on the reality of the moment, accepting and acknowledging it, without involvement in thoughts or emotional reactions. Mindfulness is closely related to emotion regulation. The use of mindfulness enhances the ability to engage in regulating emotion by decreasing emotion avoidance. It is also related to repetitive negative thinking. Repetitive thinking involves excessive thinking about current, past, and future concerns often in the form of rumination and worry (Sala et al., 2020). This term is the center of Mindfulness-Based Stress Reduction and with acceptance and commitment therapy. It is a strategy or intervention that targets experiential avoidance and in preventing negative emotions (Sojcher, Fogerite, & Perlman, 2012). Mindfulness has been found to helpful in treating eating disorders.

Mindfulness skills are taught in DBT composed of "what" and "how" skills. The "what" skills are designed to observe, describe, and participate fully in the moment. The "how" skills are to teach the client to be present in the moment with a nonjudgmental attitude focusing on one thing at a time.

Mirroring refers to a therapist's technique in reformulating and mirroring what the client is projecting through conversational actions. Reformulating is a reproduction of preceding talk and refers to the counselor's reflection understanding of what was the client's prior utterance. The communication becomes transformed and is negotiates what is relevant (Knol et al., 2020).

Mirroring and reformulation are two key core interventions techniques.

Personality disordered clients experience cognitive failure to see how they come across to others. If the counselor observes the client's expectations that others' hold the same view of the client, the influencing factor of mirroring and false meanings can be processed (Zanor, 2010).

A second example of mirroring is parental behaviors in the development for children acquiring societal and cultural learned behaviors such as empathy, respect and core values for interacting with others. The child learns and models the appropriateness in empathic delivery by the parent for teaching and demonstrating behaviors. Conduct disorder, oppositional defiant disorder, and other disruptive disorders provide examples (criteria) where the client has been assessed with a deficit in need of treatment such as empathy and a callous-unemotional response involving other individuals. Attribution training or retraining is an intervention.

Mirror psychotherapy: Griffen, Naumann, and Hildenbrandt (2018) reported that mirror exposure psychotherapy as a component of cognitive behavior therapy for treating body image disturbance and body dissatisfaction for eating disorders.

Psychological first aid: involves interventions that assist with adaptive coping, feeling safer, understanding the initial danger is over, calming, and stabilization, connecting with others, increasing self-efficacy, empowerment, and a sense of hope (Solomon, 2008)

Reflective functioning (RF): refers to the capacity to understand the self and others in terms of intentional mental states involving feelings, desires, wishes, attitudes, and goals (Babl et al., 2021). Reflective functioning is also referred to as the operationalization of the mental abilities that generate mentalization (Fonagy et al., 2002). RF refers to the capacity to understand the self and others in terms of mental states, such as feelings, desires, wishes, attitudes, and goals (Keefe, et al., 2022; Fonagy et al., 2002)

Self-control: is the "ability to override impulses to act as well as the ability to make oneself initiate or persist in boring, difficult, or disliked activity" (Carver, 2019, p. 477).

Self-immersed versus self-distance and **what** versus **why** and **abstract versus concrete** processing negative emotions and experiences without increasing negative affect (Kross, Ayduk, & Mischel, 2005). The use of 'why' often surfaces self-distance facilitating the activation of abstract representations for the underlying reasons of negative experiences. Kross et al. (2005) recommended an effortful broad model to help resolve questions about the what/why of a problem, especially why, of an emotional experience and resulting negative affect in the form of anger rumination. Self-distance and abstract provide for positive outcomes in processing and developing understanding and an adaptive mode. Clients focus on past emotional experiences typically from a self-immersed perspective in which self-relevant events and emotions are experienced in the first person. Kross et al. (2005) researched and reported that anger-associated depressive rumination in working through negative experiences can develop an adaptive mode if the client uses a distance mode of the self. The process involves abstract versus concrete, and self-immersed versus self-distance perspectives.

Social attribution: The social attribution model refers to any action that can be categorized as internal or external. Feelings and cognition mediate the relationship between mental health signals and people's response to these signals. Clients with mental health disorders externalize and internalize symptoms. Increased internalizing symptoms are prominent in depression and anxieties and include decreases in self-esteem, negative self-image, and poor academic performances (Camodeca & Goossens, 2005).

Stop-signal Task (SST) is an intentional act of control (go and stop trials) and used for inhibition (Mar et al., 2022).

Task shifting: Task shifting includes shifting service delivery of specific tasks from professionals with higher qualifications to those with fewer qualifications (WHO, 2007). Task shifting is a consideration for adjustment disorder (Javadi, Feldaus, Mancuso, & Ghaffer, 2017). Task shifting requires resources such as regular supervision, availability of resources and tools, access to medicines, quality training, and exposure to technological updates.

MONITORING

Benchmarking: Benchmarking is a program evaluation used to measure the effectiveness of an intervention. The method reinforces pre-post measures of process such as treatment adherence and integrity. This process is a component of effectiveness or efficacious evaluation for evidence-based practices (Self-Brown et al., 2012).

Momentary Ecological Assessment (MEA): refers to intensive repeated measures in naturalistic settings (IRM-NS) that integrate psychological, physiological, and behavioral data (Moskowitiz, Russell, Sadikaj, & Sutton, 2009). Most assessments derive client data retrospectively (self-reports) and are subject to generalizations and memory disturbances. Because most behavior over time tends to waver (ebb and flow), MEA measures valence and intensity of affect (pertinent for assessment and monitoring) in real time (moments or time periods) to increase accuracy of symptoms. Interviews are based on recall that rely on memory storage and are subject to effective valence effect, mood congruence memory effect and duration neglect that increase inaccuracy (Ebner-Priemer & Trull, 2009). EMA provides real time information for mood disorders (depression), bipolar disorders, and mood dysregulation. Moskowitz and Young (2006) reported that disturbances (situational specificity) in social functioning exists in many types of psychopathology. When these social interactions are altered, they can result in feelings of ease and comfort in some and distress in others. Depression and anxieties are most common forms that involve social interactions. Symptoms such as performance fears create distress and are frequently avoided or ruminated. IRM-NS measures have been documented for a variety of variables such as affect, mood, self-esteem, social behavior, personality traits, stress, cognitive performance, relationship variables, physical symptoms, and characteristics of the environment. These measures can be used for measuring reliable person-level information, obtaining estimates of within-person change over time, individual differences with changes, and documenting temporal sequences (Moskowitz et al., 2009).

Routine Outcome Monitoring (ROM): ROM is used to detect clients who deteriorate early in the treatment process. When clients go off track and the departure is noted, if ROM is utilized, the counselor can adapt the treatment strategy. ROM is critical feedback but needs help in suggesting what is needed to adapt and meet the obstacles, an intervention. One such tool to assist the counselor is the Assessment for Signal Clients (ASC), a self-report questionnaire. A counselor can develop their own decision tree by reviewing the therapeutic alliance, client motivation, social support, and stressful life events (Schilling, Zimmerman, Rubel, Boyle, & Lutz, 2021). It is further recommended the counselor assess three emotion regulation strategies (tolerating, adjusting, and concealing emotions).

Stages of change: One system to monitor for commitment is an assessment using the stages of change. The stages include precontemplation, contemplation, preparation, action, maintenance, and relapse. Precontemplation (not interested in help or thinking of change), Contemplation (aware of personal consequences/bad habits but ambivalent about change), Preparation/determination (made a commitment to change-small steps/gather information), Action/willpower (believe they can change, actively involved), and Maintenance (avoiding temptations to revert to bad habits). Prochaska and Norcross (2007) refer to this process

consisting of consciousness raising, dramatic relief, environmental re-evaluation, self-reevaluation, self-liberation, social liberation, contingency management (teaching clients to shape their behavior), changing their ways in problem solving, and in controlling the way they deal with difficult situations.

Therapy Outcome Measures: The Session Evaluation Questions (SEQ) and Session Impact Cale (SIS) are measures to monitor for therapeutic alliance. One is for the counselor and the second for the client to make comparisons and provide feedback.

RESOURCES, TREATMENT, AND INSTRUMENTS

Addiction Severity Index (ASI): is designed to detect and measure severity of problems in seven areas affected by alcohol and drug dependence (medical, employment/support, alcohol and drug use, legal, family history, family/social relationships and psychiatric problems (Khazaal et al., 2013)

American Society of Addiction Medicine (ASAM): an organization that sets standards for criteria to assess, evaluate, and identify treatment levels for addiction. ASAM has six dimensions by 5 levels of care that include acute intoxication and/or withdrawal potential, biomedical conditions/complications, emotional/behavioral/cognitive conditions and complications, readiness to change, relapse/continued use/continued problem potential, and recovery. ASAM uses benchmark levels for appropriate care. The levels are early intervention, outpatient treatment, intensive outpatient treatment/partial hospitalization, residential/inpatient treatment, and medically managed intensive inpatient treatment. An instrument is provided to determine if an individual meets the criteria for at risk and to rule out or confirm acute psychosis (Yung et al., 2015).

Attention Control Therapy: Segal, Wald, Pine, Halpern and Bar-Haim (2020) reported that attention control therapy (ACT) is a recommended theory of choice for acute stress disorder (ACD) and PTSD. ACT is a computerized intervention in reducing risk for PTSD among clients with ASD. The therapy focus of is an imbalance in the client's inability (system) to monitor threat vigilance and threat avoiding and to normalize the client's attention bias variability (ABV). The client is trained to ignore those cues and spread their attention equally across neutral and threat information. The outcome is a shifting away from threat(Segal et al., 2018). ACT is a computerized protocol using a threat detection task to normalize attention bias variability (ABV). ACT is recommended for clients with traumatic stress such as acute stress disorder (ASD) and post-traumatic stress disorder (PTSD).

Attention training: refers to a technique (cognitive process) to reduce self-focused attention, increase attention flexibility, and modify performance is an emotional attention set shifting task (Callinan, Johnson, & Wells, 2015). This training is recommended for clients who experience threat-related bias in processing cognitive factors and in difficulties in maintaining anxiety and trauma symptoms. The cognitive process is used to change beliefs about causes of one's own failures and successes and to motivate future change. It is suggested this training is useful for those who are unmotivated to change. The change process involves observing the behavior (example: conduct disorder), determining if the behavior is deliberate (receives

immediate positive reward that evolves into a negative outcome), and attributing the behavior to internal or external causes.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: The purpose or function of these measures is to provide initial direction to the assessment interview. They are to be given to the client or guardians of youth to take before the assessment interview. The counselor scans the XII or XIII domains for ratings of mild or greater domain. The counselor focuses probes to secure additional client information on the domains that reach levels of mild or greater. The three Level I Cross Cutting Measures use dimensional assessment criteria for duration, frequency, and severity of the XII and XIII domains (DSM-5-TR, APA 2022, pp. 847-853).

Panic Disorder: Panic control therapy consists of situational exposure, cognitive reappraisal techniques, diaphragmatic breathing skills, in-vivo exposure, and interoceptive exposure along with symptom reduction exercises (Barlow & Craske, 2008).

Theory of the mind (ToM): is the cognitive ability to attribute mental stats to oneself and other. Cognitive ToM refers to the attribution of emotions (the capacity to understand others' viewpoints and to consider these viewpoints when solving interpersonal problems (Struck et al., 2021).

Persistent Depressive Disorder: recommended first-line treatment is cognitive behavioral analysis system of psychotherapy (CBASP, Wiersma et al., 2021; McCullough, 2013). Two main goals are correcting interpersonal misinterpretations rooted in childhood and gaining interpersonal skills to over come isolation (Guhn et al., 2021).

Personality instrument: The Big Five Inventory (BFI) measures dimensions of personality and personality facets (Joh & Srivastava, 1999).

Posttraumatic Disorder Instruments: useful to measure include the Clinician-Administered PTSDScale, Impact of Event Scale-Revised, Posttraumatic Stress Diagnostic Scale, PTSD Checklist, and Structured Interview for PTSD (Bardhoshi et al., 2016). Posttraumatic treatment: recommended treatment is prolonged exposure therapy (McLean & Foa, 2013).

Quality of Life Profile: a goal for many disorder treatment plans includes an improvement in the client's quality of life. The World Health on Quality of Life, a division of mental health and prevention of substance abuse domains, includes physical, psychological, level of independence, social relationships, environment, and spirituality/religion/personal beliefs (WHO, 2012). Raphael, Renwick, and Brown (1996) recommended that a treatment plan should include components for physical, psychological, spiritual, community, social, and leisure.

World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), DSM-5-TR (APA, 2022, pp. 856-857): The DSM no longer uses the GAF. The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) is a self-report assessment tool that evaluates the client's ability to perform activities in six domains of functioning: understanding and communication, getting around (mobility), self-care, getting along with people, life activities, and participating in society (Gold, 2014).

Initial Session - Risks and Ethical Communication interchanges between the counselor and client concerns:

1. Stigma (types: social, public, self, institutional) attached to the disorder (psychotic, schizophrenia, OCD)
2. Informed consent procedures: Specific behaviors and disorders associated with comprehension require an assessment for client competence to fully understand obligations for consent for treatment. The CAARNS provides criteria for assessing for non-bizarre ideas, perceptual abnormalities, disorganized speech, aggression/dangerous behaviors, suicidality and self-harm, and positive symptoms (Yung et al., 2015). Several of the criteria are also noted in the DSM-5-TR criteria A for brief psychotic disorder, schizophrenia disorder, schizophrenia, schizoaffective disorder, and substance/medication-induced psychotic disorder.
3. Treatment resistance: Some disorders tend to resist treatment (substance use disorders, obsessive-compulsive disorder-OCD, GAD). Calear, Batterham, Torok, and McCallum (2021) and Stein et al. (2021) reported that young people diagnosed with generalized anxiety disorder reveal that mental health stigma affects their help seeking behaviors. The clients reported, whether it is public or personal stigma, they experience feelings of shame, embarrassment, and fear of judgment and have difficulty seeking help. Barriers for seeking treatment for OCD are stigma and poor illness recognition (McCarty et al., 2017). Acceptance and commitment therapy (ACT) may be used to help treatment-resistant clients and targets six core processes for change (Twohig et al., 2015).
4. Risk exists for clients presenting with prodromal symptoms that require reasoning and decisional capacity with psychosis (Morris & Heinssen, 2014).
5. Trust issues when clients use avoidance and escape behavior when encountering threat that directly affects their emotional responses.

UNIT III: DSM-5-TR DISORDERS

A limited number of disorders are presented in Unit IV to use as a guide for a quick reference for disorder criteria (not in completeness), core disorder features, differential diagnosis, instruments, treatments, target goals, and communication issues for client-counselor interactions. This information is used to support preparation for the four different packets of 12 case studies that are online with Career Training Concepts. None of the sections are complete or in depth to include the DSM-5-TR criteria. In some situations, words are omitted but enough words to provide awareness. The DSM-5-TR was the manual used for disorder criteria and it is recommended that the preparer for the NCMHCE visit that guide to supplement this introduction.

Disorder Trajectory

The following information has been developed from 34-36 published research articles involving early treatment trajectory, sudden and gradual therapy gains, and derailment in clinical procedures. Instability is the core of derailment and self-continuity is the connection for the past and present (Ratner, Burrow, Mendle, & Thoemmes, 2022). In psychotherapy outcome measuring for reliable change in pre and post treatment scores and using dysfunctional to functional distribution, there are four outcome categories: recovery (significant change), improvement (reliable change), non-improvement (no reliable change), and deterioration (reliable change but in negative direction).

The DSM-5-TR provided for each disorder minimal information for associated features, development and course for the disorder, risk factors, culture-related issues, functional consequences, differential diagnosis, and comorbidity. These clinical areas are the starting point in preparing for the new formatted NCMHCE. The following information is a summary of findings based on clinical studies for treatment issues and counselor-client impact in treating and monitoring symptom changes involving trajectory, sudden and gradual changes, and derailment.

Continuous feedback offers the counselor and client the opportunity to reflect on the course of therapy for changes to the alliance, shifting focus, revisiting goals, strengthening the alliance, and altering the intervention to prevent client non-response, deterioration or dropout. Psychotherapy outcome data for reliable change (intake to discharge and holding) shows about 70% of clients achieve reliable change and less than 50% of them are considered recovered (Ostergard, Randa, & Hougaard, 2020). Swift and Greenberg (2012) reported that approximately 19.7% of clients drop out of therapy. A dropout factor is a lack of early therapy progress and is considered a risk factor for not improving. Swift, Greenberg, Whipple, and Kominiak (2012) reported to reduce the drop out ratio, counselors should take time to understand the reasons clients discontinue therapy. They recommend before therapy the counselor should relate information about client perceptions and expectations for change. This is a cost analysis procedure to aid the client in developing a realistic duration and recovery expectation prior to the start of therapy. This type of analysis is based on dose-effect literature. Swift and Callahan (2008) found with duration and outcome expectations that 25% of clients expect recovery by the end of two sessions, 44% by the end of four sessions, and 62% by the end of eight sessions.

The counselor is limited in the use of instruments such as Routine Outcome Monitoring (ROM, repeated measures) to assess for regular intervals for client improvement when too few therapy sessions exist in the examination. Because of the lack of a repeating routine measurement for change (two sessions), the counselor and client resort to reflective functioning on the course of therapy (alliance stability, expectancy for change, motivation) as supportive feedback in identifying the signals that represent symptom change or lack of change. It may be difficult to predict symptom trajectory in the client's elevation of distress scores in symptom gains/losses or deterioration over time. A counselor task is to determine if the client has the capacity to engage in reflective functioning (metallization) to perceive and understand oneself and others in terms of their present mental states for feelings, beliefs, intentions, and desires (Babi et al., 2021).

The goal of therapy is change and requires the counselor to monitor progress and possible derailment both of which are influenced by multiple factors. Feedback offers the counselor and client the opportunity to reflect on the course of therapy for changes to the alliance, shifting focus, revisiting goals, strengthening the alliance, and altering the intervention to prevent client non-response, deterioration, or dropout (Boswell, Kraus, Miller, & Lambert, 2013). Feedback in the form of predictions or expectations for psychotherapy outcome data should include measurements for quantitative and qualitative alterations in assessed symptoms. Target symptoms that created the distress and in therapy sudden and gradual gains occur within sessions, during and between sessions, and at discharge are to be monitored. Factors to be assessed should include disruptions in the symptoms (in)stability, changes occurring within and between therapy sessions, treatment offered and treatment delivered, therapist's initial attachment and therapeutic encounters that transpire with the working alliance, client treatment outcome expectations, level of motivation, proneness to change, and cognitive capacity. An important consideration for change predictions can be based on the therapist and client beliefs about the mode of conduct for different cultures that may differ from Western psychology (Jadaszewski, 2017). Values are linked to motivation and affect.

A qualitative improvement analysis of outcome is 'good or poor' and often is based on symptom severity levels and/or behavioral changes including life measures such as the client's personality, life, interpersonal relations, and self-understanding. Significant events during therapy for qualitative outcome includes observed changes on the client's level of awareness, insight, self-understanding, behavioral change, problem solution ability, emotional experiencing, empowerment, and relief (De Smet et al., 2019). Autonomy, one of the ethical principles, may be the most important consideration the counselor can exercise to allow for the client to act independently and to make choices and develop the right to their own life values.

The NBCC new format provides for an initial assessment and two counseling sessions (one is the first session). The inherent issue in planning for systematic monitoring is dependent on several variables especially for two sessions of counseling. Some variables include client motivation for change, limited sessions (two), severity of symptoms, strength of the counselor-client alliance, therapist attachment styles, client ambivalence and assessing the treatment trajectory (Koffmann, 2020).

Trajectory

Trajectory is the course or path of the development of a disorder and is best understood by assessing how symptoms change over time in order to make decisions on the intensity, frequency, and length of treatment. If acute stress disorder is not treated and the symptoms continue, the trajectory and outcome is likely to become post-traumatic stress disorder. Therefore, it is important to be aware of symptom trajectory, what happens over time that affect functioning. Ambwani et al. (2019) reported that anorexia often runs a chronic course and is associated with increased mortality rates, substantial physical and psychological cormorbidities, and adverse social consequences. Longitudinal data reflects that 61% of anorexia clients continue to exhibit anorexia nervosa symptoms at 5-year follow-ups (Stoving, Andries, Brixen, Bilenberg, & Horder, 2014).

For major depressive disorder, it is important to understand the depressive trajectories across the severity and factors associated with a particular course and how the symptoms relate to functioning and quality of life. The DSM-5-TR, in many disorder criteria, makes reference to the last two weeks or month when assessing yet, these symptoms last for longer periods of time. These assessments allow the therapist to identify the high and low risks for poorer outcomes (Guhn et al., 2013).

There are early trajectory signals for the level of symptomatic distress, comorbidity, motivation to change, attachment anxiety, perfectionism, interpersonal skills, resourcefulness, coping style, and perception of the strength of the therapeutic alliance. Client reluctance and therapist directives are considered outcome predictors as well as the interaction between the client treatment preferences and treatment delivered (Swift, Callahan & Vollmer, 2011). A paucity of research exists for examining session frequency. The few studies (6) all support that psychotherapy outcome is related to the number of therapy sessions (Erekson et al., 2021).

Sudden Gains

Sudden gain is defined as a large improvement in symptoms between two sessions. Tang and DeRubeis (1999) reported three criteria to recognize sudden gains for depression by using the Beck Depression Inventory (BDI). There is to be from one session to the next a reduction of 7 points or greater to be a reliable change index. The shift in gains/losses criteria is a 25% reduction from an earlier BDI score for sequential sessions (Andrews, Hayes, Abel, & Kuyken, 2022). The final criteria for stability is defined as the mean score for three pregain sessions is larger than the three mean scores for post-gains sessions. For the NBCC new format, this assessment for sudden gains would be difficult.

Sudden gains, sometimes referred to as early rapid responders, require assessment for the size of improvement between adjacent sessions and the degree of stability over time. Clients who improve quickly experience change variables in critical situations such as suicidality, treatment expectations, previous psychotherapy, and the presence of specific symptoms (Heider, Kock, Sehlbrede, & Schroder, 2018). The NBCC new format does not provide a sufficient number of sessions for expected and lasting change. Hoffman (2020) reported summary data for six different

studies that assessed improvement for the different number of sessions where improvement was expected. A summary statement for those studies indicated that failure to improve by the halfway point in the total number of therapy sessions, that there were limited changes at discharge and in retaining previous gains.

Rapid shifts and periods of stabilization can precede change (sessions prior to gains/losses). The shifts in gains or losses may take place in the session preceding the observed gain (Tang & DeRubeis, 1999). Limited data is available to determine if the sudden gains are maintained throughout therapy and discharge. Zilcha-Mano, Errazuriz, Yaffe-Herbst, German, and DeRibeis (2019) reported the role of the cient-counselor alliance may be a mechanism for the rapid changes. Newmann, Schwob, and Rackoff (2020) reported three important symptom change pattern mechanisms: accurate therapist interpretations themes, therapeutic alliance, and cognition. Vincent and Norton (2019) reported that cognitive change, therapeutic alliance, and client engagement are predictors in transtheoretical therapy for anxiety disorders. Rapid gains can reflect disruptions in the stability of symptoms and may lead to improvement. Instability may be necessary for the client to stabilize for short or long-term change. Babi et al. (2021) reported for depression, the client is taught reflective functioning in the form of metallization.

Sudden gains do exist for different disorders, treatment modalities, and factors related to sudden gains involved the counselor and client factors. Other examples include the client's internal locus of control, expressed confidence in their ability to change and heightened motivation to engage in therapy (Lackner et al., 2010). The counselor's treatment techniques, environmental events between sessions, and that face-to-face contact with the client is not necessarily contingent on the change taking place.

Clients experiencing sudden gains and losses are significant for depression (Babi et al., 2021; Singh, Pascual-Leone, Morrison, & Greenberg, 2021; Andrews et al., 2020; Helmich et al., 2020; De Smet et al., 2019; Aderka, Nickerson, Bye, & Hofmann, 2012; Kelly, Rizvi, Monson,& Restock, 2009; Andrusyna, Luborsky, Pham, & Tang, 2006; Tang, DeRubeis, Beberman, & Pham, 2005; Tang & DeRubis, 1999), generalized anxiety (Newman et al., 2022; Visla, Constantino, & Fluckiger, 2021; Present et al., 2007), social anxiety (Thorisdottir, Tryggvadottir, Saevarsson, & Bjornsson, 2018), panic disorder and posttraumatic stress (Aderka, Applelbaum-Namdar, Shafran, & Giboa-Schechtman, 2011), and somatoform disorder (Heider et al., 2018). Psychotherapies attend to the importance of sudden gains and gradual changes for the following therapies: cognitive-behavioral therapy, trans-diagnostic cognitive-behavioral therapy, interpersonal, behavioral activation therapy and supportive-expressive therapy (Aderka, Nickerson, Moe, & Hofmann, 2012). Within these therapies strategies and counselor skills have been reported to trigger the sudden gains or losses.

Sudden gains (SG) and sudden loses (SL) need to be assessed for the size of improvement or losses between adjacent sessions and to establish stability or instability over time (Heider et al., 2018). Clients with generalized anxiety disorder who improve quickly with sudden change, may be attributed to behaviors associated with suicidality, treatment expectations, previous psychotherapy, and the presence of specific symptoms (Newman et al., 2022; Heider et al., 2018).

Client and therapist contributions or factors may account for some early change. Erekson, Clayson, Park, and Task (2020) reported a summary of client factors include the client's internal focus of control, more expressed confidence and motivation in their ability to engage in therapy, and who are older and had higher levels of initial anxiety. Andrusyna et al. (2006) reported counselor skills do influence (Domain six) readiness for change by identifying thoughts, emotions, and behaviors the client was unaware of, casual links between these thoughts, emotions, and behaviors, pointing out overall patterns of thoughts, emotions, and behaviors, and linking current thoughts, emotions, and behaviors to the client's past. These counselor skills involve building the alliances, interpretations, case conceptualizations, and interventions.

It is feasible that factors promoting sudden changes may different for different disorders. For major depression disorder, the most promising factors for sudden gains appears to be cognitive changes and therapist's interpretation in pregain sessions (Babi et al., 2021; Andrusyna et al., 2006; Andrusyna, Luborsky, Pham, & Tang, 2007; Tang et al., 2005) and confounding variables for cognitive changes may have been life events, and sudden physiological-psychological changes before the pregain session. The related or associated counselor role involved accurate interpretation of the pregain sessions.ons of relationship themes, therapeutic alliance, and cognitive changes (Andrusyna et al., 2007). The working alliance is an outcome and a strategy. When the alliance involvement is high, symptom improvement within and between adjacent sessions is evident (Hillman, Kivlighan, & Hill, 2022). The quality of the emotional bond, and client-counselor agreements exist for goals and tasks.

Clients who present with ambivalence experience difficulties in considering the costs and benefits in change. Motivational interviewing is the technique to help the client shift through the stages of change by perceiving the benefits for change and resolving the ambivalence. When assessing the readiness for change, the contemplation stage is characterized by ambivalence. If the client addresses the problem behavior and considers the costs and benefits of both, better outcomes are achieved (McEvoy & Nathan, 2007). The decisional balance theory reflects the weighing of the pros and cons of behavior change, and is a component of the transtheoretical model (TTM, DiClemente/Prochaska).

Derailment

Derailment is a sense of instability in identity and self-direction over time (Ratner, Burrow, Thoemmes, & Mendle, 2021). Instability is at the core of derailment. The client's presenting symptoms are assessed for where the symptoms are being expressed (Domain 3-focus areas) such as leaving home, new environments, making new friends, academic performance, and uncertainty. If the client lacks skills to manage stressful encounters there is often self-focusing, instability, disrupted equilibrium, lack of self-consistency, and disconnections. Adjustment and/or discovery for new therapeutic behaviors and instability and disconnections challenge the client to think differently about self which is contrary to past thinking. Thinking about oneself in a different way is a form of discovery (change). Derailment is associated with anxieties, depression, self-harm, and suicidality (Duffy, et al., 2019). Depression symptoms of self criticism and fate such as brooding is a maladaptive component of rumination (Treynor, Gonzalex, & Nolen-Hocksema,

2003). Failures and goal barriers are common targets of rumination. In reaction to the stressors, clients attempt to make meaning for these experiences and may go off-track creating frustrations (symptoms) that reinforce earlier thoughts as mistakes, self-doubting one's actions, and reflect their present standards. A client with a rigid self-oriented perfectionism may experience derailment.

Derailment exists in the counseling hour and may be a result of the client-counselor dynamics. The overall therapy goal is change. The client's self-perceived thoughts of change and adjustment is often met with instability and lack of control in self-direction. Derailment is fostered by a variety of thought patterns and experiences that promote how one reconciles changes in behavior and self-direction. Stress sensitization or "kindling" may leave the client with repeated self-styled vulnerabilities and in need of off-course cognitive reframing of therapy interactions. During the course of psychotherapy, the dynamics that exist between the counselor and client do reflect changes that differ from the client's perspective that may cause disruptions in the client's abilities to control thoughts (flexibility) about change to recover and to get back on track. The uncontrolled thoughts reflect difficulties in reconciling changes and may create a disconnect from a past self-perceived sense of self. Ratner et al. (2022, 2021) and Burrow, Hill, Ratner, and Fuller-Rowell (2018) described four cognitive styles (brooding, self-reflection, perfectionism, and cognitive flexibility) that may color a person's experiences causing derailments. The client may perceive a counselor's communication to be interpreted as criticism and develop a collection of thoughts that support prior behaviors and cognitions and may promote depressive symptoms such as brooding, self-reflection, sense of well-being, and cognitive flexibility or inflexibility. Responding to derailment can be hastened with adaptive self-reflection for making sense out of one's experiences and suppressing the negative affect that is an outcome of self-focusing thinking.

Neurodevelopmental Disorders

Attention-Deficit/Hyperactivity Disorder (APA, 2022, pp. 68-70)

Criteria

Pattern of inattention and/or hyperactivity by (1) or (2)

Inattention: 6 or more that have persisted for at least 6 months, if older than 17 or adult then 5 are required

1. fails at close attention to details (careless mistakes in schoolwork, at work or activities)
2. difficulty sustaining attention in tasks or play, and remaining focused with lectures, conversations or lengthy reading
3. does not seem to listen when spoken to directly
4. does not follow through in instructions, fails to finish homework
5. difficulty organizing tasks and activities
6. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort

7. often loses things necessary for tasksIV
8. easily distracted by extraneous stimuli
9. often forgetful in daily activities

Hyperactivity and impulsivity (6 or more for 6 months), for 17 and older, 5 or more symptoms

1. often fidgets with or taps hands/feet/squirms in seat
2. often leaves seat in situations when remaining is expected
3. often runs about or climbs in situations which are inappropriate
4. often unable to play or engage in leisure activities quietly
5. often on the 'go', acting if 'driven' by a motor
6. often talks excessively
7. often blurts out an answer before question completed
8. often difficulty waiting
9. often interrupts or intrudes on others

Several inattention or hyperactive-impulsive symptoms exist before age 12 years

Several inattention or hyperactive-impulsive symptoms are present in 2 or more settings

Symptoms: Core features

1. social and academic impairments
2. behavioral disinhibition
3. impulsive errors (Monopoli et al., 2019)
4. emotion dysregulation (Monopoli et al., 2019)
5. cognitive control (performance)
6. social impact
7. genetic predispositions
8. drift (Neece, Baker & Lee, 2013)

Specifiers: There may be a request for a specifier: combined presentation, predominately inattentive presentation, predominantly hyperactive/impulsive presentation. There might also be academic specific learning disorder such as reading, writing, numbers, and reasoning.

Differential Diagnosis: Oppositional Defiant Disorder

Deficits

1. drift, off task (inattention)
2. set shifting (away from one fixation point toward another fixation point)
3. social impairment

4. working memory
5. inhibitory control
6. response inhibition-inability to suspend a response during an active moment-to-moment behavior
7. emotion dysregulation (Monopoli et al., 2020)
8. executive functioning (working memory): to encode, tore (separate into pieces), manipulate, and retrieve information in the face of interference (Jimenez, Jane-Ballabriga, Martin, & Brophy, 2013)
9. behavior control-quickness to anger-speed of escalation, intensity, and speed of de-escalation (monopoli et al, 2019)
10. cognitive control
11. set-shifting or task shifting-redirecting one's focus away from one fixation point toward another fixation point
12. self-regulation (Curtis, 2014)

Instruments

1. Beck Depression Inventory
2. Wechsler Intelligence Scale for Children
3. Stanford-Binet Intelligence Scale
4. Conner's Rating Scales
5. Wide Range Achievement Test
6. A battery of achievement
7. Attention Deficit Evaluation Scale
8. The Strengths and Difficulties Questionnaire (Russell, Rodgers, & Ford, 2013)

Treatment

1. cognitive behavior therapy (Safren et al., 2005)
2. behavioral intervention and family based approaches have been identified as the only psychosocial intervention to be successful (contingency management), medication (Curtis, 2014)
3. psychosocial intervention (Evans et al., 2006)
4. behavioral parent training (BPT Curtis, 2014)
5. behavioral parent management training
6. behavioral classroom management (BCM, Curtis, 2014)
7. behavioral therapy, family counseling (Fabiano et al., 2009)

8. structured dyadic behavior therapy (SDBT, Curtis, 2014)

Techniques

1. benchmarking
2. social skills training and self-regulation (Fabiano et al., 2009)
3. behavioral benchmarking
4. improving communication skills
5. recognition of non-verbal messages
6. time management
7. anger management
8. impulse control measures
9. interactive rehearsal
10. modeling
11. in vivo
12. replacing negative messages with positive self-talk
13. contingency management (Grover, Hughes, Bergman, & Kingery, 2006)
14. structured behavior therapy (SDBT) techniques are goal setting, benchmarking, and redirection for ages 7 to 12 (Fabiano et al., 2009).
15. emotional self-regulation-Jarrett (2016) and Fabiano et al.(2009) reported that inattention followed by hyperactivity/impulsivity anxieties reflected a deficit in self-regulation of emotion and self-organization/problem-solving.
16. behavior management (positive reinforcement, response cost, programmed learning (Premack's Principle)
17. contingency management
18. improving communication
19. recognition of non-verbal messages
20. parent management of organization, time management, and planning for ADHD deficits (Sibley, Hughes, Bergman, & Kinfwey, 2006)
21. interactive rehearsal and parent management therapy (PMT)
22. structured dyadic behavior therapy for ages 7 to 12. Interventions include behavioral goal setting, benchmarking, and redirection strategies (Curtis, 2014).

Target Goals: Client symptoms and deficits in need of treatment

1. Response inhibition: inability to suspend a response during an active moment-to-moment behavior

2. Set shifting or task shifting: redirecting one's focus away from one fixation point toward another fixation point (Katzenmajer-Pump et al., 2021)
3. Working memory: to encode, store, manipulate and retrieve information in the face of interference
4. Drift is losing focus (fixation points in attention). Slow drift rate is one of the most salient cognitive deficits for ADHD (Feldman & Huang-Pollock, 2021). Drift is often expressed as mind wandering characteristic of expressive spontaneous mind wandering (lacking topic stability). The ADHD has error prone on tasks of executive functioning.

Communication Issues:

1. stigma (da Silve et al., 2021; Masuch et al., 2018) and courtesy stigma (Liu & Kozinets, 2021)
2. compliance (homework, follow through)
3. suicide (Katzenmajer-Pump et al., 2021)

Schizophrenia Specturn

Schizophrenia (APA, 2022, pp. 113-114)

Criteria

1. 2 or more of the following, during a 1-month period AND at least 1 of (a), (b) or (c)
    a. delusions
    b. hallucinations
    c. disorganized speech (derailment or coherence)
    d. negative symptoms
2. Significant disturbance, level of function in 1 or more areas (work, interpersonal relations, self-care, social or occupation impairment).
3. Continuous signs of disturbance for at least 6 months (that meet Criteria A and may include prodromal or residual symptoms)-During prodromal only negative symptoms, or 2 or more symptoms listed in Criteria A.
4. Deficit Schizophrenia is a syndrome of primary negative symptoms, two of six symptoms and timing distortions and working memory (Ciullo et al., 2018).

Core Symptoms: Moe and Docherty (2013) and Leucht et al., 2021 reported core features include a timing disturbance of the self-disturbance in the sense of self (SOS), anhedonia, blunted affect, and avolition of negative symptoms, and for positive symptoms hallucinations and delusions. Two distortions of consciousness define consequences of abnormalities, hyperreflexivity and diminished self-affection.

Symptoms (1-3 are core features; Moe & Docherty, 2013)

1. sense of self (SOS; Moe & Doherty, 2013)
2. anhedonia (Kwapil, 1998)
3. avolition
4. blunting (Rohricht & Priebe, 2006)
5. timing disturbance (Ciullo et al., 2018)

Deficit schizophrenia (1-6; Kirkpatrick & Galderisi, 2008)

1. restricted affect
2. diminished emotional range
3. poverty of speech
4. curbing of interest
5. diminished sense of self and purpose (Moe & Docherty, 2013)
6. diminished social drive

Deficits

1. neurocognitive deficits (Hemsley & Murray, 2000)
2. social cognitive
3. relatedness to others
4. information processing (Avila et al., 2006)
5. cognitive impairment (working memory, attention, processing speed (Velligan et al., 2004; Ciullo et al., 2018)
6. two of six symptoms, timing disturbance, and working memory (Amadeo et al., 2022; Ciullo et al., 2018)
7. hyperreflexitivity and diminished self-affection-fails to see inner speech as being external (Moe & Docherty, 2013)
8. information processing
9. olfactory impairment (Kamath et al., 2018)
10. attention (Avila et al., 2006)
11. working memory
12. processing visual stimuli-eye tracking (Green, Lee, Wynn, & Mythis, 2011)

Differential Diagnosis

Major depressive or bipolar disorder with psychotic or catatonic features

Instruments

Schizophrenia assessment should include measures for executive functioning, attention, memory, and processing speed (Green, 2011). If the client is referred for comprehensive assessment instruments 1, 2, and 3 are more extensive. Brief Cognitive Assessment (BCA) takes 15 minutes to administer (Keefe et al., 2004; Velligan et al., 2004). A predicted of schizophrenia is social anhedonia.

1. Matrics Consensus Cognitive Battery (measures all 7 cognitive domains known to impair schizophrenia clients and are the most frequently utilized (Bo et al., 2027; Bakkour et al., 2014).
2. Independent Living Skills Survey (ILSS, Wallace, Liberian, Tauber, & Wallace, 2000)
3. Maryland Assessment of Social Competence (MASC, Bellack & Meuser, 1993)
4. Positive and Negative Syndrome Scale (Kay, Fiszbeing, & Ogler, 1987)
5. Brief Psychiatric Rating Scale (BPRS)
6. Brief Cognitive Assessment Tool for Schizophrenia (BCATS)-includes subtest for verbal fluency, Trails A and B, and Hopkins Learning Test (Cuesta et al., 2011)
7. Schedule for Affective Disorders and Schizophrenia (SADS)

Treatment

Treatment is best administered according to clinical stages (Ruiz-Iriondo et al., 2013). The stages include prodromic, acute, residual, subchronic, and Chronic. Stages include: a) Acute (positive symptoms, hallucinations, disorganized speech, behavior alterations), b) Remission phase (cognitive symptoms, negative symptoms, limited positive symptoms)

1. Medication is first line treatment
2. Interpersonal Social Rhythm therapy
3. Integrated psychological therapy (Roder et al., 2006)
4. Social skills training (Addington, Piskulic, & Marshall, 2010)
5. Mindfulness-based cognitive therapy (Langer et al., 2017)
6. Acceptance and Commitment therapy (ACT)
7. Behavioral Activation system (BAS) involves behavioral charting such as mood and sleep charting (duration, frequency)
8. Family education, and maintenance
9. Family-focused psychoeducational (FFT; Miklowitz, 2008)
10. Interpersonal social rhythm therapy (Frank, 2007; Frank, 2005)
11. CBT depending on severity (Scott et al., 2016; Hemsley & Murray, 2000)
12. Supportive therapy if delusions are prominent

13. Compassion-Focused Therapy has an effect on self-reassurance and happiness (Ascone, Sundag, Schlier, & Lincoln, 2017; Gilbert, 2009)
14. Group and family therapy
15. Antipsychotic medication,
16. Cognitive Behavior therapy and social skills, family therapy (Wallace et al., 2000)

Techniques

1. psychosocial intervention (Addington, et al., 2010; Hemsley & Murray, 2000)
2. behavior therapy
3. social skills training
4. social skills and support (Roder, Mueller, Mueser, & Brenner, 2006)
5. body-oriented techniques (Rohricht & Priebe, 2006)
6. group therapy
7. sleep dysregulation
8. sleep chart
9. psychoeducation (Hemsley & Murray, 2000)
10. problem-solving skills

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.

Target Goals

1. response inhibition
2. self-regulation
3. self-disturbance in the sense of self (SOS)
4. anhedonia
5. avolition
6. negative symptoms
7. Information processing
8. working memory

Communication Issues (Counselor-Client)

1. stigma (Hofman, 2016)

2. self-stigma (Vidal et al., 2022)
3. suicide (Lopez & Mamani, 2020)
4. consent, informed consent, decision-making (Dunn, 2007)
5. treatment resistant (Rohricht & Priebe, 2006)
6. genetics (Avila et al., 2006)

Terms

1. Derailment: disruption in thought, jumping from one idea to another unrelated idea
2. Prodromal period: precedes the onset of psychotic symptoms by weeks or months (SEE below terms)
3. Social anhedonia: a disinterest in social contact and social isolation and are features of the prodromal, active, and residual phases of schizophrenia.
4. Negative symptoms: refer to an absence or lack of normal mental function involving thinking, behavior, and perception. You might notice:
    a. Lack of pleasure: The person may not seem to enjoy anything anymore. A doctor will call this anhedonia.
    b. Trouble with speech: They might not talk much or show any feelings. Doctors call this alogia.
    c. Emotional flattening: The person with schizophrenia might seem like they have a terrible case of the blahs. When they talk, their voice can sound flat, like they have no emotions. They may not smile normally or show usual facial emotions in response to conversations or things happening around them. A doctor might call this affective flattening.
    d. Withdrawal: might include no longer making plans with friends or becoming a hermit. Talking to the person can feel like pulling teeth. If you want an answer, you have to really work to pry it out of them. Doctors call this apathy.
    e. Struggling with the basics of daily life: They may stop bathing or taking care of themselves.
    f. Lack of follow-through: People with schizophrenia have trouble staying on schedule or finishing what they start. Sometimes they can't get started at all. A doctor might call this avolition.
5. Positive symptoms: are highly exaggerated ideas, perceptions, or actions that show the person can’t tell what’s real from what isn’t. Here the word "positive" means the presence (rather than absence) of symptoms. They can include:
    a. Hallucinations: People with schizophrenia might hear, see, smell, or feel things no one else does. The types of hallucinations in schizophrenia include:

b. Auditory: The person most often hears voices in their head. They might be angry or urgent and demand that they do things. It can sound like one voice or many. They might whisper, murmur, or be angry and demanding.

c. Visual: Someone might see lights, objects, people, or patterns. Often, it is loved ones or friends who are no longer alive. They may also have trouble with depth perception and distance.

d. Olfactory and gustatory**:** This can include good and bad smells and tastes. Someone might believe they're being poisoned and refuse to eat.

e. Tactile: This creates a feeling of things moving on your body, like hands or insects

6. Delusions: These are beliefs that seem strange to most people and are easy to prove wrong. The person affected might think someone is trying to control their brain through TVs or that the FBI is out to get them. They might believe they're someone else, like a famous actor or the president, or that they have superpowers. Types of delusions include:

   a. Persecutory delusions. The feeling someone is after you or that you're being stalked, hunted, framed, or tricked.

   b. Referential delusions. When a person believes that public forms of communication, like song lyrics or a gesture from a TV host, are a special message just for them.

   c. Somatic delusions. These delusions center on the body. The person thinks they have a terrible illness or bizarre health problem like worms under the skin or damage from cosmic rays.

   d. Erotomanic delusions. A person might be convinced a celebrity is in love with them or that their partner is cheating. Or, they might think people they're not attracted are pursuing them.

   e. Religious delusions. Someone might think they have a special relationship with a deity or that they're possessed by a demon.

   f. Grandiose delusions. They consider themselves a major figure on the world stage, like an entertainer or a politician.

7. Confused thoughts and disorganized speech. People with schizophrenia can have a hard time organizing their thoughts. They might not be able to follow along when you talk to them. Instead, it might seem like they're zoning out or distracted. When they talk, their words can come out jumbled and not make sense.

8. Movement disorders. Some people with schizophrenia can seem jumpy. Sometimes they will make the same movements over and over again. But sometimes they might be perfectly still for hours at a stretch, which experts call being catatonic. Contrary to popular belief, people with the disease usually aren't violent.

TERMS (Schizophrenia):

Prodromal period (prodrome) consists of low-grade symptoms assessed retrospectively that gradually emerge before the onset of psychosis but are considered for relapse. Examples of prodromal symptoms in the last one month include loss of interest in work, social activities and personal appearance (hygiene), generalized anxiety, mild degrees of depression all of which may precede psychotic symptoms. This phase is mostly limited to negative symptoms such as blunting (incongruity of emotional response, apathy, paucity of speech, and breaks in train of thought (Keith & Matthews, 1991).

Symptoms occurring in prodromal and/or residual phases for schizophrenia include the need for longer exposure rates for perception and speech, low processing, dementia praecox, olfactory impairment (differentiation for odor and color), alogia, anhedonia, agnosia, avolition, iconic memory, delusions, hallucinations, visual backward masking (short term visual storage or iconic memory), temporal sounds before a loud sound (two brief stimuli where one stimuli interferes with the identification of the other), increased susceptibility for backward masking, forward masking, schizoid, working memory, and emotion-behavior decoupling.

Residual symptoms follow directly from the psychotic episode (Category A) and collected prospectively.

Deficit schizophrenia or deficit syndrome is defined by the presence of at least two out of six negative symptoms and are present for 12 months: (1) restricted affect (observed), (2) diminished emotional range, (3) poverty (paucity) of speech, (4) curbing of interest, (5) diminished purpose, and (6) diminished social drive (Kirkpatrick & Galderisi, 2008).

Visual masking is a concept that suggests evidence for short-term visual storage. Short-term memory is referred to as iconic memory or sometimes called visual persistence and lasts only a few seconds. Visual backward masking findings are consistent with slow information processing (Saccusso & Schubert, 1981). Masking is considered to be a causative factor in the development a thought disorder characteristic for schizophrenia.

Critical stimulus duration (CSD) is observed when reality is disturbed, like schizophrenia and psychotic conditions and are characterized by alterations in temporal and color discrimination and resulting in cognitive deficits and cognition impairment (Ciullo et al., 2018). Wu, Wang, and Li (2018) reported impairments in target-speech recognition (TSR) in noisy environments with multiple people talking.

Working memory is important for reasoning and decision-making and includes active processing of incoming visual-spatial stimuli and auditory information that requires focusing and attention for new and old learning. Working memory is a cognitive component that allows for the capacity to hold information temporarily. Working memory controls for the duration in temporal and color discrimination both of which reflect a timing disturbance for clients with schizophrenia (Ciullo et al., 2018).

Iconic memory is the picture one sees in one's mind, is short in duration perhaps, 1 second, and is important for utilization at the time of observation for processing meaning, understanding and immediate responding. This memory is involved with change detection of our visual

environment which assists in the perception of motion. Iconic memory is an assessment area for considerations if the client is experiencing masking (backward/forward).

Decoupling is a process between an internal experience (thoughts/feelings, feelings/urges) and another internal experience or an overt behavior (Wang et al., 2020). Client deficits include attention, learning and memory, information processing, and eye-tracking performance. Clients tend to use emotion-behavior decoupling (Lui et al., 2016). Moritz et al. (2023) reported that decoupling is a technique (habit reversal) used in body-focused repetitive behaviors typically with trichotillomania, nail biting, and lip-check biting.

Deficit schizophrenia is a syndrome of primary negative symptoms, two of six symptoms and timing distortions and working memory (Ciullo et al., 2018).

Brief Psychotic Disorder (APA, 2022, pp 108-109)

Criteria

Presence of 1 (or more) of 1-4 and one must be in (1), (2), or (3)

1. delusions
2. hallucinations
3. disorganized speech
4. grossly disorganized or catatonic behavior

Duration: 1 day but less than 1 month with full return to premorbid level of functioning

Core Symptoms:

Core features are hallucinations, delusions, and consciousness clouding (Cak, Kultur, & Pehlivanturk, 2007). Loneliness is reported more often than any other symptom for a psychosis. Loneliness is a barrier for treatment and for recovery. Loneliness is an internalized emotion that is accompanied by self-stigma, racial discrimination and labeling (Anglin, Greenspoon, Lighty, Corcoran, & Yang, 2014; Lim, Gleeson, Alvarez-Jimenez, & Penn, 2018; Denenny, Thompson, Dixon, & Pitts, 2015; Deluca et al., 2021).

Communication Issues (counselor-client interactions)

1. discrimination, loneliness, labeling
2. shame
3. stigma
4. suspiciousness
5. trust

Differential Disorder

Other medical conditions (APA, 2022, p. 96)

Deficits

1. cognitive impairment (thought disorder)
2. decisional capacity
3. sensory Inhibition
4. impulsivity
5. executive functioning
6. cognitive thoughts
7. social functioning (Weijers et al., 2021)
8. attentional focusing (Morris & Heinssen, 2014)

Instruments

Treatment

1. Acceptance and Commitment Therapy (Twohig et al., 2010)
2. Cognitive Behavior Therapy
3. Group and family therapy (Twohig et al., 2010)
4. Supportive therapy (if delusions are prominent)
5. Brief Compassion-Focused Imagery Intervention (Ascone et al., 2017; Gilbert, 2009, a pilot study)

Techniques/Interventions/Therapy

1. medication, if delusions are prominent
2. psychoeducation
3. psychosocial interventions
4. social skills training and maybe CBT
5. imagery therapy
6. mentalization-based therapy (Weijers et al., 2021)

Treatment Goals

1. social skills deficit
2. impoverished social network

Bipolar I Disorder (APA, 2022, pp. 140-141)

Criteria

Necessary to meet manic episode followed by hypomanic OR major depressive episodes. Bipolar disorders are marked by major fluctuations in affect and activity and in perception and cognition.

Manic Episode Criteria: Lasting at least 1 week, present most days, nearly every day, persistent abnormal and elevated, expansive, or irritated mood plus goal-directed or energy. Three (3) of 7 or more of mood disturbance, increased energy (4 of 7, if mood is irritable)

1. inflated self-esteem or grandiosity
2. decreased need for sleep (rested after 3 hours)
3. more talkative than usual, keeps talking
4. flight of ideas/thoughts racing
5. distractibility
6. increased goal-directed activity or psychomotor agitation
7. excessive involvement in activities for situation with high potential for painful results

Must also meet one or the other of hypomanic episode or major depressive episode

Hypomanic Episode:

Lasting at least 4 consecutive days, present most days, nearly every day, persistent abnormal and persistent elevated, expansive, or irritated mood plus goal-directed or energy

Three of 7 or more of mood disturbance, and increased energy (4 of 7 if mood is irritable).

1. inflated self-esteem or grandiosity
2. decreased need for sleep (rested after 3 hours)
3. more talkative than usual, keeps talking
4. flight of ideas/thoughts racing
5. distractibility
6. increased goal-directed activity or psychomotor agitation
7. involved in activities that have high potential for negative consequences

Or a Major Depressive Episode: Meets 5 of 9 symptoms for 2-week period and one of the symptoms has to be (1) depressed mood or (2) loss of interest or pleasure

1. depressed mood (sad, empty, hopeless)
2. diminished interest or pleasure
3. significant weight loss when not dieting or weight gain (5% of body weight)
4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation

6. fatigue or loss of energy
7. feeling worthless or excessive guilt
8. diminished ability to think or concentrate (indecisive)
9. recurrent thoughts of death, suicidal ideation without a specific plan

Core Symptoms

Core features are manic episode, cognitive inflexibility, emotional dysregulation, working memory deficit, instability of interpersonal relationships, self-image, lonliness, affect and impulsivity (Chakrabarty et al., 2020). The client is likely to experience intense anger which is revealed with decompensation (Liam, Gleeson, Alvarez-Jimenez, & Penn, 2018; Schimmel, 1999).

Euphoric and Depressive Symptoms (Diaz et al., 2022)

Euphoric symptoms (elation, irritability, feelings of grandiosity, flight into ideas, racing thoughts, decreased need for sleep, decreased self-criticism, heightened sexuality, speech pressure, distraction, and energy levels)

Depressive symptoms (anhedonia, difficulty with concentration, lack of energy, sadness, irritability, and sleep alterations)

Differential Diagnosis: Major Depressive Disorder

Deficits:

1. cognitive dysfunction-flexibility (Chakrabarty et al., 2020; Evans et al., 2017; MacQueen & Memedovich, 2017)
2. working memory (Evans et al., 2017)
3. quality of life (Jermann, Perroud, Favre, Aubry, & Richard-Lepouriel, 2022)
4. low self-esteem (Liam, Gleeson, Alvarez-Jimenez, & Penn, 2018)
5. neurocognitive impairment is one of the strongest in dysfunctional cognitive control loss (Demmo et al., 2017)
6. impulsivity
7. inhibitory control (MacQueen & Memedovich, 2017)
8. attention
9. executive functioning involves verbal memory, set-shifting, inhibitory control, and working memory (Demmo et al., 2017; Evans, Kellett, Heyland, & Majidet, 2017; MacQueen & Memedovich, 2017)
10. relationships (self-others)
11. poor social support (Liam, Gleeson, Alvarez-Jimenez, & Penn, 2018)

Instruments: (Zimmerman, 2014) recommended four screeners to assess for lifetime history of manic/hypomanic symptoms. The four instruments include:

1. The Hypomanic Checklist (HCL-32): Purpose is to recognize bipolar II from major depression with a cutoff score of 14. The cutoff score yielded a sensitivity of 80% and specificity of 52%.
2. Bipolar Spectrum Diagnostic Scale (BSDS): BSDS is recommended for bipolar I and less so for bipolar II. A cutoff score of 13 yielded a 75% sensitivity and 93% specificity for bipolar disorder from major depression. Bipolar Spectrum Diagnostic Scale is to determine, bipolar II, hypomanic episodes.(Mood Disorder Questionnaire (MDQ) measures for a lifetime for mania and hypomania but not recommended for monitoring because both mania and hypomania episodes are to be evaluated. A cutoff score of 7 symptoms yielded a 73% sensitivity and 90% specificity.
3. Mood Swings Questionnaire/Survey (MSQ-46): The MSQ screens for bipolar II disorder in depressed clients and to distinguish bipolar I and bipolar II. The MSQ-46 has a cutoff score of 46 yielding a sensitivity score of 84% and specificity of 93%. The shorter 27-item form using a cutoff of 22 yielded a sensitivity score of 81% and specificity of 98%.

Treatment Popovic et al. (2013) reported that medication (first line treatment) treatment adherence and early recognition of mood symptoms has a stronger effects on mania while treatments that emphasize cognitive and interpersonal coping have stronger effects on depression.

1. Pharmacotherapy is the treatment of choice (Frank, 2009; Scott, Clap, Mileviciute, & Mousseau, 2016; Sylvia, Peters, Deckersbach, & Nierenberg, 2013)
2. Cognitive Behavioral Therapy (CBT)
3. Cognitive Analytic Therapy (CAT; Evans, Kellett, Heyland, Hall, & Majid, 2017)
4. Interpersonal and Social Rhythm Theory (IPSRT) with medication (Frank, 2007; Pilgrim & Schub, 2018) and with psychoeducation, social rhythm, and interpersonal psychotherapy)
5. Mindfulness-Based Cognitive Therapy (Bruns, LaGuardia, Brubaker, Farrow, Cotton, & DelBellow, 2021)
6. Cognitive Analytic Therapy (CAT; Evans et al., 2017)

Techniques/interventions (some examples, need specific symptoms to list others)

1. restructuring
2. psychosocial intervention (Chen et al., 2018)
3. psychoeducation (Chen et al., 2018; Wiener et al., 2017)
4. mindfulness (Burns et al., 2021)
5. relapse prevention
6. communication training

Communication and risk behaviors

1. Relapse for mania or depression depends on polarity index of psychotherapies (Popovic et al., 213).
2. Preservation is a reluctance to change as opposed to adaptation. The outcome is a slow return to a previous baseline (Hamaker, Grasman, & Kamphuis, 2016). The client is reluctant to change from one occasion to the next. There is a carry-over from yesterday's mood to consecutive days based on perturbations.
3. suicide and suicide ideation (Karanti et al., 2019)
4. treatment resistant for depression (Diaz, Fernandes, Quevedo, Sanches, & Soares, 2022)
5. stigma on autonomy (de Chazeron, Bellivier, & Llorca, 2016)
6. self-stigma is referred to as a reduction in self-esteem or self-worth caused by labeling oneself as socially unacceptable (Denenn, Thompson, Dixon & Pitts, 2015).
7. reasoning and decisional capacity (Morris & Heinssen, 2014)
8. spontaneous labelling (Anglin, Greenspoon, Lighty, Corcoran, & Yang, 2014)

Bipolar II Disorder (APA, 2022, pp. 150-151)

Bipolar I disorder typically has featured episodes of mania and usually depression while bipolar II disorder type presents with hypomanic and depressive episodes (Karanti et al., 2019). Rapid cycling is to meet four or more manic, depressive, or mixed manic-depressive episodes in last 12 months (Amsterdam, Lorenzo-Luaces, & Derubeis, 2016).

Criteria

Hypomanic Episode:

A. Lasting at least 4 consecutive days, present most days, nearly every day, persistent abnormal and persistent elevated, expansive, or irritated mood plus goal-directed or energy. Must have at least one (1) hypomanic episode

B. Three of 7 or more of mood disturbance, and increased energy (4 of 7 if mood is irritable).

1. inflated self-esteem or grandiosity
2. decreased need for sleep (rested after 3 hours)
3. more talkative than usual, keeps talking
4. flight of ideas/thoughts racing
5. distractibility
6. increased goal-directed activity or psychomotor agitation
7. involved in activities that have high potential for negative consequences

Major Depressive Episode: Meets 5 of 9 symptoms for at least a minimum of a 2-week period and one of the symptoms has to be (1) depressed mood or (2) loss of interest or pleasure

1. depressed mood (sad, empty, hopeless)
2. diminished interest or pleasure
3. significant weight loss when not dieting or weight gain (5% of body weight)
4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation
6. fatigue or loss of energy
7. feeling worthless or excessive guilt
8. diminished ability to think or concentrate (indecisive)
9. recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Core symptoms (both depressive signs and hypomanic)

1. self-other difficulties
2. mood and hypomanic
3. somatic complaints
4. fluctuations
5. alexithymia (Boen et al., 2020)
6. hyperarousal
7. Impulsivity

Deficits

1. cognitive impairment
2. self-image (Boen et al., 2022)
3. instability of interpersonal relationships (Boen et al., 2022)
4. impulsivity (Boen et al., 2022)
5. inhibitory control
6. self-other difficulties—alexithymia (Boen et al., 2020)
7. inattention
8. executive functioning (verbal memory, set-shifting, task-shifting, inhibitory control)
9. working memory (Evans et al., 2017; MacQueen & Memedovich, 2017)

Treatment

1. Cognitive Behavior Therapy (CBT)

2. Dialectical Behavior Therapy (DBT)
3. Eye Movement Desensitization and Reprocessing Therapy (EMDR)
4. Interpersonal and Social Rhythm therapy (ISPRT, Frank, 2007; Leary, 2007) reduces denial
5. Cognitive Analytic Theory (CAT; Evans et al., 2016)

Techniques

1. psychoeducation (Wiener et al., 2017; Leahy, 2007)
2. cognitive structuring
3. decision-making aids (DA; Fisher et al., 2020; Fisher, Sharpe, Anderson, Manicavasagar, & Juraskova, 2018)
4. life-chart methodology (Seitz et al., 2009)

Communication Issues

1. emotional trauma
2. suicide is higher rate for bipolar II than bipolar I (Born et al., 2009; Amsterdam & Brunswick, 2003; Karanti et al., 2019)
3. denial (Frank, 2007)
4. self stigma (autonomy; De Chazeron, Vieta, Bellivier, & Liora, 2016)
5. social stigma (Wiener et al., 2017)
6. relapse
7. genetic determination (Leahy, 2007)
8. relapse for mania or depression depends on polarity index of psychotherapies (Popovic et al., 213).
9. preservation is a reluctance to change as opposed to adaptation. The outcome is a slow return to a previous baseline (Hamaker, Grasman, & Kamphuis, 2016). The client is reluctant to change from one occasion to the next. There is a carry-over from yesterday's mood to consecutive days based on perturbations.

Delusional Disorder

Core features are delusional beliefs (false), negative affect, and exaggerated vigilance. Other features include flexibility (shifting from task to task), impulsivity or inhibition (inappropriate responses), violence, aggression, and updating (ability to incorporate relevant information and remove non-relevant information). If executive functioning is impaired, the result is working memory and rigidity (Ibanez-Casas et al., 2013).

Symptoms:

1. cognitive bias (Bhotga & Sengar, 2022)
2. hallucinations

3. false beliefs (Barous & Parks-Chapman, 2018; Ibanez-Casas et al., 2013)
4. impulsivity and inhibition (Ibanez-Casas et al., 2013)

Deficits

1. cognitive deficits (Bhotga & Sengar, 2022)
2. inflexibility
3. impulsivity
4. inhibition
5. vulnerability, cognitive
6. executive functioning (memory, rigidity; Ibanez-Casas et al., 2013)
7. working memory (Oflaz et al., 2014; Ibanez-Casas et al., 2013)
8. poor awareness for emotions
9. attention shifting (one task to another)
10. understanding social circumstances

Delusional Types (APA, 2022)

1. erotomanic
2. grandiose
3. jealous
4. persecutory
5. somatic
6. mixed

Treatment

1. Metacognition-oriented therapy and training (Bhogta & Sengar, 2022; Salvatore, Russo, Russo, Popolo, & Dimaggio, 2012)

Techniques

1. stress response techniques (breath-inhalation)
2. autonomic techniques
3. communication skills in terms of threat, defense mechanisms, resistance for treatment

Communication issues and risk behaviors

1. stigma (Cuttler & Ryckman, 2019)
2. harm to self or others (anger)

3. suicide (somatic & persecutory; Gonzilez-Rodriguez et al., 2023; Barous & Parks-Chapman, 2018)
4. family history increases risk of delusional disorder (Kornusky & Barous, 2018)
5. sensory impairment (Maher, 2005)
6. mistrust in alliance (Salvatore et al., 2002)
7. trajectory may be dementia in old age (Gonzalez-Rodriguez et al., 2022; Korner et al., 2008).
8. lack of insight and in seeking treating for grandiose type (Beddoe & Smith, 2018)

Depressive Disorders

Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, and Persistent Depressive Disorders

Disruptive Mood Dysregulation Disorder (APA, 2022, p. 178)

Criteria

1. severe temper outbursts (verbal or behavior)
2. temper outbursts are inconsistent with developmental levels
3. temper outbursts occur, on average, 3 or more times per week
4. the mood for temper outbursts is irritable or angry
5. criteria (A-D) has been present for 12 or more months
6. criteria (A-D) present in 2 of three settings (school, home, with peers)
7. diagnosis not made before 6 years of age and not after 18 years of age
8. age of onset is before 10 years of age

Core Symptoms

1. irritability and mood (Singh, Hu, & Mikiowirtz, 2022; LaPorte et al., 2021; Sharifi et al., 2021; Chase, Harvey, & Pogge, 2020)
2. angry (negative) mood (LaPorte et al., 2021)
3. loss of control
4. temper outbursts (LaPorte et al., 2021; Sharifi et al., 2021)

Deficits

1. cognitive control
2. emotional dysregulation

3. executive functioning (working memory; Sharifi et al., 2021)

Differential Diagnosis: Bipolar Disorders

Instruments

1. Children's Psychiatric Symptom Rating Scale (GPR; Pogge, 2007)
2. Children's Global Assessment Scale (CGAS)

Treatment

Little is known for treatment with the exception of individual therapy with family (Benarous, et al., 2017).

1. Cognitive Behavioral Therapy with exposure (Linke et al., 2020)
2. Metacognitive therapy improves depressive symptoms and significant improvement in rumination and worry (Winter et al., 2019)
3. Exposure-based Cognitive Behavioral Therapy (Linke et al., 2020)
4. Cognitive Analytic Therapy (Evans et al., 2017)
5. Cognitive Behavior Therapy and parent training
6. Dialectical Behavior Therapy (Hendrickson, Girma, & Miller, 2020; Perepletchikova et al., 2017)
7. DBT to target mood dysregulation, with parent training (Perepletchikova et al., 2017)
8. Interpersonal Psychotherapy (IPT), Henderson, Girma, & Miller, 2020 targeting depressive symptoms in an interpersonal context
9. Parent Management training

Techniques

1. psychoeducation
2. stop-signal
3. set-shifting
4. breath inhalation
5. go/no go task (Shafiei, Rezaei, & Sadeghi, 2021)
6. psychosocial interventions (Hendrickson, Girma, & Miller, 2020)
7. anger control skills
8. therapeutic alliance
9. social skills training (Benarous et al., 2017)
10. reward-based learning program
11. affect regulation and parent training

Target Goals

1. rumination (Hvenegaard et al., 2015)
2. depressive symptoms

Communication Issues:

1. stigma (Isbell, Kag, Barysky, & Quinn, 2022)

Persistent Depressive Disorder (APA, 2022, pp. 193-194)

Criteria

1. mood most of day for at least 2 years
2. poor appetite or overeating
3. insomnia or hypersomnia
4. low energy or fatigue
5. low self-esteem
6. poor concentration, or difficulty making decisions
7. feelings of hopelessness

Core Symptoms

1. rumination
2. worry
3. fear
4. interpersonal fear and avoidance (Wiersma et al., 2021)
5. angry
6. sleep
7. loneliness and isolation (Reinhard et al., 2021)
8. childhood trauma/maltreatment (Shafiei et al., 2021)
9. rejection sensitivity

Differential Diagnosis: Major Depressive Disorder

Deficits

1. fear and chronic worry (Roemer & Orsillo, 2002; Stein, 2020)
2. interpersonal
3. rejection sensitivity
4. anhedonia

5. loneliness and isolation (Reinhard et al., 2022; Wiersma et al. 2021)
6. social support (Struck, Gartner, Kircher, & Brakemeier, 2021; Wiersma, Klein, Schramm, Furukawa, & Favorite, 2021).
7. intolerance of uncertainty is a risk factor in maintaining anxiety (Ren et al., 2021; Saulnier et al., 2021)
8. sensitivity to rejection (Wiersma et al., 2021)
9. self-regulation
10. social cognition
11. childhood trauma/maltreatment (Guhn, Brakemeier, & Sterzer, 2021; Serbanescu et al., 2020)

Instruments

1. Hamilton Rating Scale for Depression
2. Montgomery-Asberg Depression Rating Scale
3. Clinical Global Impression Scale

Therapy Treatment

Wiersma et al. (2021) and Serbanescu et al.(2020) reported that CBASP is a first-line treatment for persistent depressive disorder. Treatment goals and focus should include lonliness, childhood maltreatment, rejection sensitivity, and interpersonal relationships (Reinhard et al., 2021; Guhn et al., 2021).

1. Cognitive Behavioral Analysis System of Psychotherapy (CBASP; Guhn et al., 2021; Wiersma et al., 2021), first choice therapy (Serbanescu et al., 2020) and focuses on correcting interpersonal misinterpretations and gaining interpersonal skills.
2. Interpersonal Psychological Therapy (IPT; Kriston, von Wolf, Westphal, Hoizel, & Harter, 2014)
3. Metacognitive Therapy (Winter et al., 2019)
4. Supportive Therapy (Serbanescu et al., 2020)
5. Cognitive Behavioral Analysis System (Guhn et al., 2021)

Target Goals (1 and 2 main goals, Guhn et al., 2021)

1. correcting interpersonal misinterpretations rooted in childhood maltreatment
2. gaining interpersonal skills in overcoming social isolation, loneliness
3. social cognition
4. submissiveness and hostility
5. modify or regulating thinking styles of rumination
6. empathic distress

7. avoidant/submissive interpersonal behavior
8. alleviate thinking styles of rumination and worry (Winter et al., 2019)

Communication Issues

1. treatment resistance (Kohler et al., 2015)
2. childhood maltreatment
3. emotional safety
4. suicidal thoughts (Kohler et al., 2015; Walker & Druss, 2015)
5. low quality of life (Walker & Druss, 2015)

Major Depressive Disorder Criteria (APA, 2022, pp. 183-185)

Criteria A

Five (5) of 9 symptoms for two-week period and one of the symptoms has to be (1) depressed mood or (2) loss of interest or pleasure.

1. depressed mood (sad, empty, hopeless)
2. diminished interest or pleasure
3. significant weight loss when not dieting or weight gain (5% of body weight)
4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation
6. fatigue or loss of energy
7. feeling worthless or excessive guilt
8. diminished ability to think or concentrate (indecisive)
9. recurrent thoughts of death, suicidal ideation without a specific plan

Core Features

1. anhedonia-core feature (Fang et al., 2021)
2. self-esteem-core feature (Moloud et al., 2022)
3. social withdrawal
4. cognitive impairment, inflexibility (Cui et al., 2021; Bailey et al., 2019)
5. rumination: residual symptom, a major factor in vulnerability to depression (Hvenegaard et al., 2015)
6. reflection and brooding (Gooding, Taylor, & Tarrier, 2012)
7. emotional blunting (Christensen, Ren, & Fagioloini, 2022)
8. sad, down, mood, decreased energy

9. hopelessness
10. prosody (voice emotion, rhythm, pattern, pauses; Shinohara et al., 2021)
11. sleep (Jermann et al., 2022; Cui et al., 2021)
12. somatic complaints (Fang et al., 2021)
13. vegetative symptoms (fatigue, appetite and weight (Keyframer et al., 2006)

Differential Diagnosis: Manic episodes with irritable or mixed episodes

Deficits

1. perseveration cognition
2. set-shifting
3. emotion dysregulation
4. cognition impairment (working memory, inhibition, set-shifting; Cui et al., 2021)
5. executive functioning (working memory)
6. impaired concentration (Boyd et al., 2022)
7. autonomic nervous system rigidity (Bailey et al., 2019)
8. vegetative automatic thought (AT; Bailey et al., 2019)
9. narrow attentional scope (Fang et al., 2018)
10. quality of life
11. sleep (Jermann et al., 2022)

Instruments

1. Beck Depression Inventory (BDI)
2. Hopkins Self-Report Scale (HSCL-D)
3. Hamilton Depression Rating Scale (HDRS)
4. Zung Self-Rating Depression Scale
5. Wakefield Self-Report Questionnaire

Treatment

Clients with depressive disorders have a tendency to ruminate and feel worse from a perspective of self-immersed or self-distance (Kross et al., 2012).

1. Cognitive Behavior Therapy (DeRubeis & Crites-Christoph, 1998; Martell et al., 2010; Sturney, 2009; Weissman, Markowitz, & Klerman, 2000; Hvenegaard et al., 2015)
2. Behavioral Activation Therapy (BAT)
3. Mindfulness-based cognitive therapy (Holle & Smith, 2021)

4. Behavior Therapy (Blieberg & Morowitz, 2008; DeRubeis et al.,1998; Resick, Monson, & Rizvi, 2008; Sinha & Rush, 2006; Swartz, 2015)
5. Interpersonal Psychological Therapy (IPT)
6. Psychodynamic Interpersonal Psychotherapy (IPT; NCIE, 2004)
7. Emotion regulation
8. Family-based parent psychoeducation (Ale, Arnold, Whiteside & Storch, 2014)
9. Emotion-Focused Therapy (Robinson, McCague & Whissell, 2014) is an evidence-based treatment (depression and trauma).

Techniques

1. bibliotherapy
2. relaxation
3. mindfulness-based stress reduction (MBSR; Williams, Teasdale, Segal, & Kabat-Zinn, 2007)
4. mentalization (Babi et al, 2021)
5. emotion regulation (Radkovsky, McArdle, Bockling, & Berking, 2014)
6. exercise

Target Goals: depressive episodes

Communication Issues

1. relapse prevention (Zisook et al., 2019; Hvenegaard et al., 2015)
2. treatment resistant (Moser et al., 2022)
3. self-esteem (Moloud, Saeed, Mahmonir, & Asi Rasool, 2022)
4. derailment-instability is the core instability (Ratner et al., 2022)
5. denial
6. thoughts of death, suicide ideation

Anxiety Disorders

Separation Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Agoraphobia Disorder, Generalized Anxiety Disorder

Separation Anxiety Disorder (APA, 2022, p. 217)

Criteria

1. Excessive fear or anxiety about separation from attached figures and 3 of 8 symptoms. Symptoms include:

a. distress anticipating or experiencing separation from home or attached figures
b. worry about losing major attachment figure (harm, illness, disaster, injury, death)
c. worry about experiencing untoward event (lost, kidnapped, having accident, ill) caused by separation from major attachment figure
d. reluctance and refusal to go out, work, away from home, and school
e. fear or reluctance to being alone, without attachment figure at home or other setting

2. reluctance or refusal to sleep away from home, or to go to school without being near attachment figure
3. repeated nightmares (theme of separation)
4. repeated complaints of physical symptoms (headaches, stomachaches, nausea)
5. fear, anxiety, or avoidance is persistent at least 4 weeks in children and adolescents, and typically 6 months or more in adults

Core Symptoms

Core features include fear, worry, separation, internalizes physical symptoms, school refusal, loss of or harm to significant figure, alone (Cornacchio, Chous, Sacs, Pincus, & Comer, 2015; Cooper-Vince, Emmert—Aronson, Pincus, & Comer, 2014).

1. panic attacks
2. hyperventilation
3. anxiety
4. derealization
5. fear of losing control
6. worry
7. fear
8. sleep (nightmares; Cooper-Vince et al., 2014)
9. somatic complaints (headaches, nausea, stomachaches, palpitations, trembling; Hannesdottir et al., 2018; Cooper et al., 2014; Doobay, 2008)
10. respiratory reactivity (Kossowsky et al., 2012)
11. avoidance

Differential Diagnosis: Generalized Anxiety Disorder

Deficits

1. cognitive distortions (Dia, 2005)
2. intolerance of uncertainity (IU, Boelen, Reijntjes, & Carleton, 2014)
3. inhibition (behavioral; Pini et al, 2022)

4. respiratory reactivity (Kossowsky et al., 2012)
5. avoidance
6. social skills
7. avoidant attachment style (Ben-Israel et al., 2016)
8. insure attachment style for adults (Ben-Israel et al., 2016)
9. controllability for homesickness coping(Flett, Besser, & Endler, 2009)
10. poor emotional awareness, emotional dysregulation (Davis, Kendall, & Suveg, 2019)

Instruments

1. The Coping Questionnaire (CQ-parent and child version; Crane & Kendall, 2020)
2. Separation Anxiety Scale for Children (SASC)-ages 8-11, measures worry about separation, distress for separation, and calm at separation
3. Separation Anxiety Avoidance Inventory (SAAI)
4. Separation Anxiety Assessment Scale (SAAS)

Treatment

1. Cognitive Behavior Therapy (APA Div 12 SCP, 2013, Doobay, 2008)
2. Cognitive Behavior Therapy with exposure (Shikatani et al., 2014)
3. Acceptance-based Group Therapy (mindfulness)
4. Emotion-focused CBT (ECBT; Davis, Kendall, & Suveg, 2019; Shahar, Bar-Kalifa, & Alon, 2017; Shahar, 2014)
5. Interpersonal Psychotherapy (IPT)
6. Coping Cat

Treatment (Children)

1. Cognitive behavioral therapy is the treatment of choice
2. Individual cognitive behavior therapy (ICBT)
3. Parent-child Interaction Therapy (Choate, Pincus, Eyberg, & Barlow, 2005)
4. Group Cognitive Behavior Therapy (GCBT), GCBT with parents, GCBT for social phobia (SOP)
5. SET-C for SOP probably efficacious using criteria for efficacious designs and protocols for Types I-V (Silverman, Pina, & Viswesvaran, 2008)
6. Coping Cat, (Kendall,2000; Southam-Gerow et al., 2021)
7. Individual published evidence-based articles report exposure therapy is highly effective, cognitive-behavioral is most effective, and Coping Cat model (manualized design).

Techniques

1. children 7 to 9 years of age (Grover, Hughes, Bergman, & Kingery, 2006)
   modeling
2. breathing techniques
3. imaginal techniques (relaxation)
4. cognitive restructuring (Doobay, 2008)
5. contingency management
6. extinction methods such as active ignoring
7. social skills training (Grover et al., 2006; Schneider et al., 2013)
8. Trennungs Angstprogramm Für Families (TAFF) techniques include psychoeducation, reframing, irrational beliefs, coping strategies and relapse prevention (Schneider, Unnewehr, & Margraf, 2009; Schneider et al., 2013). The efficacy of a family-based cognitive-behavioral treatment for separation anxiety disorder in children aged 8-13 is a randomized comparison with a general anxiety program.
9. coping cat model can be used up to 17-years of age, parents are included in ten sessions.
10. psychoeducation
11. exposure tasks
12. somatic management (relaxation)
13. cognitive restructuring problem-solving

Target Goals

1. intolerance of uncertainty (IU)
2. cognitive control
3. attentional control
4. social withdrawal

Communication Issues:

1. resistance to separation
2. genetics-children (vulnerability; Feigon et al., 2021; Cronk et al., 2004)
3. avoidant attachment style (Ben-Israel et al., 2015)

Social Anxiety Disorder (APA, 2022, p. 229-230)

Criteria

Fear or anxiety in 1 or more social situations-exposed to scrutiny by other people performing, meeting unfamiliar people, and being observed

1. fears will act in a way or show anxiety symptoms during interactions
2. social situations almost always provoke fear or anxiety
3. social situations are avoided
4. fear or anxiety is out of proportion
5. fear, anxiety or avoidance-distress or impairment in social, occupational, or other significant areas of functioning
6. specify if fear is restricted to speaking or performing

Core Features:

The core features are involved in fear of social interaction, fear of being observed, fear in performing in front of others, and avoidance of social situations (Vogel et al., 2023).

1. fear
2. worry
3. avoidance
4. attentional bias
5. social threat
6. monitoring-blunting-coping strategy and worsening of sumptoms (Mezo et al., 2005)
7. performance scrutiny (Crome & Baillie, 2014; Shikatani et al., 2014)
8. rumination (Wilson et al., 2023)
9. perseverative cognition
   Clients will use blunting and seek out distractions when confronted with a threat (Mezo et al., 2005).

Specific symptoms

1. public speaking (Crome & Ballie, 2014)
2. interaction fears
3. avoidance of social situations
4. physical symptoms including choking, blushing, sweating, trembling or twitching, dry throat and mouth, fast heartbeat or lightheadedness, flushes or chills, palpitations, fainting, shaking, fear of dying and headaches (Scaini, Belotti, & Ogliari, 2014)

Deficits

1. avoidance
2. attentional bias for social threats (Carleton et al., 2015; Rowa & Antony, 2005)
3. self-appraisal biases (Lau et al., 2023)
4. perseverative cognition (Bailey et al., 2019)

5. rumination and worry (Bailey et al., 2019)
6. social inhibition
7. blunting and monitoring (Mezo et al., 2005; Muris, Zuuren, & deVries, 1994)
8. false safety behavior (Arai et al., 2023)

Differential Diagnosis: Normative Shyness

Instruments:

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. Coping Questionnaire (Crane & Kendall, 2020)
2. Social Interaction Anxiety Scale (SIAS; Orsillo, 2001)
3. Child Anxiety Life Interference Scale (CALIS; Lyneham et al, 2013)
4. Socially Anxious Rumination Questionnaire (SARQ; Wilson et al., 2023)
5. Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990)
6. Penn State Worry Questionnaire—Adults (PSWQ-A; Hopko et al., 2003), a screener
7. Beck Anxiety Inventory (BAI; Beck & Steer, 1990a, b)
8. Social Phobia and Anxiety Inventory (SPAI; Turner, Stanley, Beidel, & Bond, 1989)
9. Social Phobia and Anxiety Inventory (SPAI-18; de Vente, Majdandzic, Voncken, Beidel, & Bogels, 2014)
10. Diagnostic Interview Schedule for Children (Costello, Edelbrock, Kalas, Dulcan, & Klaric, 1984)
11. Schedule for Affective Disorders and Schizophrenia for Children (Puig-Antich & Chambers, 1978)
12. The Anxiety Disorders Interview Schedule for Children (Albano & Silverman, 1996)
13. Social Anxiety Scale for Children-Revised (Ia Greca & Stone, 2010)
14. Social Phobia and Anxiety Inventory for Children (SPAI; Beidel, Turner, & Cooley, 1993; Beidel, Turner, & Morris, 1995, 1999; Carleton et al., 2009)
15. Social Phobic Scale and Social Interaction Scale (SIAS; Mattick & Clarke, 1989, 1998)
16. The Social Avoidance and Distress (SAD) and Fear of Negative Evaluation (FNE; Watson & Friend, 1969)
17. The Interaction Anxiousness Scale (IAS; Leary, 1983)
18. Brief Social Phobia Scale (BSPS; Davidson et al., 1991)

19. Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987)

Treatment

Threat is a critical symptom for SAD. Treatment goals should focus on the three cognitive stages social interactions. The stages are: a) anticipatory processing-worry and apprehension, b) in-situation processing-acute attention and self-talk, and c) post-mortem or post-event processing (PEP)-scrutiny of past interactions (Clark & Wells, 1995)

Exposure-based therapies require the client to remain in a feared social situation with the goal of developing new experiences to challenge their beliefs and potential social negative evaluations (Crome & Baillie, 2014). CBT is considered to be one of the most effective treatment for anxiety disorders (McCann et al., 2014).

Social skills training is based on the concept of the deficit model which conveys that poor social skills leads to ineffective and discouraging interpersonal interactions (Inderbitzen-Nolan et al., 2007). In addition, the bias model focus is attentional resources to negative threat cues and th client will exhibit a hypercritical cognitive style in evaluating their own performance in social interactions (Beck et al., 2005). The integrated model reports will attend to both underlying deficits and biases (Hopko et al., 2001).

1. Cognitive Behavior Therapy-to reduce anxiety by targeting cognitions and behaviors (DeRubeis & Crites-Christoph, 1998; Martell et al., 2010; Sturney, 2009; Weissman et al., 2000)
2. Acceptance-based therapies (Shikatani et al., 2014)
3. Family-based Cognitive-Behavioral treatment (Schneider et al., 2013)
4. Behavioral Activation Therapy (BAT)
5. Behavior Therapy (Blieberg & Morowitz, 2008; DeRubeis & Crites-Christoph,1998; Resick et al., 2008; Sinha & Rush, 2006; Swartz, 2015)
6. Parent-child interaction therapy (Choate, Pincus, Eyberg, & Barlow, 2005)
7. Social-effectiveness therapy (SET; Beidel, Turner, & Morris, 2000)
8. Coping Cat (Flannery-Schrader & Kendall, 2000)
9. Interpersonal Psychological Therapy (IPT; NCIE, 2004)
10. Family-based-parent psychoeducation (Ale et al., 2014)
11. Emotion-focused therapy (Robinson et al., 2014), evidence-based treatment (depression & trauma)
12. Cognitive Behavioral and attachment based family therapy (Siqueland, Rynn, & Diamond, 2005)

Techniques

1. bibliotherapy

2. relaxation
3. cognitive restructuring (Shikatani et al., 2014)
4. mindfulness for post event processing (PEP) and being present in the moment, accept, decrease experiential avoidance and act with awareness. The objective is to change their relationship to their thoughts to accepting their thoughts without judgment (Shikatani et al., 2014)
5. decentering is the ability to observe one's thoughts and feelings (Kuo, Hashtpari, Chea, & Tao, 2022; Shikatani et al., 2014)
6. social skills training (Beidel et al., 2014)
7. coping strategies
8. attentional control conditioning (ACC; Carleton et al., 2015)
9. mindful-based stress reduction (MBSR; Williams et al., 2007)
10. emotion regulation (Radkovsky et al., 2014)
11. exercise

Target Goals

1. prosocial skills
2. fear, worry, anxiety reduction (social situations)
3. perseverate cognition (PC; Bailey et al., 2019)
4. attention control condition (ACC)
5. decentering refers to the ability to observe one's thoughts and feelings as transient objective events in the mind, as compared to true reflections of oneself (Kuo, Hashtpari, Chea, & Tao, 2022; Shikatani et al., 2014)
6. blunting
7. monitoring

Communication Issues

1. monitoring-blunting
2. suicidality (Lyneham, 2013)
3. false safety behavior-coping strategies that temporarily alleviate anxiety (Arai et al., 2023; Schmid et al., 2012). Example: When a client is stressed and cognitive behaviors engage in slow breathing and griping objects tightly to avoid shaking, trembling while reading to an audience or speaking. The engagement with false safety is with the intention of feeling safe and in control.

Panic Disorder (APA, 2022, PP. 235-236)

Criteria

Recurrent unexpected panic attacks, abrupt surge of intense fear or intense discomfort that peaks in minutes and 4 of 13 symptoms are required

1. palpitations, pounding heart
2. sweating
3. trembling or shaking
4. sensations of shortness of breath or smothering
5. feelings of choking
6. chest pain or discomfort
7. nausea or abdominal distress
8. feeling dizzy, unsteady, light-headedness or faint
9. chills or heat sensations
10. pareasthesias (numbness or tingling sensations)
11. fear of losing control or “going crazy”
12. fear of dying

At least one of the attacks has been followed by 1 month (or more) of 1 or both of the following:

1. Persistent concern or worry about additional attacks or the consequences (control, crazy, etc.)
2. Significant maladaptive change in behavior related to the attack (avoidance)

Core Symptoms

Insecure attachment leads to poor treatment outcome and leads to conflict with autonomy and dependence (Lange, Goerigk, Nowak, Rosner, & Erhardt, 2021).

1. hyperventilation
2. attentional bias (Shim, Lee, & Park, 2016)
3. fear

Deficits

1. social relationship (Shim et al., 2016)

Differential Diagnosis: Limited symptoms panic attacks

Instruments

1. Panic Disorder Severity Scale (PDSS; Shear et al., 2001)
2. Fear Questionnaire (FQ; Marks & Matthews, 1979)

Treatment

1. Pharmacotherapy and Cognitive Behavior Therapy is the first-line treatment.
2. Panic Control Therapy (PCT)
3. CBT-exposure based and applied relaxation (Addis et al., 2006; Levitt et al., 2001))
4. Interoceptive Exposure (IE;Deacon et al., 2013)
5. Situational Exposure and Systematic Exposure
6. Acceptance and Commitment therapy (ACT)
7. Sensation-Focused Intensive Therapy (SFIT)

Techniques

1. in vivo (removal of safety features; Deacon et al., 2013; Levit, Hoffman, Grisham, & Barlow, 2001)
2. psychoeducation (to correct common myths, cognitive misappraisals, and overt avoidance behaviors)
3. cognitive restructuring (types of errors; Addis et al., 2006; Levitt et al., 2001)
4. applied relaxation training
5. interoceptive exposure (induced feared physical sensations and correct misappraisal about sensations; Deacon et al., 2013)
6. psychoeducation for physical sensation symptoms including shortness of breath, heart palpitations, sweating, and dizziness that are most distressing
7. breathing retraining (targets hyperventilation; Addis et al., 2006; Levitt et al., 2001)
8. cognitive restructuring targets misinterpreting body sensations
9. self-monitoring (on-going changes in panic, anxiety, and avoidance improving in self-awareness, and increased accuracy in self-observation)
10. attack record (cues, maximal distress symptoms, thoughts, and behaviors)
11. mood chart (situations avoided)

Target Goals: fear of losing control

Communication Issues

1. relapse prevention

2. avoidance/escape behaviors
3. anxious attachment (Manicavasagar et al, 2009)
4. insecure attachment which leads to poor treatment outcome, reduced working alliance, and conflicts with autonomy and dependence (Lange et al., 2021)

Agoraphobia Disorder (APA, 2022, P. 246)

Criteria: Situational Exposure (White, Umpfenbach, & Alpers, 2014), marked fear in 2 of 5 symptoms

1. using public transportation
2. marked fear in 2 of 5 symptoms
3. using public transportation
4. being in open spaces
5. being in closed spaces
6. standing in line
7. being alone outside of home

Core Symptoms

1. fear of anxiety and or worry and that escape is impossible (Comacchio,Chou, Sacks, Pincus, & Comer, 2015)
2. avoidance threats (Tursi, Sellers, & Marquis, 2021)
3. cognitive thoughts (something terrible to happen)
4. demoralization

Differential Diagnosis: Specific phobia, situational type

Deficits

1. cognitive control

Techniques

1. psychoeducation
2. relaxation techniques
3. breathing retraining
4. cognitive restructuring to correct catastrophic interpretations of bodily sensations (Quero et al., 2014)
5. In vivo to disconfirm misappraisals and eliminate conditioned emotional responses to exposure to external situations and internal cues (Klan, Jasper, & Hiller, 2017; Quero et al., 2014).

Treatment

1. Cognitive behavior therapy (Gallo & Cooper-Vince, 2014)
2. Situational exposure and in using GPS technology (White, Umpfenbach, & Alpers, 2014)
3. interoceptive exposure

Communication and Risk behaviors

1. suicide ideation (Tiesmann et al., 2018)

Generalized Anxiety Disorder (APA, 2022, PP. 250-251)

Criteria

1. Excessive anxiety and worry more days than not for 6 months, difficult to control worry
2. Anxiety and worry for 3 of 6 symptoms and at least some for symptoms for past 6 months
    a. restlessness or feeling keyed up
    b. being easily fatigued
    c. difficulty concentrating or mind going blank
    d. irritability
    e. muscle tension
    f. sleep disturbance Core Symptoms

Core Symptoms

1. fear
2. chronic worry (Roemer, Orsillo, & Salters-Pedneault, 2008; Stein, 2021)
3. emotion dysregulation (Tsypes, Aldao, & Mennin, 2013)
4. impulsivity (Fresam et al., 2021)
5. intolerance of uncertainity (Ren et al., 2021)
6. sleep (Tsypes, Aldao, & Mennin, 2013)
7. avoidance response (Ren et al., 2021)
8. childhood maltreatment may be present (Lakhdir et al., 2021; Shafiei, Rezaei, & Sadeghi, 2021)

Crucial components contributing and linked to worry are threat, perseverative processing, intolerance of uncertainty (IU), cognitive control, and attentional control (Cullinan, Johnson, & Wells, 2015; Saulnier et al., 2021). Marcotte-Beaumier et al. (2022) reported the importance of overt and covert avoidance strategies.

Differential Diagnosis: Anxiety disorder due to another medical condition

Deficits:

1. intolerance of uncertainty (IU, Ren et al., 2021; Saulnier et al., 2021), absence of information and repetitive negative emotions)
2. social interactions and worry, cognitive vulnerability (interpersonal cognition and self-related cognition; Penedo, Hilpert, Holland, & Fluckiger, 2021)
3. lack of emotional awareness and negative reactions
4. cognitive vulnerability
5. inhibition control (Saulnier et al., 2021)
6. emotional dysregulation
7. attention control (Saulnier et al., 2021)
8. cognitive overt avoidance regarding threat that maintains worry, beliefs, cognitive biases, and cognitive avoidance strategies (Marcotte-Beamier et al., 2022 (suppression-regarding threat and maintains worry)
9. lack of emotional awareness and negative reactions
10. impulsivity (Fresan et al., 2021)

Instruments

1. Hamilton Anxiety Inventory (adults, adolescents, and children)
2. Mood and Anxiety Symptom Questionnaire (MASQ; Watson & Clark, 1991)
3. Generalized Anxiety Disorder (GAD-Q-IV; Moore, Anderson, Barnes, & Haigh, 2014)
4. Generalized Anxiety Disorder Scale (GAD-7; Spitzer, Kroenke, Williams, & Lower, 2006)
5. Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Telligan,1988)
6. Watson and Clark (1991) defined PANAS as the most widely used measure of affect, has two scales each with 10 adjectives (positive and negative). NEGATIVE affect include: distressed (upset), hostile, irritable (angry), scared, guilt, afraid (fearful), ashamed, jittery, and nervous. The 10 POSITIVE include attentive, interested, alert, excited, enthusiastic, inspired, proud, determined, and active.

Instruments for children

1. Beck Anxiety for youth (ages 7-14) for anxious symptoms
2. Revised Children's Manifest Anxiety Scale, second edition (RCMAS-2; Reynolds & Richmond, 2008) The RCMAS contains 49-items and appropriate for ages 6 to 19-years. Scales include physiological anxiety, worry, social anxiety, and defensiveness.
3. Child Behavior Checklist (CBL; Achenbach & Rescoria, 2001) [ages 4 to 18, parent form (CBCL), youth self-report (YSR) and teacher report form (TRF).

4. CBCL scales include internalizing and externalizing and eight subscales. Internalizing subscales (withdrawn, somatic, complaints, anxious/depressed)
5. State Trait Anxiety Inventory for Children (STATIC-C; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs,1973), is appropriate for ages 9-12 years, and has 20 items per scale.
6. Fear Survey Schedule for Children-Second edition (FSSC-II; Gullone & King,1992; Burnham & Gullone, 1997) The FSSC is designed for ages 7 to 18 years and contains 75 items. Scales included are total fear and 5 subscales (fear of unknown, fear of failure/criticism, animal fears, fear of death and danger, and school/medical fears).
7. Anxiety Disorders Interview Schedule for DSM-IV Child Version (ADIS-C; Albino & Silverman, 1996), for ages 6-16 years and the interview is to assess anxiety, mood, and externalizing symptoms.
8. Burns Anxiety Inventory
9. Thirty-three items measure for the past several days are rated according to: absent [0], somewhat [1], moderately [2], a lot [3], and include three categories (anxious feelings, anxious thoughts, and somatic symptoms).

Treatment

1. Cognitive Behavior Therapy (CBT; Penelo, Hilpert, Holfort, & Fluckiger, 2021; Herbert et al., 2009; DeRubeis & Crites-Christoph,1998; Roemer et al., 2008)
2. Acceptance and Commitment Therapy (ACT; Roemer et al., 2008)
3. Mindfulness-Based Stress Reduction (Hoge et al., 2017)
4. Acceptance-Based Behavior Therapy (ABBT; Roemer et al., 2008). ABBT targets experiential avoidance and worry as a means to escape or avoid internal thoughts, emotions, and physiological sensations.
5. Emotion-Focused Therapy (EFT; Timulak et al., 2022)

Techniques

Three crucial contributing factors for GAD that maintain worry (1) IU, (2) cognitive control, and (3) attentional control (Saulnier et al., 2021)

1. cognitive restructuring, relaxation, in vivo exposure (Roemer & Orsillo, 2002)
2. recommended for children relaxation techniques (Grover et al., 2006)
3. attentional control (Saulner et al., 2021)
4. go/no tasks (Ansar & Derakshan, 2011)
5. imaginal techniques
6. problem solving skills
7. habituation
8. mindfulness (Roemer & Orsilla, 2002)

9. progressive muscle relaxation
10. diaphragmatic breathing
11. psychoeducation
12. daily diaries
13. relapse prevention
14. regulate personal feelings
15. interoceptive exposure to bodily sensations (Velting, Setzer, & Albano, 2004)

Target Goals

1. intolerance of uncertainty (IU)
2. cognitive control and attentional control (Saulnier et al., 2021)
3. decisional capacity
4. experiential avoidance and worry

Communication Issues

1. stigma (Calear et al., 2021)
2. treatment resistant
3. helpfulness (outcome expectations focusing on alliance and worry; Visla, Constantino, 2021)
4. maltreatment (Shafiei, Rezaei, & Sadeghi, 2021)

Obsessive-Compulsive and Related Disorders

Obsessive-Compulsive Disorder (APA, 2022, P. 265)

Criteria

Obsessions are:

1. urges or images that are experienced, as intrusive and unwanted, and cause marked anxiety or distress.
2. attempts to ignore or suppress thoughts, urges, or images to neutralize some thought or action.

Compulsions are:

1. repetitive behaviors (hand-washing, ordering, checking) or mental acts (counting) and feels compelled or driven to perform the behavior.
2. acts are performed to prevent or reduce anxiety or distress.

Obsessions and or compulsions are time consuming (more than 1 hour a day)

Core Symptoms

1. Obsessions and compulsions, or both involving recurrent thoughts and behaviors that have to be carried out in order to control stress and anxiety.
2. Doubt is created suggesting impaired memory. Alexithymia is a constellation of cognitive and affective characteristics observed in OCD.

Symptoms (others)

1. rumination (Wahl et al., 2021)
2. doubting is created suggesting impaired memory
3. intolerance of uncertainity (IU)
4. perfectionism
5. alexithymia
6. obsessions
7. compulsions

Deficits:

1. executive functioning (working memory impairment; Angelakis & Gooding, 2021; Persson et al., 2021)
2. doubting
3. response inhibition (Mar et al., 2021; Wahl et al., 2021; Adams, 2015)
4. intolerance of uncertainty (IU; Alonso et al., 2013)
5. cognitive control
6. alexithymia (Tapanci et al., 2018)
7. negative social relationships (Angelakis & Gooding, 2021)
8. dissociation
9. stop-signal task (Mar et al., 2022)

Instruments

1. Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
2. Most frequently applied test in clinical settings for OCD. The scale assesses for the presence and severity of obsessions and compulsions in the past week. The Y-BOCS is composed of 10 items, 5 measure the severity of obsessions and 5 measure the severity of compulsions (Lopez-Pina, Sanchez-Meca, & Lopez-Lopez, 2015).
3. Thought Fusion Instrument (TFI; Wells, Gwilliam, & Cartwright-Hatton, 2001; Simpson et al., 2011)

4. 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).
5. Family Accommodation Scale measures the most frequently occurring phenomenon that is linked to treatment response, increased OCD symptoms severity and lower levels of functioning (Wu et al., 2016).

Treatment

First-line treatment for OCD include exposure and response prevention (ERP) and CBT.

1. Cognitive Behavior Therapy: first-line treatment (Cervin et al., 2021; Schwartz et al., 2017)
2. Prolonged Exposure and Response Prevention Therapy is the treatment of choice (van der Heiden et al., 2016). If the client rejects ERP, then CBT is a treatment of choice targeting thinking and is recommended when there is high emotional reactivity, poor insight, or difficulty comprehending the rationale of treatment procedures (Ben-Arush, Wexler, & Zohar, 2008; Conelea & Freeman, 2015; DeRubeis & Crites-Christoph, 1998; Franklin & Foa, 2011; Simpson et al., 2011). Self-esteem and self-efficacy are increased with CBT (Schwartz et al., 2017) and with ERP (Craske & Barlow, 2008; Craske et al., 2014).
3. Cognitive Behavior Therapy (CBT) and Exposure and Relapse Prevention (ERP; Whittal, Thordarson, & McLean, 2005)
4. Metacognitive Therapy (van der Heiden et al., 2016)
5. Behavior Activation (Arco, 2015)
6. Medication is recommended although it may take 6 to 10 weeks before changes appear (Franklin & Foa, 2008).
7. Metacognitive Therapy (van der Heiden et al., 2016; Fisher & Wells, 2008)
8. Conelea and Freeman (2015) reported four CBT models (habituation, inhibitory learning, cognitive, and acceptance and commitment therapy (ACT; Wiggs & Drake, 2016).
9. Mindfulness-Based Cognitive Therapy (MBCT) teaches the client for acceptance of internal experiences, decreases in depressive and anxiety symptoms, increased ability to be nonjudgmental and nonreactive, discourages suppression and avoidance of thoughts that lead to increased habituation and less reliance on compulsions (Key, Rowa, Bieling, McCabe, & Pawluk, 2017).
10. Exposure and Relapse Prevention (Foa et al., 2005; Simpson et al., 2011)
11. Acceptance and commitment therapy (ACT; Bluett, Homan, Morrison, Levin, & Twohig, 2014; Twohig, Hayes, & Masuda, 2006; Twohig et al., 2010)
12. Acceptance-based behavioral therapy (ABBT; Twohig et al., 2015)
13. Stop-signal is the intervention for response inhibition (Mar, Townes, Pechlivanoglou, Arnold, & Schachar, 2022; Johnson et al., 2015).

Techniques/Interventions

1. behavioral activation and pharmacotherapy (Arco, 2015)
2. diaphragmatic breathing (APA, 2008; Van Oppen et al., 1995)
3. in vivo
4. cognitive defusion (ACT)
5. relaxation training
6. muscle relaxation
7. cognitive restructuring (Ludvig & Boschen, 2015)
8. mindfulness (Ludvig & Boschen, 2015; Twohig et al., 2015)
9. reframing
10. stop-signal task-a measure of cancelation to treat response inhibition (Mar et al., 2022)
11. cognitive restructuring and mindfulness techniques are useful for checking tasks (Ludvig & Boschen, 2015).
12. Acceptance and Commitment Therapy techniques include defusion, values, and acceptance. Defusion helps the client to change how they relate to their inner experiences as what they are, rather than what they present themselves to be. They defuse from obsessional stimuli when they use exposure in practice. Values provide a rationale for engaging in exposure tasks and resisting urges (Franklin & Foa, 2008).
13. Exposure and Response Prevention (ERP) uses a feared hierarchy supported by a well-established efficacious finding (Chambless & Holland, 1998).
14. cognitive restructuring
15. psychoeducation
16. stress management (breathing retraining, progressive muscle relaxation, and structured problem-solving)
17. stress inoculation training (SIT)
18. relapse prevention
19. control thoughts (thought record, thought repression, downward arrow for meaning of negative thoughts, and cognitive continuum, a rating of beliefs (Wilhem, 2001)

Target Goals

1. learn to interact with feared stimuli (ACT, Twohig et al., 2015)
2. working memory deficit (Angelakis & Gooding, 2021)
3. intolerance of uncertainty (IU; Alonso et al., 2013)
4. response inhibition (Mar et al., 2022)
5. lack of cognitive control

6. psychological flexibility
7. doubt
8. rumination (Wahl et al., 2021)
9. perception of negative social experiences
10. relapse prevention
11. quality of life
12. avoidance

Communication Issues

1. suicide ideation (Angelakis & Gooding, 2021; Pilgrim, Karakahian, & Hanson, 2021)
2. stigma (Trompeter et al., 2022; McCarty et al., 2017)
3. childhood maltreatment (Angelakis & Gooding, 2021), 5 major forms (sexual, physical, emotional abuse, physical neglect, and emotional neglect)
4. dissociation (disruption in consciousness, memory, identity, and perception of the environment)
5. engaging in risk behaviors

Trauma-and Stressor-Related Disorders

Posttraumatic Stress Disorder (APA, 2022, PP. 301-304)

Criteria

Exposure to actual or threatened death, serious injury, or sexual violation in 1 or more of 4 ways:

1. directly experiencing the traumatic event
2. witnessing, in person, the event as it occurred to others
3. learning that the event occurred to a close family member or close friend (event violent or accidental)
4. experiencing repeated or extreme exposure to aversive details of the traumatic event

Presence of 1 or more of 5 intrusion symptoms

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event
2. Recurrent distressing dreams where content and/or effect of the dream are related to the event

3. Dissociative reactions in which the individual feels or acts as if the traumatic event were recurring
4. Intense or prolonged psychological distress at exposure to internal and external cues that symbolizes the event
5. Marked physiological reactions in response to internal or external cues that symbolizes the event

Dissociative Symptoms

1. altered sense of the reality of one's surroundings or oneself
2. inability to remember an important aspect of the traumatic event

Avoidance Symptoms (persistent avoidance of stimuli with traumatic event by 1 or both)

1. avoidance of or efforts to avoid distressing memories, thoughts, or feelings closely associated with the traumatic event
2. avoidance of or efforts to avoid external reminders

Negative alterations in cognitions: and mood associated with traumatic event as evidenced by 2 or more of 7 symptoms

1. inability to remember important aspects of traumatic event
2. persistent exaggerated negative beliefs or expectations about oneself, others or the world
3. persistent distorted cognitions about the cause or consequences of the traumatic event that lead the person to blame self or others
4. persistent negative emotional state
5. diminished interest or participation in significant activities
6. feelings of detachment or estrangement from others
7. persistent inability to experience positive emotions

Marked alterations in arousal and reactivity associated with traumatic event beginning with or after the event (2 or more of 6)

1. irritable behavior and angry outbursts
2. reckless or self-destructive behavior
3. hypervigilance
4. problems with concentration
5. exaggerated startle response
6. sleep disturbance

Duration: is more than 1 month after trauma exposure

Core Symptoms

Core features are hallucinations and delusions, alternating episodes of avoidance and intrusions, memories, emotion regulation, inhibitory control, impulsivity, sleep, and alexithymia (Oglodek, 2022; Contractor et al., 2019).

Differential Diagnosis: Adjustment Disorder

Deficits

1. alexithymia—children experiencing emotional neglect are more prone to alexithymia (Edwards, 2022; Oglodek, 2022). Alexithymia may contribute to treatment resistance (Edwards, 2022).
2. emotional dysregulation (Oglodek, 2022)
3. intolerance of uncertainty (IU, Badawi, Steel, Harb, Mahoney, & Berle, 2021; Bardeen, Gergus, & Wu, 2013; Fetzner, Horswill, Boelen, & Carleton, 2012)-absence of information
4. cognitive vulnerability
5. impulsivity (Contractor et al., 2019; Roley et al., 2016)
6. inhibition control
7. repetitive thinking-deliberate and/or intrusive (Eames & O'Connor, 2022)
8. cognitive overt avoidance (suppression-regarding threat and maintains worry)
9. cognitive processing
10. deliberate and intrusive rumination (Eames & O'Connor, 2022)
11. lack of emotional awareness and negative reactions

Instruments

1. Boal, Vaughan, Sims, and Miles (2017) identified the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990) to be the 'gold standard' PTSD assessment. It is lengthy in questions and takes approximately 50-60 minutes to administer.
2. The Posttraumatic Checklist (PCL) is the most widely used self-report measure for PTSD. The PCL has 17 items and is aligned with the DSM-5 criteria.

The most recent review conducted listed the following 6 of 15 instruments for most widely used (Bardnoshi et al., 2016).

1. CAPS; Clinician-Administered PTSD Scale (Bardhoshi et al., 2016; Blake et al., 1990)
2. IES-R: Impact of Event Scale-Revised (Weiss & Marmar, 1997)
3. PDS: Posttraumatic Stress Diagnostic Scale (Foa, Hearst-lkeda, & Perry,1995)
4. PCL: PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993)
5. M-PTSD Mississippi Scale for Combat-Related PTSD (Keane, Caddell, & Taylor, 1988)

6. SI-PTSD Structured Interview for PTSD (Davidson et al., 1991)

Treatment

Three most popular treatments include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and EMDR (Lenz, Haktanir, & Callender, 2017). A treatment goal is reducing impulsivity (Roley et al., 2016).

1. Prolonged Exposure Therapy (PET) is the gold standard treatment for PTSD (Bryant et al., 2008; Foa et al., 2005; McLean & Foa, 2013; Schnurr et al., 2007; Shaley, 2009; Foa, Keane et al., 2009; Cooper et al., 2017)
2. Behavior Therapy (exposure-based; DeRubeis & Crites-Christoph, 1998; Makinson & Young, 2012)
3. Eye Movement Desensitization Reprocessing (EMDR) adaptive information processing related to traumatic and/or distressing experiences (Bisson & Andrews, 2007; Bradley, Greene, Russ, Dutra, & Westen, 2005; Korn, 2009; Lee, 2008; Makinson & Young, 2012; McLean & Foa, 2013)
4. Mindfulness-Based Cognitive Therapy (MBCT)
5. Cognitive Processing Therapy (Makinson & Young, 2012; Mueser et al., 2008)

Techniques

Gentry, Baranowsky, and Rhoton (2017) reported four elements common to PTSD treatments that include, cognitive restructuring and psychoeducation, relaxation and self-regulation, exposure, and improving therapeutic relationship.

1. prolonged exposure (McLean & Foa, 2013)
2. in-vivo
3. exposure and response prevention (Resick et al., 2008)
4. progressive desensitization
5. stress inoculation (Gentry, Baranowsky, & Rhoton, 2017)
6. flooding
7. anxiety management
8. deep muscle relaxation
9. controlled breathing (MaLean & Foa, 2013)
10. cognitive restructuring
11. emotional self-regulation
12. imaginal exposure
13. stress inoculation training (SIT) has been effective treating rape victims for fears, anxiety, tensions, and depression (Falsetti & Resnick, 2001)

14. resiliency training (Toledo & Carson, 2022)

Target Goals

1. fear based re-experiencing emotional and behavioral symptoms
2. anhedonia
3. negative cognitions
4. arousal and reactive externalizing symptoms
5. reducing impulsivity (Roley et al., 2016)

Communication Issues and risk behaviors

1. suicidal thoughts and death (APA, 2022, p. 311)
2. treatment resistant (Dunlop, Kaye, Youngner, & Rothbaum, 2014)
3. nonsuicidal self-injury (Ennis et al., 2020)

Acute Stress Disorder (APA, 2022, PP. 313-315)

Criteria:

Exposure to actual or threatened death, serious injury, or sexual violation in 1 or more of 4 ways:

1. directly experiencing the traumatic event
2. witnessing, in person, the event as it occurred to others
3. learning that the event occurred to a close family member or close friend (event violent or accidental)
4. experiencing repeated or extreme exposure to aversive details of the traumatic event

Presence of 9 or more of 14 symptoms in 5 categories (intrusion, negative mood, dissociative, avoidance, and arousal symptoms)

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event
2. Recurrent distressing dreams where content and/or effect of the dream are related to the event
3. Dissociative reaction in which the individual feels or acts as if the traumatic event were recurring
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolizes the event

Negative Mood

1. inability to experience positive emotions

Dissociative Symptoms

1. altered sense of the reality of one's surroundings or oneself
2. inability to remember an important aspect of the traumatic event

Avoidance Symptoms

1. efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event
2. efforts to avoid external reminders

Arousal Symptoms

1. sleep disturbance
2. irritable behavior and angry outbursts
3. hypervigilance
4. problems with concentration
5. exaggerated startle response

Duration: Restricted to 3 days and only up to one (1) month after trauma exposure

Core features

Core features include traumatic event (3 days to 1 month), dissociation (personalization & derealization), avoidance and increased arousal.

1. intrusive memory
2. depersonalization
3. emotion regulation
4. alexithymia
5. dissociation (reality), self-compassion (Hoffman, Hamama-Raz, Ben-Ezra, & Lavenda, 2021)
6. avoidance
7. sleep
8. hyperventilation
9. startle reactions

Deficits

1. self-compassion
2. personalization and dissociative symptoms (Geoffrian et al., 2022)

3. negative thoughts

Differential Diagnosis: Adjustment disorder

Instruments

1. Structured Clinical Interview
2. Impact of Event Scale-Revised

Treatment

1. Cognitive Behavioral Therapy (Bryant, Moulds, & Nixon, 2003; Koucky, Galowski, & Nixon, 2012)
   Bryant et al. (2003) conducted a 4-year study of patients who received CBT and reported less intense PTSD symptoms, less frequent and fewer avoidance symptoms than those in supportive therapy.
2. Cognitive Behavioral Therapy with Prolonged Exposure
3. Cognitive Processing Therapy (CPT)
4. Supportive Therapy
5. Eye Movement Desensitization Reprocessing (EMDR) effectiveness studies are few in the therapy literature for acute stress disorder (Buydens, Wilensky, & Hensley, 2014).

Techniques

1. cognitive behavior therapy (Bryant et al., 2008; Gallagher & Resick, 2012)
2. prolonged exposure
3. imaginal
4. in-vivo exposure
5. cognitive restructuring
6. cognitive restructuring exploring prior beliefs, rules, and experiences
7. psychoeducation and progressive relaxation (Freyth, Eisesser, Lohrmann, & Sartory, 2010)
8. bilateral stimulation (Amaco & Toichi, 2016)

Psychological First Aid (Solmon, 2008)

1. psychoeducation
2. breathing control
3. imaginal exposure
4. cognitive restructuring
5. anxiety management training
6. relaxation training

7. coping skills training
8. prolonged exposure
9. in-vivo exposure

Target Goals

1. transform dysfunctional memories into adaptive resolution
2. negative thoughts
3. sensory reduction
4. memory gaps
5. disoriented and confused
6. increasing resiliency
7. intrusive symptoms

Communication Issues

Adjustment Disorder (APA, 2022, P. 319)

Criteria A

Identifiable stressor within 3 months of the onset of the stressor
Emotional and behavioral symptoms in response to identifiable stressors occurring within three months of the onset of stressors. Bachem and Maercker (2016) reported two core groups of adjustment disorder symptoms are preoccupation with the stressor and failure to adapt.

Criteria B

One or both of 1 and 2: 1) the distress is out of proportion to severity or intensity of stressor (cultural and external context) and 2) impairment in occupation, social and other areas.

Events-stressors

Lorenz (2015) and Glaesner, Romppel, Brawler, Hinz, and Maercker (2015) reported from the Adjustment Disorder New Module (ADNM-20) 16 events (7 acute and 9 chronic) stressors occurring during the last 2 years (Einsle, Kollner, Dannemann, & Maercker, 2010).

Acute Stressors

1. death of a loved one
2. divorce
3. moving
4. criminal act

5. accident
6. retirement
7. termination of leisure activities

Chronic Stressors

1. financial difficulties
2. family conflict
3. serious illness
4. conflict with neighbors
5. too much/too little work
6. illness/care of a loved one
7. unemployment
8. conflict at job
9. pressure to meet deadlines

Core Features

Core symptoms are preoccupation with the stressor (worry and distressing thoughts) and failure to adapt to the stressor/symptoms. O'Donnell, Agathos, Metcalf, Gibson and Lau (2019) added avoidance and impulsivity. O'Donnell, Metcalf, Waton, Phelps, and Varker (2018) indicated that intrusions, rumination, avoidance, and adaptive failure are central to adjustment disorder.

Maercker and Lorenz (2018) reported core symptoms include (1) preoccupation with the stressor or consequences involving accessory symptoms such as excessive worry, recurrent and distressing thoughts, avoidance, impulse regulation, rumination and (2) failure to adapt symptoms to the stressor that interferes with everyday functioning, difficulties concentrating or sleep disturbance.

Symptoms

1. rumination
2. childhood trauma
3. anhedonia (Kohler, Fishcher, & Sterzer, 2015)
4. anger
5. worry
6. sleep

Deficits

1. interpersonal (Guhn et al., 2021)

2. rejection sensitivity
3. loneliness
4. social support
5. intolerance of uncertainty (IU)
6. self-regulation
7. social cognition

Differential Diagnosis: Major Depressive Disorder

Instruments:

1. Adjustment Disorder New Model (ADMN-8): Two parts; 1) 17-life-stressors, and 2) 8 items of symptoms
2. Peritraumatic Distress Inventory (PDI)-life threatening and 12 physical and emotional responses

Treatment

Suggested techniques include four groups:

1. Sense of self (coping strategies and psychoeducation)
2. Coping (replacing negative thoughts , anti-rumination training, homework of written exposure exercises, and dealing with anxiety)
3. Activation (life review, setting personal and realistic aims, activation of social network, hobbies, and social activities, and the effect of sport)
4. Relaxation (balanced activities, physical, mental, and emotional correlates of relaxation, practicing relaxation)

Casey (2009) recommended brief interventions because adjustment disorder is short-lived unless there is underlying personality pathology. Brief interventions include three types:

1. reduction or removal of the stressor
2. facilitation for adaptation utilizing reframing, psychoeducation, bibliotherapy, problem-solving, cognitive restructuring, and developing a support system
3. altering the response to the stressor, symptom reduction and behavioral change (APA, 2022, p. 934)

The major therapies include (outcome data support):

1. Acceptance and Commitment Therapy (ACT): Wiggs and Drake (2016) recommended ACT with mixed anxiety and depressive systems (an evidence-based treatment)
2. Interpersonal Psychological Therapy (IPT)
3. Brief Adjustment Disorder Intervention (BADI)

4. Supportive Therapy
5. Psychoeducation
6. Cognitive Behavioral Therapy

Symptoms (The first five are central to adjustment disorder (WHO, 2017)

1. intrusions
2. avoidance
3. rumination
4. adaptive behavior
5. impulsivity
6. sense of self
7. interpersonal
8. intolerance of uncertainty
9. self-regulation

Techniques

Brief Adjustment Disorder Intervention (BADI) recommends the use of the first four interventions (Rubis et al., 2016)

1. relaxation (Bachem & Maerckem, 2016)
2. time management
3. mindfulness (Skruibis et al., 2016)
4. task shifting (O'Donell, Agathos, Metcalf, Gibson, & Lau, 2019)
5. strengthening relationships
6. problem solving
7. miracle question (solution-focused therapy; deShazer, 1991)
8. bibliotherapy (helpful for preoccupation and posttraumatic symptoms)
9. psychoeducation
10. support groups
11. behavioral activation
12. stress inoculation training (Carta, Balestrieri, Murru, & Hardoy, 2009; Dannahy, & Stopa, 2009)
13. solution focused therapy interventions include: 1. sense of self, 2. coping, 3. activation

Theory

1. Cognitive Behavioral Analysis System (Guhn et al., 2021)

2. Cognitive Behavior Therapy (Skruibis et al., 2016)
3. Interpersonal Psychological Therapy (IPT; Kriston et al., 2014)
4. Cognitive Behavioral Analysis System of Psychotherapy (CBASP; Guhn et al., 2021; Wiersma et al., 2021), first choice therapy (Serbanescu et al., 2020)
5. Metacognitive Therapy (Winter et al., 2019)
6. Supportive Therapy (Serbanescu et al., 2020)
7. Brief Adjustment Disorder Intervention (BADI; Skruibis et al., 2016)

Target Goals

Communication Issues: suicide ideation (Fegan & Doherty, 2019)

Prolonged Grief Disorder

Criteria (APA, 2022, pp. 322-323)

1. The death, at least 12 months ago close to the bereaved, at least 6 months ago by one or both of the following symptoms:
   a. intense yearning for the deceased
   b. preoccupation with thoughts or memories of the deceased
2. Since the death, at least three of following symptoms:
   a. identity disruption
   b. marked sense of disbelief
   c. avoidance reminders that person is dead
   d. intense emotion pain
   e. difficulties reintegrating with one's relationships or activities
   f. emotional numbness
   g. feeling life is meaningless
   h. intense lonliness

Core features (symptoms)

1. rumination (Wenn et al., 2019)
2. worry (Wenn et al., 2019)
3. avoiding

Differential Diagnosis

1. normal grief
2. depression disorders

Deficits

Complicated grief symptoms fall into four categories, a) feelings,-most common is sadness, anger, lonliness, shock, fatigue, b) physical responses-physical sensations, depersonalization, lack of energy, c) cognitions-hallucinations, disbelief, preoccupation, and d) behaviors-sleep, appetite disturbance, and avoidance (Enez, 2017)

1. self-compassion
2. low self-esteem (Dellmann, 2018)
3. quality of life impairments (trust difficulties associated with social qualities of life; Maccallum & Bryant, 2020)

Instruments

1. The Trauma Grief Inventory-Clinician Administered (Lenferink et al., 2023)
2. The Traumatic Grief Inventory-Self Report Plus ITGI-SR+; Lenferink et al., 2022)

Treatment

Grief is a process of oscillation between confrontation and avoidance of loss-oriented stressors.

1. Complicated Grief Treatment: An evidence-based grief therapy (Shear & Bloom, 2017)
2. Cognitive Behavioral Therapy (Lenferink et al., 2023)
3. Mindfulness-based interventions (O'Connor, Piet, & Hougaard, 2014)

Techniques

1. person-centered skills and factors for ego resiliency and self-enhancement (Mancini et al., 2015)

Communication and risk factors

1. public stigma/labeling (Gonschor et al., 2020)
2. binge drinking (Miles et al., 2023)
3. denying reality (Smith & Langer, 2023)
4. trajectories (resilience, gradual recovery, chronic distress; Mancini et al., 2015)
5. anxious attachment style and dependency (Mancini et al., 2015)
6. shame is correlated with insecure attachment and could be hidden behind secondary emotions of anger, fear, and grief (Dellmann, 2018)

Somatic Symptom and Related Disorders

Somatic Symptom Disorder (APA, 2022 p. 351)

Criteria

The symptoms usually are accompanied by pain.

1. One or more bodily complaints-disruption in daily life
2. Excessive thoughts, feelings, or behaviors related to somatic symptoms by at least one of:
    a. persistent thoughts of seriousness of one's symptoms
    b. high level of anxiety about health
    c. excessive time and energy devoted to those symptoms and severity
3. State of being symptomatic is usually 6 months or more (APA, 2022, p. 351):
    a. mild is one symptom
    b. moderate is two or more symptoms
    c. severe is two or more symptoms plus multiple sources of complaints

Core Symptoms

Core features may be medically unexplained symptoms such as fatigue, dizziness (van Driel et al., 2018; Dimsdale et al., 2013).

1. explained and unexplained symptoms
2. alexithymia (Erikic et al., 2017)
3. cognitive features focused on medical pain and medical condition, attribution of somatic symptoms to bodily sensations to physical illness, worry about illness, self-concept of bodily weakness, and intolerance of bodily complaints.
4. emotional features are negative affectivity, desperation, and demoralization.
5. pain and non-pain complaints (Smith, 2001)

Differential Diagnosis: Other medical conditions

Deficits

1. cognitive impairment
2. impairment in affect perception and expression (Erkic et al., 2017)
3. suppression of negative feelings
4. emotion regulation (inability to identify emotions)
5. affect expression(

6. trust

Instruments

1. Health Preoccupation Diagnostic Interview (HPDI)-the aim of this inventory is to discriminate between SSD and illness anxiety disorder (IAD; Axelsson et al., 2016).
2. Somatization subscale of Symptom Checklist-90
3. Patient Health Questionnaire-15
4. Beck Anxiety Inventory (BAI)
5. Beck Depression Inventory (BDI)
6. Short Form Health Survey (SF-36)

Treatment goals

Hijne reported nine goals, nine factors that influence goal attainment and factors influencing goal attainment (Hijne et al., 2022)

Goals

1. empowerment
2. personal values, committed action
3. self-esteem
4. skill improvement
5. interpersonal skills
6. emotion and stress regulation
7. symptom reduction
8. psychological symptoms
9. active and structured lifestyle

Influencing factors for goal attainment (Hijne et al., 2022)

1. therapeutic alliance
2. social and everyday context
3. family systems
4. meaningful daily schedule
5. social and economic circumstances
6. ability to change
7. externalizing tendency
8. reflective and psychological skills
9. perspective and motivation

10. psychological vulnerability
11. comorbidity

Treatment

Demirci et al. (2017) reported that no single treatment has out performed another treatment modality.

1. Cognitive Behavior Therapy-theory of choice (Cetin & Varma, 2021; Looper & Kirmayer, 2002; Erkic et al., 2017, Demirci at al., 2017)
2. Eye Movement Desensitization and Reprocessing (EMDR; Demirci, Sagaltici, Yildirim, & Boysan, 2017)
3. Mindfulness therapies (Tibben et al., 2019) Detach from feeligs related to the event and emotional reactions, mindfulness techniques help to regulate emotional reactivity and help the person to recover from unpleasant feelings and emotions (Ho et al., 2017).

Techniques

1. cognitive restructuring (Looper & Kirmayer, 2002)
2. mindfulness helps to regulate emotional reactivity and to recover from unpleasant experiences and emotions (Aktas, Giulen, & Sevi, 2019)
3. psychoeducation (Cetin & Varma, 2021)

Target Goals

1. emotional regulation
2. pain complaint
3. quality of life
4. impaired cognition
5. alexithymia (Erkic et al., 2017)

Communication Issues

1. stigma
2. trust (Erkic et al., 2017)
3. suppression of negative feelings (Erkic et al., 2017)
4. tend not to use psychological services, even refusal when referral is made by a medical doctor.
5. compliance

Feeding and Eating Disorders

Anorexia Nervosa Disorder (APA, 2022, P. 381)

Criteria

1. Restriction of energy intake relative to requirements, leading to significantly low body weight (age, gender, trajectory and physical health)
2. Intense fear of gaining weight, becoming fat or behavior that interferes with weight gain
3. Ways in which body weight or shape is experienced, lack of seriousness of current low body weight

Core Symptoms

1. body image dissatisfaction (Ciwoniuk, Wayda-Zalewska, & Kucharska, 2023)
2. body image disturbance (Grilo, Crosby, & Machado, 2019).
3. intense fear of gaining weight
4. disturbance in self-perceived weight or shape

Differential Diagnosis: Medical conditions, Major depression disorder

Deficits

1. meta-cognitive beliefs (beliefs about control abilities) referred to as cognitive attention syndrome (CAS, Carver & Scheier, 2012)
2. self-control coping strategies (Hennecke & Burgler, 2022, Wells, 2000)
3. perservative thinking in the form of rumination and worry (Wells, 2000)
4. purging
5. semi starvation (associated feature)
6. cognitive attentional syndrome, CAS; Wells, 2000

Instruments

1. Eating Disorder Examination (EDE)
   Luce, Crowther, and Pole (2008) considered EDE as the gold standard; 22 items, measures core areas of behavioral and attitudinal features of eating disorders. Four subscales measure dietary restraint, shape concern, weight concern, and eating concern.
2. Eating Disorder Inventory (EDI-3)
   Evaluates traits and symptoms to development and maintaining eating disorders
3. Eating Attitudes Test (EAT)
   First instrument developed to measure anorexia nervosa and one of most widely used (Mintz & O'Halloran, 2000)

4. Body Shape Questionnaire (BSQ)
   The BSQ measures concerns about body shape perceptions for those with eating issues

Treatment

1. Acceptance and Commitment therapy (ACT); Juarascio et al. (2010), mindfulness/acceptance
2. Cognitive behavior therapy-anorexia (CBT-AN)
3. Family therapy
4. Cash's Body Image therapy
5. Mirror Exposure Therapy (Griffen, Naumann, & Hiildebrandt, 2018; Krohmer, Tuschen-Caffier, & Svadi, 2022)-used for body disturbance disturbances
6. Cognitive Behavior Therapy Guided Self-care for binge eating
7. DBT (Eisler, 2005; Lenz, Taylor, Fleming, & Serman, 2014; Wilson & Fairburn, 1993)
8. Maudsley model is ACT (Juarascio, Forman, & Herbert, 2010)
9. Maudsley family-based
10. Multidisciplinary approach
11. Cognitive-behavioral therapy
12. Dialectical behavior therapy (DBT), group therapy
13. Transdiagnostic approach
14. Interpersonal psychotherapy and family therapy

Techniques

1. mindfulness (Sala, Ram, Vanzhula, & Levinson, 2020)-used for emotion regulation
2. structured eating routine weighing,
3. monitoring of food intake
4. cognitive restructuring (Waller, Stringer, & Meyer, 2012)
5. psychoeducation

Target Goals

1. fear of weight gain
2. impaired decision-making

Communication Issues: suicide risk, minimization, denial

Bulimia Nervosa Disorder (APA, 2022, pp. 387-388)

Criteria A

1. recurrent episodes of binge eating (examples) within a 2-hour period of time an amount larger than most people would eat in similar amount of time and situation
2. lack of control over eating during episode
3. inappropriate compensatory behaviors to prevent weight gain (self-induced vomiting, laxatives, diuretics or medication, fasting exercises)
4. binge eating and compensatory behavior occur on average, once a week for 3 months
5. self-evaluation is by body weight and shape

Core Symptoms

1. binge-eating and purging (core features; Shapiro et al., 2007)
2. dietary restraint
3. body dissatisfaction, body image disturbance

Core symptoms are binge-eating and purging. Development occurs in adolescent years.

Symptoms:

1. dietary restraint,
2. body dissatisfaction,
3. body image and body disturbance.
4. craving
5. low self-esteem
6. dissatisfaction with body weight
7. negative affect, negative emotion (sadness, anxiety, anger, lonliness, guilt), negative emergency (Leenaerts et al., 2023)
8. emotional reactivity
9. impulsivity
10. rumination (Samtani et al., 2022; Milman et al., 2018)

Control Deficits

1. impulsivity
2. control deficits (Shapiro et al., 2016)
3. social processing (Schaumberg et al., 2021; Lydecker & Grilo, 2019)
4. low self-esteem (Barous & Schub, 2021)
5. suicide ideation

6. relapse

Differential Diagnosis: Anorexia Nervosa, binge eating/purging type

Deficits:

1. suicide ideation, red flag (Shapiro et al., 2007)
2. group culture regarding values for food
3. self-regulation (Presseller et al., 2021)
4. impulsivity ((Presseller et al., 2021)
5. relapse prevention
6. social processing (Schaumberg et al., 2021)
7. attentional bias

Instruments

Sandberg and Erford (2013) using a survey reported 16 inventories used in clinical practice for bulimia and binge eating disorders. Five instruments are the most commonly reported.

1. Eating Disorder Examination (EDE)
   Luce et al. (2008) considered EDE as the gold standard; 22 items, measures core areas of behavioral and attitudinal features of eating disorders. Four subscales measure dietary restraint, shape concern, weight concern, and eating concern
2. Eating Disorder Inventory (EDI)
   Evaluates traits and symptoms in developing and maintaining eating disorders
3. Eating Attitudes Test (EAT)
   First instrument developed to measure anorexia nervosa and one of most widely used (Mintz & O'Halloran, 2000).
4. Bulimic Investigatory Test, Edinburgh (BITE)
   The BITE identifies symptoms of binge eating or bulimia.
5. Body Shape Questionnaire (BSQ)
   The BSQ measures concerns about body shape perceptions for those with eating issues.

Treatment

1. Cognitive Behavior Therapy (gold standard; Accurso et al., 2016; Fairburn, 2008; Grilo, Masheb, Wilson, Gueorguieva, & White, 2011; Linardon, Wade, Garcia, & Brennan, 2017; Wilson & Fairburn, 1993)
2. Dialectical Behavior Therapy (DBT; Lenz et al., 2014; Linehan, 1993; Wilson, Grilo, & Vitousek, 2007)
3. Integrative cognitive affective therapy for BN (Peterson et al., 2020; Accurso et al., 2016), ecological measurement assessment (EMA) is recommended for assessment (Ebner-

Priemer & Trull, 2009), and ethnic group culture is a consideration regarding values for food (Patmore, Meddaoui, & Feldman, 2019). Treat self-care (Jenkins et al., 2007; Schmidt et al., 2007)

4. Mirror Exposure Therapy (Griffen, Naumann, & Hiildebrandt, 2018; Krohmer, Tuschen-Caffier, & Svadi, 2022)
5. Interpersonal Psychotherapy (IPT) targets personal stress and interpersonal relationships; Carleton, 2016a)
6. Exposure Response Therapy (ERP) has been useful when treating eating disorders and anxiety together.
7. Acceptance and Commitment Therapy (ACT), Cognitive Behavior Therapy (CBT), and Compassion-Based components (Fogelvist, Gustafsson, Kjellin, & Parling, 2020; Heffner, Sperry, Eifert, & Detweiler, 2002)
8. Family therapy (adolescents; Eisler, 2005)
9. BEfree program is a psychological program treating shame and self-criticism (Pinto et al., 2017). It is a newer approach and the study supported less external shame, less depressed, less self-critical, and decreased flexibility related to body image but lacks in comparative research effectiveness.
10. Treat shame, fused body image and eating as an avoidance strategy (Pinto et al., 2017)

Techniques

1. homework
2. self-monitoring
3. structured eating
4. routine weighing
5. monitoring of food intake
6. exposure-based methods
7. psychoeducation about dangers of vomiting and purgative abuse, food monitoring and dietary management, identification of antecedents to loss of control, target social cognitive aspects of the thin ideal, standards for self-comparison, poor self-evaluation, body image, shame, self-criticism
8. problem-solving
9. ERP, exposure and relapse prevention
10. body image and body image therapy (Carleton, 2016b)
11. cognitive strategies (restructuring) to change beliefs and attitudes about importance of weight and body shape on self-evaluation and approval of self (Waller et al., 2007; Waller, Stringer, & Meyer, 2012)

12. relaxation training (Kocovski, Fleming, Hawley, Huta, & Antony, 2013; Wong & Moulds, 2010)
13. mindfulness (focus is internal experiences, self-accepting attitudes, interrupting conditioned patterns, and decreasing reactive automatic responses to negative affect (Kabat-Zinn, 1994).

Target Goals

1. body dissatisfaction
2. purging (compensatory behaviors)
3. shame
4. attempts to conceal (secrecy)

Communication Issues

1. physical care
2. suicide ideation and self-injurious behaviors (red flag): Barous & Schub, 2021
3. relapse prevention is a major concern (Leraas et al., 2018)
4. systematic barriers inhibit seeking treatment (stigma and shame; Reas, Isomaa, Gulliksen, & Levallius, 2021)

Binge-Eating Disorder (APA, 2022, PP. 382-383)

Criteria

1. Recurrent episodes of binge eating (examples):
   a. within a 2-hour period of time an amount larger than most people would eat in similar amount of time and situation
   b. lack of control over eating during episode
2. 3 of 5 for binge-eating
   a. eating much more rapidly than normal
   b. eating until feeling uncomfortably full
   c. eating large amounts of food when not feeling physically hungry
   d. eating alone because of embarrassed by amount one is eating
   e. feeling disgusted with oneself, depressed, or very guilty afterwards
3. Distressed binge eating is present
4. Binge eating occurs, on average, once a week for 3 months
5. Not associated with compensatory behaviors

Core Symptoms

Childhood maltreatment is linked to self-blame (Szabo & Nelson, 2019)

1. binge-eating
2. body dissatisfaction (Mason, Dolgon-Krutolow, Smith, & Leventhal, 2022)
3. emotion dysregulation (Walenda et al., 2021)
4. rumination
5. impulsivity (Pavey & Churchill, 2017)
6. anhedonia (Mason, Smith, & Anderson, 2020)
7. alexithymia (Schaumberg, Zerwas, Bulk, Fiorentini, & Micakum, 2021)
8. body shame (Nechita, Bjud, & David, 2020).
9. body checking and avoidance (weigh and shape: Lewer, Bauer, Hartmann, & Vocks, 2017)
10. negative emotions
11. suicide ideation (red flag)

Deficits

1. loss of control (Naumann, Svaldi, Wyschka, & Heinrichs, & von Dawans, 2018)
2. emotion dysregulation (Walenda et al., 2021)
3. rumination (Arbuthnott, Lewis, & Bailey, 2015)
4. suppression (Walenda, Kostecka, Santangelo, & Kucharska, 2021)
5. attentional bias can be treated with mirror exposure therapy (Krohmer et al., 2022)
6. impulsivity (Pabry & Churchhill, 2017)
7. attentional bias to social threat (Schaumberg et al., 2022)
8. anhedonia
9. social cognition and processing (Schaumbeg et al., 2021)
10. self-compassion and self-esteem (Naumann, Svalidi, Wyschka, Heinrichs, & Dawans, 2218; Pinto-Gouveia et al., 2017; Schwitzer, 2012)
11. situational bias to social threat
12. attentional scope (Fang et al., 2018)

Differential Diagnosis: Bulimia Nervosa

Instruments

1. Eating Disorder Examination (EDE)
   Luce, Crowther, and Pole (2008) considered EDE as the gold standard; 22 items, measures

core areas of behavioral and attitudinal features of eating disorders. Four subscales measure dietary restraint, shape concern, weight concern, and eating concern)

2. Eating Disorder Inventory (EDI-3)
   Evaluates traits and symptoms to development and maintaining eating disorders
3. Eating Attitudes Test (EAT)
   First instrument developed to measure anorexia nervosa and one of most widely used (Mintz & O'Halloran, 2000)
4. Body Shape Questionnaire
   The BSQ measures concerns about body shape perceptions for those with eating issues
5. Bulimic Investigatory Test, Edinburgh (BITE)
   The BITE identifies symptoms of binge eating or bulimia.

Treatment

1. Cognitive behavior therapy is the gold standard treatment (Fairburn, 2008; Grilo et al., 2011; Linardon et al., 2017; Wilson & Fairburn, 1993).
2. Dialectical Behavior Therapy (Kenny, Carter, & Safer, 2020; Lenz et al., 2014; Linehan, 1993; Wilson et al., 2007)
3. Interpersonal Psychotherapy Therapy (IP) targets personal stress and interpersonal relationships (Carleton, 2016a).
4. Cognitive integrated cognitive-affective therapy (Peterson et al., 2020)
5. Mirror Exposure Therapy (Krohmer, Naumann, Tuschen-Caffier, & Svaldi, 2022): used to treat biased attentional processes
6. Family therapy (adolescents; Eisler, 2005)
7. Exposure Response Therapy (ERP) has been useful when treating eating disorders and anxiety together.
8. ACT, CBT, and compassion-based components (Heffner, Sperry, Eifert, & Detweiler, 2002; Juarascio, Forman, & Herbert, 2010)
9. BEfree program is a psychological program for treating shame and self-criticism (Pinto et al., 2017). It is a newer approach and the study supported less external shame, less depressed, less self-critical, and decreased flexibility related to body image but lacks in comparative research effectiveness.
10. Treat shame, fused body image and eating to treat avoidance strategy (Pinto-Gouveia & Ferreira, 2017)

Techniques/Interventions

1. psychoeducation (target social cognitive aspects of the thin ideal, standards for self-comparison, poor self-evaluation, body image, shame, self-criticism)

2. cognitive restructuring strategies to change beliefs and attitudes about importance of weight and body shape on self-evaluation and approval of self (Waller, Stringer, & Meyer, 2012)
3. relaxation training (Kocovski et al., 2013; Wong & Moulds, 2010)
4. body image therapy
5. mindfulness (focus is internal experiences, self-accepting attitudes, interrupting conditioned patterns, and decreasing reactive automatic responses to negative affect (Sojcher, Fogerite, & Perlman, 2012; Kabat-Zinn, 1994; Sala, Ram, Vanzhula, & Levinson, 2020)-used for emotion regulation.
6. structured eating routine weighing
7. monitoring of food intake
8. cognitive restructuring (Waller, Stringer, & Meyer, 2012)
9. relapse prevention
10. psychoeducation (Pinto-Gouvia et al., 2017)

Target Goals

Body dissatisfaction, emotion dysregulation, rumination, negative emotions, suicide ideation

Communication Issues

1. suicide ideation (Boling & Karakashian, 2018)
2. nonsuicidal self-injury (Arbuthnott, Lewis, & Bailey, 2015)
3. suppression (Walenda et, al., 2021)
4. denial, minimization (Berg, Peterson, & Frazier, 2012)
5. treatment resistant

Disruptive, Impulse-Control, and Conduct Disorders

Oppositional Defiant Disorder (APA, 2022, P. 522-23)

Criteria

Pattern of angry/irritable mood, argumentative/defiant behavior or vindictiveness for at least 6 months. Four (4) of 8 symptoms with at least 1 individual who is not a sibling

Angry/Irritable Mood

1. loses temper
2. touchy or easily annoyed
3. angry and resentful

Argumentative/Defiant Behavior

1. argues with authority figures
2. actively defies or refuses to comply with requests by authority or with rules
3. deliberately annoys others
4. blames others for his/her mistakes or behavior

Vindictiveness

1. has been spiteful or vindictive at 2 times within the past 6 months

Core Symptoms

1. anger and irritable mood (Doerfler, Volungis, & Connor, 2020)
2. emotion dysregulation syndrome (Craig et al., 2021; Doerfler, Volungis, & Connor, 2020).
3. attention scope is narrow and focuses on information in the center (Fang, Sanchez-Lopez, & Koster, 2018).
4. failure to manage is a result of a lack of inhibitory control.

Deficits

1. executive dysfunctioning (Figueiredo, Ramiao, Barroso, & Barbosa, 2022; Diamond, 2000)
2. inhibitory control (Bonham, Hawkins, Waters, & Stanley, 2020)
3. emotional dysregulation syndrome (Craig, Hernandez, Moretti, & Pepler, 2021)
4. cognitive and social deficits (Erford et al, 2014)
5. relational aggression-parent-child and child-peer interactions (Erford et al., 2014)
6. may have insecure attachment reflection avoidance and attachment ambivalence (Craig et al., 2021)

Differential Diagnosis: Conduct Disorder

Instruments

1. Child Behavior Checklist
2. Achenbach System of Empirically Based Assessment
3. The Eyberg Child Behavior

Treatment

1. cognitive behavior therapy (Prout, Goodman, Chung, & Sherman, 2021)
2. Mirror Therapy (Griffen, Naumann, & Hiildebrandt, 2018; Krohmer, Tuschen-Caffier, & Svadi, 2022)
3. Regulation Focused Psychology (Prout et al., 2021)
4. parent management training

5. anger control training
6. Parent-child Interaction Therapy (PCIT), ages 2.5 to 6, efficacious studies
7. individual and group counseling
8. family interventions (parent training)-Erford et al., 2014)
9. 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 of 20 Type I studies and 14 Type II studies and included specific information regarding sample type, child race, sex, and age.
10. Well-established efficacious was met for parent management training-Oregon mode (PMTO)
11. Probably efficacious included 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, and PSST + parent (PSST + PM).

Target Goals

1. inhibitory control
2. attention scope
3. anger reduction
4. emotional regulation (temperamental)

Communication Issues

1. trust
2. compliance
3. affect dysregulation, attachment anxiety, and insecure attachment are key risks (Craig et al., 2021)

Intermittent Explosive Disorder (APA, 2022, p. 527)

Criteria

1. recurrent behavioral outbursts representing a failure to control aggressive impulses by either (a) or (b)
    a. verbal expression, temper tantrums, tirades, verbal arguments or fights OR physical aggression toward property or animals occurring twice (2) weekly on average, for a period of 3 months

b. behavioral outbursts involving damage or destruction of property and/or physical injury to animals or individuals with a 12-month period

2. grossly out of proportion to the provocation or precipitating psychosocial stressors
3. aggression outbursts are not premeditated (they are impulsive and/or anger based)
4. outbursts cause occupational or interpersonal impairment

Core Symptoms

Coccaro et al. (2017) reported (1) callous unemotional and social deviant/social threat are the focus for IES (Ogbuagu, Keedy, Phan, & Coccaro, 2021).

1. callous unemotional and social deviant/social threat (Bonham et al., 2022; Coccaro, Lee, & McCloskey, 2017; Ogbuagu, Keedy, Phan, & Coccaro, 2021).
2. social deviant (Ogbuagu, Keady, Phan, & Coccaro, 2021).
3. behavioral symptoms include failure to resist an impulsive aggression, impulsivity, emotional lability
4. alexithymia
5. negative affect (Fettich et al., 2014)
6. emotional dysregulation (lability)
7. anger (Jennings, Wildes, & Coccaro, 2017)
8. aggression (Medeiros et al., 2019)

Symptoms

1. callous-unemotional
2. aggression
3. social behavior (threat)

Differential Diagnosis: Disruptive Mood Dysregulation Disorder (Rachwan & Coccaro, 2020; APA, 2022)

Deficits

1. emotional dysregulation includes emotionality, grandiosity, lack of remorse, lack of empathy, deceitfulness, and denial of responsibility (Coccaro, Lee, & mcCloskey, 2014; Fettich et al., 2014)
2. response inhibition
3. impulsivity
4. cognitive distortions (Fettich et al., 2015)
5. disconnects from self
6. alexithymia

7. psychosocial impairment (McCloskey, Lee, Berman, Noblett, & Coccaro, 2008)
8. callous unemotional (Bonham et al., 2022; Coccaro, Lee, & McCloskey, 2014)
9. lack of behavior control

Instruments

1. Intermittent Explosive Disorder Screening Questionnaire (IED-SQ)-Coccaro, Berman, and McCloskey (2016)-used for adults
2. Barratt Impulsivity Scale (BIS-11; Patton et al., 1995)
3. Buss-Perry Aggression Questionnaire (BPAQ; Buss & Perry, 1992)

Treatment

1. Cognitive Behavior Therapy
2. Cognitive-Behavioral group therapy (Costa et al., 2018)
3. Behavior therapy
4. Family therapy
5. Group therapy

Technics/Interventions

1. social skills training
2. cognitive restructuring
3. situational attribution training (SAT; Pekrun, 2010, 2007)
4. anger management
5. emotion regulation
6. impulse control
7. distraction
8. habit reversal
9. problem-solving training

Target Goals

1. automatic thoughts (AT; Hollon & Kendall, 1980)
2. anger bursts (verbal and physical)
3. emotional regulation
4. decision-making
5. relationship issues

Communication Issues

1. red flag for risk: threat to self-aggression, attempted suicide (Schub & March, 2018).
2. aggressive (Fanning, Lee, & Coccaro, 206)

Conduct Disorder (APA, 2022, PP. 530-531)

Criteria

Persistent pattern of behavior in which basic rights of others or societal norms or rules are violated-3 of 15 symptoms in past 12 months, with at least one in the past 6 months.

Four Categories of symptoms: 1. aggression to people and animals (7), 2. destruction of property (2), 3. deceitfulness or theft (3), and 4. serious violations of rules (3)

Aggression to People and Animals

1. bullies, threatens or intimidates others
2. often initiates physical fights
3. has used weapon that causes serious physical harm to others
4. has been physically cruel to people
5. has been physically cruel to animals
6. has stolen while confronting a victim
7. has forced someone into sexual activity

Destruction of Property

1. has deliberately engaged in fire setting
2. has deliberately destroyed property

Deceitfulness or Theft

1. has broken into someone else's house, building
2. often lies to obtain goods or favors to avoid obligations
3. has stolen items of nontrivial value without confronting a victim

Serious Violations of Rules

1. often stays out late at night, before age 13
2. has run away from home overnight, at least twice or once without returning for a lengthy period
3. often truant from school, beginning before age 13

Core Symptoms

1. lack of guilt

2. lack of remorse
3. lack of empathy
4. impulsivity
5. anger management (Tonyali, Goker, & Sukran Uneri, 2019)
6. lack of motivation
7. shallow affect
8. callous-unemotional empathy (Bonham et al., 2022; Colins, Van Damme, Fanti, & Andershed, 2017; Hawes, Price, & Dudds, 2014)

Symptoms

1. inhibitory control (Bonham et al., 2022)
2. callous-unemotional (Bonham et al., 2022; Pisano et al., 2017; Dawes et al., 2014)
3. blunted emotions (Fairchild & Freitag, 2019)
4. aggression
5. destruction
6. deceitfulness (APA, 2022, p. 531).

Differential Diagnosis

Oppositional Defiant Disorder

Deficits

1. inhibitory control (Bonham et al., 2022)
2. executive functioning (Figueiredo et al., 2022, Diamond, 2000)
3. limited pro-social emotions (LPE, Castagna, Babinski, Waxmonsky, & Waschbusch, 2022)
4. self-regulation
5. cognitive shifting, working memory (Bonham et al., 2022)
6. information processing and distortion deficits (problem solving skills)
7. blunted use for threat
8. interpersonal reactivity (hyporesponsivity, a trajectory if not treated antisocial personality disorder: Martin-Key, Allison, & Fairchild, 2020)

Instruments

1. Children's Depression Inventory (Kovacs, 2003; Ages 7-17)
2. Beck Depression Inventory-II (Beck & Steer, 1996)
3. Hamilton Rating Scale for Children (Hamilton, 1960)
4. Child Behavior Checklist Internalizing Scale and Anxious/Depressed subscale

5. Center for Epidemiologic Studies Depression Scale (CES-D)

Treatment

1. Cognitive Behavior Therapy (Mpofu & Crystal, 2001)
2. Psychosocial interventions
3. Mentalization-based therapy for conduct disorder (MBT-CD; Tauber et al., 2021)
4. Emotion-focused therapy (EFT; Adams & Bibbons, 2019)
5. Parent management training
6. Multidimensional treatment
7. Multisystemic therapy

Techniques

1. psychosocial skills training (Tauber et al., 2021)
2. attribution retraining
3. problem-solving skills training (Mpofu & Crystal, 2001)
4. dysregulation
5. impulsivity social skills
6. anger management
7. parent management

Target Goals

Goals include callous-unemotional (CU), inhibitory control, reciprocal relations, and limited prosocial emotions (LPE).

Clients demonstrate hyposensitivity to emotional stimuli. Children's behavior problems are a result of parental inconsistency, poor parental supervision, and physical punishment (harsh and hard discipline), and deteriorating family functioning (Tonyali, Goker, & Uneri, 2019). The goal is to solve the disturbance in impulsivity and anger control by increasing communication and problem solving skills. Maltreatment and abuse are common during the toddler and elementary school years and there is a decrease in maternal warmth and paternal overreactivity (Rolon-Arroyo, Arnold, Breaux, & Harvey, 2018). Recommended treatment consists of psychosocial interventions consisting of problem-solving, anger management, moral reasoning, and mindfulness. Limited prosocial emotion, a specifier includes a lack of remorse or guilt, callousness/lack of empathy, unconcern about performance, shallow/deficient affect (Castagna et al., 2022).

Communication Issues

1. trajectory: if not treated a risk for developing antisocial personality disorder (Tauber et al., 2021)

2. treatment engagement (TE) for readiness, motivation, working alliance (bonding), and cognition (problem-solving; Colins et al., 2021)
3. lack of motivation for tasks (Bonham et al., 2022; Castagna et al., 2022)
4. relationship between child abuse and conduct disorder increased (Bauer, Hammerton, Fraser, Fairchild, & Halligan, 2021)
5. relationship between child abuse and conduct disorder increased (Bauer et al, 2021; Bauer, Hammerton, Fraser, Fairchild, & Halligan, 2021)
6. trust (Aebi et al., 2022)

Substance-Related and Addictive Disorders

Alcohol Use Disorder (APA, 2022, pp. 553-554)

Criteria

Two of 11 symptoms within 12-month period

1. alcohol taken in larger amounts
2. persistent desire to cut down or control alcohol
3. great deal of time devoted to obtaining alcohol or recover from its effects
4. craving, or strong desire or urge to use alcohol
5. recurrent alcohol use
6. continued alcohol use despite social or interpersonal problems
7. occupational, social, or recreational activities are given up or reduced
8. recurrent use of alcohol in which it is physically hazardous
9. continued use of alcohol despite knowledge of physical or psychological problems
10. tolerance
11. withdrawal

Core Symptoms

1. urge to drink is considered a core feature of SUD (Hallgren, McCrady, & Epstein, 2015)
2. vegetative changes
3. anergia
4. hypersomnia
5. increased appetite, craving for carbohydrates, and weight gain (Enggasser & Young, 2007)
6. urge to drink: Hallgren, McCrady, and Epstein (2015) reported the main core feature is the urge to drink despite wanting to reduce alcohol use.

Symptoms (continued)

1. rumination
2. inhibitory control
3. impulsivity
4. cognitive vulnerability

Deficits

1. inhibitory control
2. cognitive vulnerability
3. anxious temperament (Khazaal et al., 2013)
4. insecure attachment (Khazaal et al., 2013)
5. decision-making (Khazaal et al., 2013)
6. poor self-regulation (Haeny et al., 2021)

Instruments

1. Subtle Substance Alcohol Screener Inventory (SSASI)
2. Michigan Alcohol Screening Test (MAST)
3. Alcohol Severity Scale
4. Nonpathological use of alcohol
5. Cut, Agitation, Guilt, Eye (CAGE)

Techniques

1. relationship skills
2. attribution training (AT)
3. resilience development (buffering; Sheerin et al., 2017)
4. motivational interviewing (Ehman & Gross, 2019)

Treatment:

1. Cognitive behavior therapy (Brooks et al., 2021)
2. Dialectic behavior therapy (Giles, 2017)
3. Acceptance and Commitment therapy (Ehman & Gross, 2019)

Target Goals

1. quality of life (Carlon et al., 2022)
2. impulsivity (Haeny et al., 2021)
3. rumination

4. cognitive vulnerability
5. inhibitory control
6. memory issues
7. judgment (decision making)
8. disorientation
9. inability to focus attention
10. circadian rhythmicity

Treatment Outcome

Haaga, McCrady, and Lebow (2006) reported that the treatment trajectory was based on several factors. Factors included working alliance, client motivation, client's awareness of dysfunctional patterns of repetitive of thinking and behavior, dysfunctional attention to negative affective emotions, and maintenance of substance use disorders. Three client variables critical for change are positive expectations for change, readiness for change, and the severity of the substance use disorder.

Communication Issues and risk factors

1. relapse (Brooks et al., 2021; Maisto, Hallgren, Roos, Swabn, & Witkiewitz, 2020; Stillman & Sutcliff, 2020; Maisto et al., 2020; Sliedrecht, Waart, Witkiewitz, & Roozen, 2019; Durazzo, Mon, Gazdzinski, & Meyerhoff, 2016)
2. public stigma (Strzeleckii & Waldron, 2021)
3. impulsivity and impulse control (Haeny et al., 2021)
4. craving is a strong predictor of drinking (Kuerbis et al., 2020)
5. denial
6. suicide (Hsu et al., 2022)
7. attachment style (Simsek, Onubol, & Bilici, 2021)

Neurocognitive Disorders

Major and Mild Neurocognitive Disorder

Core features for major mild are based on a continuum from severe (major) to modest (mild) for executive functioning, cognitive decline and independence in daily living involving mental, physical, and social engagement, completion, and planning. Each subtype has specific diagnostic criteria involving mood (depression, anxiety), agitation (more pronounced in major with disruptive vocal and motor concerning), apathy (lack of motivation and goal-directed behavior), and behavioral disturbances specific to subtypes (wandering, hyperphagia, ad hoarding (APA, 2022, pp. 694-695).

Diagnostic features are on a continuum spectrum for cognitive and functional impairment and based on the client's core features of cognitive decline involving the client's concern about cognition. Is their evidence of a knowledgeable informant? Performance in mental, social, and physical domaines is assessed in terms of a decline over time. Memory (short and long) issues involve recall for recent events, facts, verbal exchanges, resuming a task, organizing and resuming tasks or activities. Assessing for independent living is critical in association with the cognitive decline. Everyday functioning involves physical adaptation and cognitive execution to provide for independence. The person may in decline where assistance in the form of a caregiver or provider.

Early signs of cognitive decline usually are observed by family members, physicians, and the person's awareness to recall. The assessment should include quantitative and qualitative markers. A quantitative criteria based on a qualitative involves six errors. The errors are size, graphic difficulties, stimulus-dependent responses, conceptual deficits, spatial/planning deficits, and preservations (Aguilar-Navarro et al., 2018; Pinto & Peters, 2009). The most frequent errors for qualitative analysis involved conceptual, graphic, and spatial/planing difficulties.

The Clock Drawing Test (CDT) is administered during a physical examination (Aguilar-Navarro, et al., 2018). The CDT, a brief screening test, provides for a wide range of cognitive processes. Attention, understanding of instructions, planning, visuospatial ability, visual construction, programming and graphomotor performance, numerical knowledge, abstract thinking, symbolic representation, and semantic memory are domains for further elaboration and assessment. Secondary instruments are often utilized to determine a base rate or level functioning at the time. Achievement batteries and intelligence instruments are often choices in this process.

Episodic memory is common with cognitive impairment due to Alzheimer's disease. The Five-Word Test for detection of neurocognitive disorder in older adults is useful for episodic deficits and cultural application usefulness (Aguilar-Navarro et al., 2019).

A consideration for impairment for independent and everyday activities for daily living (ADL) assessment may be to use the Everyday Abilities Test (Indu, Beegum, Kumar, Sarma, & Vidhukumar, 2021). The abilities examined are core tasks (eating, bathing, dressing) and higher level tasks such as instruments involving cooking, shopping, medication, transportation, and managing finances.

Capacity to consent for treatment is critical, the University of California Brief Assessment of Capacity to Consent (UBACC) is a brief (5 minute administration) test for capacity. The most frequently used for capacity is the MacArthur Test although requires 15-20 minutes and a trained evaluator (Sacco et al., 2021).

Treatment

Psychoeducation is important treatment to promote acceptance of illness, handling role adjustment, developing a positive lifestyle, improving relationships with family caregivers, and facilitating emotional support among others (Young, 2016). Young (2016) reported that treatment for major neurocognitive disorder is focusing on improving and maintaining health-related quality of life as cognitive abilities that are declining. The World Health Organization stipulates care is to include the perception of an individual in their position in life within the context of one's culture and value system involving goals, expectations, standards and concerns (WHO, 1995). The goals are to promote acceptance of the illness, handling role adjustments, developing a positive life style, improving relationships with care givers, and facilitating emotional support among those involved with the client.

Cognitive stimulation therapy is recommended to stimulate reminiscence, reality orientation, and social and sensorimotor activities (Rao, Sivakamar, Srivastava, & Sidana, 2020). Family intervention and psychosocial interventions are recommended. Exergaming is helpful to improve physical and cognitive tasks through body movements in response to visual, auditory, and somatosensory cues. Step training involving gait speed, balance, and execution of daily life actives (Swinnen, Vandenbulcke, de Bruin, Akkerman, Stubbs, Firth, & Vancampfort, 2021). Rao et al. (2020) recommended the following cognitive and behavioral objectives:

1. cognitive functions include attention and concentration
2. memory and new learning
3. visuospatial orientation
4. language, executive function
5. social cognition

Behavioral goals involve daily living (cooking, managing medication, transportation, and finance)

1. apathy
2. agitation
3. aggression
4. delusions
5. hallucinations
6. sleep disturbances
7. wandering

Communication and risk behaviors

1. capacity for consent (Sacco et al., 2021)
2. memory impairment (Bland & Newman, 2001)

Personality Disorders

Avoidant Personality Disorder (APD)

APD clients are sensitive to others' internal states and expressed as emotions, sensitive to rejection, internalized shame, need to belong, anxious attachment, avoidance of close relationships, adaptive defense mechanisms. APD shares common symptoms with BPD such as anger expression and emotion dysregulation (McGonigal & Dixon-Gordon, 2020).

Core Symptoms

1. lack of sensitivity to others' internal states and their emotions
2. sensitive to rejection
3. lonliness (Martens, 2010)
4. internalizes shame
5. need to belong
6. anxious attachment
7. avoidance of close relationships
8. adaptive defense mechanisms

Schizoid Personality Disorder (SPD)

Core feature

1. mentalization and egosyntonic (Fong, 1995).
2. anhedonia-avoidance of close relationships (Candel & Constanti, 2017)
3. attachment (avoidant)
4. ambivalence (core feature; Thylstrup & Hesse, 2009)
5. aloof (Candel & Constanti, 2017)
6. disorganized perception and thinking (March & Karakashian, 2018)
7. rejection sensitivity (indifferent to social feedback), need to belong, social anhedonia, attachment style, shame, and defense style; Winarick & Bornstein, 2015)
8. empathy (lack capacity for mentalization)
9. defense style (maladaptive styles).
10. This client experiences identity diffusion, shame, social isolation and lonliness (Martens, 2010).

Deficits

1. capacity for mentalization (Winarick & Bornstein, 2015)
2. lack of empathy (Winarick & Bornstein, 2015)

3. social anhedonia
4. avoidant attachment
5. disorganized perception and thinking (March & Karakashian, 2018)

Treatment

Treatment interventions include building collaboration (alliance), maintaining consistency, validating, and building motivation (Livesley, 2005). The client perceives the therapist as sadistic, dangerous, and depriving (Roberts, 1997).

1. Mentalization-based therapy (Choi-kain & Unruh, 2017)

Techniques

1. mirroring (Knoi et al., 2020)

Communication Issues

1. lack of motivation (Thylstrup & Hesse, 2009)
2. splitting (Kernberg
3. labeling (Parpottas, 2012)
4. ambivalence (Thylstrup & Hesse, 2009)

Antisocial Personality Disorder (ASP)

1. hostility (characterized by irritability manifested in aggression toward others), low self-control, impulsivity (hallmark characteristics; Wojciechowski, 2022)
2. social dominance (Stanton & Zimmerman, 2019)
3. callousness unemotional (Hopwood & Bleidorn, 2021)
4. anger characterized as an expression of aggression (Yazici & Batmaz, 2021)
5. deception-
6. manipulation
7. hostility (Knack, Blais, Baglol, & Stevenson, 2021)
8. failure to conform to social norms
9. deceitful
10. impulsivity (Hesse, Palacio-Gonzalez, & Thylstrup, 2022)
11. irritability (Caple & Schub, 2018)
12. low self-control

Deficits

1. low self-control
2. impulsivity (Azevedo et al., 2020)

3. empathy deficits (Rhee et al., 2021)
4. emotion dysregulation (McGonigal & Dixon-Gordon, 2020)
5. deceitfulness
6. self and others functioning (Anderson & Kelley, 2022)
7. behavior activation system (Espinoza-Romero et al., 2022)
8. parentification issues (Rhee et al., 2021)
9. externalizing disorder-the subject is subject to malingering/faking bad (Knack, Blais, Bagole, & Stevenson, 2021; Elowsky, 2002)

Communication Issues

1. treatment resistant (Hesse et al., 2022; McGonial, Dixon-Gordon, 2020; Messina,Wish, Hoffman, & Nemes, 2002; Caple & Schub, 2019)
2. conning (Rogers et al., 2002)
3. malingering-faking (Rogers et al., 2002)
4. self and others functioning
5. stigma (based on misconceptions, misinformation, and mistaken assumptions about the disorder (van den Bosch, Rijckmans, Decoene, & Chapman, 2018)

Treatment techniques

1. psychoeducation (Kisilik et al., 2021)
2. mentalization-based therapy for ASPD (Fongay et al., 2020)

Borderline Personality (BPD)

Criteria

The child grows with an invalidating environment where communication are not accepted as an accurate indication of his/her true feelings (stormy attachments). The child oscillates between opposite poles of emotional inhibition in an attempt to gain acceptance and extreme displays of emotion in order to have feelings acknowledged. Self-invalidation therefore is a dilemma. Pervasive pattern of instability of interpersonal relationships, self-image, and affect marked with impulsivity, beginning in early adulthood and 5 or more of 9 criteria:

1. frantic efforts to avoid real or imagined abandonment
2. pattern of unstable and intense interpersonal relationships alternating between extremes of idealization and devaluation
3. identity disturbance, unstable self-image or sense of self
4. impulsivity in at least 2 areas that are self-damaging
5. recurrent suicidal behavior (gestures, threats, or self-mutilating)
6. affective instability due to marked reactivity of mood

7. chronic feelings of emptiness
8. inappropriate intense anger or difficulty controlling anger
9. transient, stress related paranoid ideation of dissociative symptoms

Core symptoms: Rapid cycling has to meet four or more manic, depressive, or mixed manic-depressive episodes in last 12 months

1. anger, irritability, and aggression (Guillden et al., 2022; McGonigal & Dixon-Gordon, 2020)
2. impulsivity (Hummelen et al., 2022)
3. alexithymia (Hummelen, Boye, Elvsahagen, & Malt, 2020)
4. unstable mood
5. hypomanic
6. negative affectivity
7. somatic complaints
8. impulsivity (Hummelen, Boye, Elvsahagen, & Malt, 2020; McGonigal & Dixon-Gordon, 2022).
9. shifts in idealization
10. unstable and instability of relationships
11. Instability of self-image (Hummelen et al., 2022)

Differential diagnosis: Depressive and bipolar disorders

Deficits

1. cognitive impairment
2. unstable identity (Keefe et al., 2022)
3. impulsivity
4. emotional vulnerability (affective instability) and emotion regulation (Howard & Cheavens, 2022)
5. inhibitory control
6. reflective functioning (capacity to understand self and others; Keefe et al., 2022))
7. attention
8. disinhibition
9. executive functioning (verbal memory, set-shifting, inhibitory control)
10. working memory (Evans, Kellett, Heyland, Hall, & Majid, 2017; MacQueen & Memedovich, 2017)

Instruments

1. General Assessment of Personality Disorder (GAPD; Livesley, 2006). GAPD is a self-report assessing core component features of personality dysfunction. Assessment includes 11 personality disorders (Berghuis, Kamphuis Verheul, Larstone, & Livesley, 2013).
2. Personality Inventory (PID-5) for the DSM-5 (scales or factors: emotional lability, anxiousness, separations insecurity, hostility, depressivity, impulsivity, risk taking, and negative affectivity)
3. Personality Assessment Inventory-Borderline Personality Subscale

Treatment

1. Dialectical Behavior Therapy (DBT; Schub & Hanson, 2021; Kiehn & Swales, 2006); May, Richardi, & Barth, 2016)
2. Emotional Regulation Group Therapy (ERGT)
3. Interpersonal Social Rhythm Therapy (IPSRT; Leahy, 2007)
4. Cognitive Behavioral Therapy
5. Interpersonal Psychotherapy (IPT)
6. Cognitive Analytic Therapy (CAT)

Techniques/Interventions

1. mindfulness (Feliu-Solermk et al., 2014), what and how communication skills
2. attention regulation
3. body awareness
4. psychoeducation

Target Goals: irritability

Counseling Issues and risk behaviors:

1. **c**ompliance (counseling & medication),
2. poor treatment response (McGonigal & Dixon-Gordon, 2022)
3. social stigma (Wiener et al., 2017),
4. denial (Frank, 2007).
5. shift from Idealization to devaluation
6. suicide attempts (Jorgensen et al., 2021; Karanti et al., 2019)

Narcissistic Personality Disorder (NPD)

Core features include self-absorption, grandiosity, exploitation, vulnerability, and lack of empathy (Giacomo et al., 2023). Clients tend to have overly positive self-views, self-

importance, and entitlement (Coleman et al., 2022; Dehaghi & Zeigler-Hill, 2021). Issue is lack of trust. Suffers from relational disruptions.

Symptoms

1. entitlement
2. exploitation and manipulation (Giacomo et al., 2023)
3. poor self-esteem
4. angry outbursts
5. physical aggression
6. self-absorption-overly positive self-views, self-importance, and entitlement (Dehaghi & Zeigler-Hill, 2021)
7. insensitive
8. grandiosity
9. vulnerability-a need for acceptance and belonging (Kealy et al., 2023; Coleman et al., 2022)
10. negative agreeableness (Stanton & Zimmerman, 2019)
11. disturbed sense of self (SOS, Lefter, 2020)

Deficits

1. lacks social trust (Dehaghi & Zeigler-Hill, 2021)
2. emotional dysregulation
3. lack of empathy-affective dissonance (Giacomo et al., 2023)
4. impaired self-reflective capabilities (tend to intellectualize; Dimaggio, 2022)
5. interpersonal difficulties, relational disruptions
6. self-concept swings from inferior to superior (Dimaggio, 2022)
7. fragile self-image and self-esteem (Kealy et al., 2023; March & Cabrera, 2018)
8. impulsivity

Techniques

1. problem-solving training
2. social skills training

Treatment (Bateman, Bolton, & Fonagy, 2014)

Muir et al. (2021) reported that there is no “gold standard” treatment for narcissistic personality disorder.

Therapy focus or goals should emphasize increasing self-reflection and reducing intellectualization, reducing maladaptive schemas to form healthier ideas about self and others, and promoting empathy (Dimaggio, 2022).

Therapists to develop and maintain a relationship (alliance) should provide validation and support and be careful to avoid criticism. The focus should be on the client's actual qualities and actions, capacities for communication, and displaying painful feelings which they are unaware of.

1. Group-based cognitive and behavioural therapy interventions
2. Mentalization-based therapy (Muir et al, 2021; Drozek & Unruh, 2020)
3. Metacognitive Interpersonal Therapy (Muir et al., 2021; Dimaggio et al. 2020)
4. Cognitive behavior therapy
5. Dialectical Behavior therapy (Campbell & Miller, 2011)
6. Emotion-regulation skills training

Communication issues

1. suicide ideation and self-harm (Kealy et al., 2023; March & Cabrera, 2018)
2. ruptures appear in the alliance, unpredictable behavior in that the client may belittle or insult the therapist with subtle irony (Muran, Eubanks, & Samstag, 2021).
3. lack of trust (Dehaghi & Zeigler-Hill, 2021)
4. dissociation (Dimaggio, 2022)
5. isolation, withdrawal, and emotional distancing
6. trajectory (if childhood adversity) and misattuned parent-child relationship is toward depression (Kealy et al., 2023; Fjermestad-Noll et al., 2019)

Issues Cutting Across Personality Disorders

Symptoms

Some symptoms are known to exist in different disorders. A few symptoms will be shared with sources to serve as examples. Preparers may want to add to this symptom list and pairing techniques and interventions that are used for treatment.

Alexithymia:

Alexithymia refers to difficulties in identifying and describing feelings, differentiating between bodily sensations and feelings, and considered to be a cognitive style of concrete thinking. Alexithymia is a common symptom in somatoform disorder, panic disorder, obsessive-compulsive disorder, and depression (Tapanci, Yildirum, & Boysen, 2018).

a. Binge disorder (Schaumberg et al., 2021)

b. Schizoid personality disorder (Miller & Davis, 2020)
c. Obsessive-compulsive disorder (Wahl et al., 2021; Tapanci et al., 2018)
d. Bipolar II (Boen et al., 2020)
e. Borderline personality disorder (Boen et al., 2020)
f. Persistent depressive disorder (Winter et al., 2019)
g. Posttraumatic stress disorder (Oglodek, 2022)
h. Somatic symptom disorder (Erkic et al., 2012)
i. Eating disorder (Schaumberg et al., 2021)

Anhedonia:

Anhedonia is the loss of interest, inability to experience pleasure when experiencing things that use to be pleasurable (characteristic of depression).

a. Major depressive disorder (Fang et al., 2021)
b. Bipolar II (Fang et al., 2021)
c. Schizoid personality disorder (Winarich & Bornstein, 2015)

Maltreatment: refers to all types of abuse and neglect of a child under the age of 18. Childhood maltreatment is linked to self-blame (Szabo, Nelson, & Lantrip, 2019), body dissatisfaction, emotion dysregulation, rumination, negative emotions, and suicide ideation (red flag) are concerning issues

a. Binge-eating disorder (Szabo et al., 2019)
b. Borderline personality disorder (May, 2016)
c. Narcissistic personality disorder (Glickauf-Hughes & Mehlman, 1995)
d. Obsessive-compulsive disorder (Angelakis & Gooding, 2021)
e. Persistent depressive disorder (Guhn et al., 2021)

Treatments of Choice: There are other treatment modalities that are recommended for the following disorders, but this will be a start-up list.

1. Acute stress avoidance: Psychological first aid followed by critical incident debriefing, EMDR (Buydens, Wilensky, & Hemsley, 2014)
2. Adjustment disorder: CBT and self-help
3. Agoraphobia disorder: CBT (psychoeducation, restructuring, relaxation, breathing retraining, and exposure to internal and external cues (Klan, Jasper, & Miller, 2017), situational exposure is recommended for agoraphobia avoidance (White et al., 2014)
4. Anorexia Nervosa disorder: CBT, DBT (Gowens, 2006; Lenz et al., 2004)
5. Binge-eating disorder: ACT, CBT (Juarascio et al., 2010), DBT (Kenny et al., 2020)
6. Bipolar disorder: Interpersonal Psychotherapy, Social Rhythm therapy (Leahy, 2007)

7. Bipolar II disorder: Interpersonal Psychotherapy, Social Rhythm therapy (Leahy, 2007)
8. Borderline Personality disorder: DBT (May, Richard, & Barth, 2016)
9. Bulimia Nervosa disorder: CBT-E (enhanced) and ICAT-BN (Accurso et al., 2016)
10. Delusional disorder: Meta-cognitive CBT (Salvatore, Russo, Russo, Popolo, & Dimuggio, 2012)
11. Disruptive Mood Dysregulation disorder: Exposure-based CBT (Linke et al., 2020), Social skills training, affect regulation (Barker, Copeland, Maughan, Jaffee, & Uher, 2012; Benarous et al., 2017)
12. General Anxiety disorder: CBT, Integrating Mindfulness, acceptance and commitment therapy (ACT; Roemer, Orsillo et al., 2008)
13. Major Depressive disorder: CBT

Treatment: Techniques/Interventions

1. Acceptance and Commitment therapy techniques include introspective-exposure, mindfulness, psychoeducation, stress inoculation, problem solving, assertiveness training, and self-monitoring.
2. Adlerian Counseling techniques include early recollections, lifestyle analysis, family constellation, family values, encouraging, setting tasks, acting as if, catching one's self, paradoxical intention, using push buttons, thin slicing (client with goal limited perspective), avoiding the tar baby, creating images, and spitting in the soup. Treatment disorders include depression, GAD, eating disorders, and borderline personality.
3. Behavior therapy techniques include systematic desensitization, relaxation exercises, in vivo desensitization, assertive training, and self-management training. Treatment is recognized for depression, OCD, GAD, and phobic disorder.
4. Cognitive theories includes techniques such as cognitive distortions, all or nothing cognitions, negative predictions, catastrophizing, overgeneralization, labeling, minimization, thought stopping, personalization, cognitive rehearsal, cognitive restructuring, reframing, self-monitoring, and homework.

   Cognitive-behavioral techniques include stress inoculation, assertive training, muscle relaxation, breath-inhalation, cognitive restructuring, reframing, and downward arrow (identify core beliefs).

   Cognitive-Behavioral therapy for anxiety disorders including agoraphobia, social anxiety disorder, panic disorder, generalized disorder involves muscle relaxation, thought stopping, thought switching, assertive training, cognitive restructuring, breath control, guided dialogue, covert modeling, and role playing (Seligman & Reichenberg, 2012).

   Social anxiety techniques include exposure, cognitive restructuring, social skills training, self-monitoring, and relaxation.

5. Dialectical Behavior therapy uses mindfulness. Mindfulness skills are divided into 'what' and 'how' communication. What skills teach the client to observe, describe, and participate fully in the present moment. The 'how' skills teach clients to be present in the moment with a nonjudgmental mindset, focusing on one thing at a time (Feliu-Solermk et al., 2014).
6. EMDR is best known for eye movement desensitization, and reprocessing and involves moving eyes in a certain way while processing traumatic events. Processing is through bilateral visual, auditory or tactile stimulation. It is also known as dream sleep.
7. Existential therapy techniques for treatment involves telling the story, dream work, sharing existence in the moment, making meaning, and developing closure. This treatment is recommended for depression, borderline personality, OCD, anxiety disorders, and alcoholism.
8. Gestalt therapy technique focus is with "what" and "How" questions to surface unfinished business, present awareness, staying with the feeling, giving directives, empty chair, talking to parts of oneself, and playing projections. Disorders for treatment includes depression, anxiety, PTSD, and substance abuse.
9. Narrative therapy major technique is asking questions, eliciting stories, deconstruction of stories,metaphors, reflections, therapeutic writing, and mapping.
10. Prolonged Exposure therapy (image the feared situation, in vivo)
11. Psychoanalytic theory techniques/strategies involve interpretation, free association, and dream analysis. Treatment includes borderline personality disorder, narcissistic disorder, childhood anxiety, and depression.
12. Person-centered therapy and existential counseling encourage being genuine, and relationship development rather than techniques. Treatment recommendations include depression, grief and loss, and borderline personality disorder.
13. Rational Emotive therapy techniques include disputing, encouraging, setting tasks, acting as if, catching one's self, paradoxical intention, using push buttons, avoiding the tar baby, creating images, role playing, spitting in the soup, and written homework. Treatment disorders include depression, GAD, eating disorders, and borderline personality.
14. Reality therapy treatment focus is for five basic needs involving belonging, power, fun, independence, and survival. Techniques include metaphors and paradoxical techniques but there is not a list for a host of techniques. The treatment is best known by WDEP (wants, direction/doing, evaluation, and planning).
15. Solution-focused therapy techniques include miracle question, exception-finding questions, scaling questions, coping questions, fast-forward questions (unable to think of exceptions), and compliments to normalize the problem. SFBT is a strength-based evidenced-based intervention with a focus on the client's strengths, identify exceptions to problems, and highlights small successes (Himmelberger, Ikonomopoulos, & Vela, (2022). Himmelberger et al, (2022) defined SFBT as a future-focused and goal-directed approach that focuses on searching for solutions and is created on the belief that clients have knowledge and

resources to resolve their problems. The counselor assists the client to imagine how they would like things to be different and what it will take to make small changes (miracle question).

Theories Aligned With Different Disorders

Specific Theories aligned with specific disorders include:

1. Acute Stress Disorder-Attention Control Therapy, EMDR, ACT
2. Adjustment Disorder-CBASP, Metacognitive therapy, and Brief Adjustment Intervention (BADI)
3. Agoraphobia Disorder-CBT, Interoceptive Exposure Therapy (relaxation, breathing retraining, and paradoxical intervention)
4. Anorexia Nervosa Disorder-CBT, DBT, Meta-cognitive Therapy, and Interpersonal Psychotherapy (IPT)
    1. Antisocial Personality Disorder-No evidence for ASP although literature support for Mentalization-based therapy, CBT, and Schema Focused Therapy (SFT)
5. Attention Deficit/Hyperactive Disorder-DBT, CBT
6. Binge Eating Disorder-CBT (gold standard), DBT, ACT, Integrative Cognitive Affective Therapy
7. Bipolar I Disorder-Interpersonal Social Rhythm Therapy (IPRST), CBT, and Cognitive Analytic therapy
8. Bipolar II Disorder-Interpersonal Social Rhythm Therapy (IPRST) ,DBT, CBT, EMDR, and Cognitive Analytic theory
9. Borderline Personality Disorder-Dialectical Behavior Therapy, Mentalization-based Therapy (MBT)
10. Brief Psychotic Disorder-Mentalization-based Therapy
11. Bulimia Disorder-CBT, Integrative Cognitive Affective Therapy, Mentalization-based Therapy
12. Conduct Disorder-CBT, Mentalization-based Therapy, Emotion-focused Therapy
13. Delusional Disorder-Metacognitive Therapy and CBT
14. Disruptive Mood Dysregulation Disorder-DBT, CBT
15. Generalized Anxiety Disorder-Meta-Cognitive Therapy, Emotion-focused Therapy, Cognitive-Behavioral Therapy, Acceptance and Commitment Therapy
16. Intermittent Explosive Disorder-CBT
17. Major Depressive Disorder-Mindfulness Cognitive Therapy, CBT. Emotion-focused Therapy, Acceptance and Commitment Therapy, Behavioral Activation Therapy
18. Major Depression Seasonal Affective Disorder-Interpersonal Social Rhythm-Seasonal-CBT-SAD, Light Therapy

19. Narcissistic Personality Disorder-CBT, DBT, Mentalization-based Therapy
20. Obsessive Compulsive Disorder-MetacognitiveTherapy, CBT, ERP (Exposure Response Prevention)
21. Oppositional Defiant Disorder (ODD)-CBT, DBT)
22. Panic Disorder-Interoceptive Exposure Therapy (IE), Panic Control Therapy (PCT), CBT
23. Paranoid Personality Disorder
24. Persistent Depressive Disorder-Cognitive Behavioral System of Psychotherapy (CBASP) and metacognitive therapy
25. Posttraumatic Stress Disorder-Prolonged Exposure Therapy, Mindfulness-based Cognitive Therapy, Eye Movement Desensitization and ReprocessingTherapy, Cognitive Exposure Therapy, Cognitive Processing Therapy, and Stress Inoculation Training. EMDR is an alternating bilateral stimulation of visual, auditory, and/or tactile.
26. Prolonged Grief Disorder-CBT
27. Schizoid Personality Disorder-Mentalization-based Therapy
28. Schizophrenia-Mindfulness-based Cognitive Therapy, ACT, ISRT, Body-oriented Psychological Therapy
29. Separation Anxiety Disorder-CBT, Coping Cat, Emotion-focused CBT
30. Social Anxiety Disorder-CBT, Social Effectiveness Therapy (SET), Coping Cat, social skills training
31. Somatic Symptom Disorder-CBT, Affective Cognitive-behavioral Therapy
32. Substance Use Disorder (alcohol)-CBT, DBT, Cognitive-behavioral Coping Skills Therapy (CBCST), Acceptance, Commitment Therapy (ACT), Social SkillsTraining

Counselor-Client Relationship (alliance)

1. Psychodynamic-transference and countertransference and defense mechanisms (repression, denial, projection, sublimation, rationalization, displacement, and regression)
2. Adlerian therapy-friendly and genuine relationship
3. Person-Centered Counseling-unconditional positive regard, congruence, empathy and to make contact with the client (warm relationship and client in state of incongruence)
4. Existential therapy-counselor and client alliance is a focus on the mechanism for change, an I-Thou relationship, a movement away from an I-It relationship with others
5. Gestalt therapy-help clients to learn to use their sensorimotor equipment for heightened awareness and to enter an authentic relationship, a primary mechanism for change
6. Reality therapy-an expert role teaching clients about the fundamentals of choice theory and to communicate hope

7. Rogerian conditions: warmth, positive regard, empathy, and consistency
8. Behavior therapy-role of expert, teacher, and powerful reinforcer
9. Solution-focused is as a consultant and the client is the expert. Empowerment of the client is critical
10. Narrative therapy-the counselor is skilled at facilitating conversations (a post-modern constructionist worldview and acceptance in the realities we create)

Optional Reading:

Writer's Speculation About a Possible Design for the New Format

The writer would like to offer an impression to possibly help build an understanding for the NBCC format change. Even though the previous examination was based on the clinical procedures used for client care, the examinee was required to have a bank of knowledge for each set of clinical procedures or domains for several diagnoses. That format targeted what is best client care procedures and prioritized choices to be applied in the examination. The client and counselor needed to decide to make choices based on positive, negative, and/or therapeutic best content during the procedures. The format had five to ten questions per scenario that required the examinee to have a priority in selecting choices. This was problematic for many who had extensive counseling experiences and for those just entering the field. The examination was an approximation of real time counseling and as a result, the outcome came up short because many examinees had knowledge and experiences that were beyond the question depth.

The understanding I offer to improve the past examination does not ideally fit the case study three-part segments spaced over two client sessions. However, when researching the literature for best client care, what is evident is treatment integrity and adherence. The NBCC information for each case narrative is much like a running chart where in part one the assessment has been conducted and the counselor processes the material before meeting the client, begins to develop the clinical work to develop an alliance with the client, isolates key (hallmark) disorder symptoms and deficits, and provides ethical constructs at the onset. This may consume three to five questions. Questions in the second part are preceded by an information box that cues the counselor to some recent and/or between session developments that will require the counselor to be additive by responding (intervening dynamics) with understanding, clarification, and modification to the treatment. The third part of the narrative is similar except the therapy has reached a different level of need.

Treatment integrity or fidelity is composed of three components: treatment alliance, treatment differentiation, and counselor competence. Treatment alliance and adherence refers to the counselor's delivering the treatment as intended (case study section 1). Treatment differentiation refers to where treatment differs from another treatment (theory or technique) that may be defined by a treatment manual (case study, section 2). An example may be an intervention recommended within a statistical research study, but another treatment modality may suggest a different intervention. Counselor competence refers to the level of skill and degree of responsiveness demonstrated by the counselor (section three of the case study). The three components for evidenced-based treatment, when delivered throughout the counselor-client therapy sessions, provide for the best opportunity for change to occur (Gresham, 2009; McLeod & Isam, 2011). These components are outlined in Domains 1: Professional Practice and Ethics, Domain 2: Intake, Assessment, and Diagnosis, Domain 4: Treatment Planning, Domain 5: Counseling Skills and Interventions, and Domain 6: Core Counseling Attributes. Given a short narrative of three sections over a few weeks, it might be difficult to evaluate for accomplishing treatment delivery; however, the narrative does emphasize the importance for feedback.

Southam-Gerow et al. (2021) provided a CBT protocol as an example of counselor adherence for an anxiety disorder in applying a youth adherence scale (CBAY). The protocol included standard, model, and delivery. The CBT protocol standard was to represent CBT interventions (e. g., homework assigned). Model identified specific content (e.g., relaxation, exposure), and delivery referred to how the model item was delivered (e.g., rehearsal, coached). A therapist's skillfulness and responsiveness can be assessed using the CBAY-C for counselor competence. Routine monitoring ensures that the treatment protocol and conditions are a component of the treatment plan to provide for influencing factors (risk, change, relief, derailment), however in two sessions this would be difficult or limited in scope to attain. Monitoring for change is important to reflect client relief for those symptoms that have generated heightened stress as well as to bring awareness for improved client outcome in order to empower positive client expectations, motivation, and gain a sense of relief.

Treatment integrity refers to how closely treatment delivery matches the intended plan. Purity is to be considered for the counselor to avoid non-prescribed treatment (differentiation). Clients can go off track or deteriorate early in therapy for a variety of reasons, and counseling tools are applied and represent the counselor's competence to right the treatment or adjust. Lambert, Whipple, and Kleinstauber (2018) reported there were four factors that relate to change. Their findings suggest that 40% of recovery can be attributed to client variables and extra therapeutic factors, 30% of improvement can be the result of therapeutic relationship factors, and 15% for each of hope and expectancy factors, psychotherapy models and techniques/interventions.

Lambert supported these findings with the development of the Assessment for Signal Clients (ASC) that assesses three of the four above factors. Extra therapeutic factors include social support, life events, and relationship factors including alliance, hope, and expectancy that involve motivation. Client derailments can be observed concerning the therapeutic alliance, motivation, social support, stressful life events, and relationships factors including alliance, hope, and expectancy that involve motivation. Derailments can occur because of a counselor's emotional response that has an influence on the alliance. A counselor may experience anger feelings left unattended toward a client (examples-late to therapy, suddenly ends therapy, contacts you too often, or is not cooperative). Barriers surfacing with counselor boundary violations and boundary crossings involving intimate relationships, emotional and dependency needs, altruism, and unavoidable and unanticipated circumstances disrupt client progress (Audit, 2021). A primary ethical principle at stake for the client is autonomy (Jadaszewski, 2017). Wiersma et al. (2021) reported that clients with persistent depressive disorder often derail normal social-emotional maturational development and are entrapped in the therapy. A frequent observation of the entrapment may reveal the client grew up with a depressed mother. White et al. (2015) added other possible barriers or obstacles for client deterioration to include client severity for different cognitive, affective, and behavior deficits such as emotion regulation, anxieties, depressed states, rumination, and personality features. These deviations can differ for the various disorders and include attachment styles, personality features, defense mechanisms, avoidance features, affective, resistance, compliance, secretiveness, and stigma styles that often become risk factors for derailment.

The importance of treatment integrity and adherence is to ensure treatment purity. Treatment purity is an index ratio of prescribed interventions for a treatment condition to the sum of all prescribed interventions (pro or presubscriptions). Treatment purity, along with treatment specificity, achieves a high level of treatment differentiation. The reason to be cognizant of integration of each of these terms related to treatment integrity is that there are four types of treatment interventions: unique and essential, essential but not unique, acceptable but not necessary, and proscribed interventions. Proscribed interventions involve an intervention in treatment A that is an unwanted B treatment (focus on defense mechanisms). The goal is to use more unique prescribed than proscribed essential/not unique treatments (Grikscheit et al., 2015).

If the design of this new format is for treatment integrity and adherence, it is admirable. However, the training that an entry-level counselor receives may not fully align with this new format. It is, however, very important that the counselor is equipped to understand the overall impact of this treatment planning. Routine monitoring (ROM) tracts and follows the execution of the planned treatment adherence and integrity. This addition guarantees a planned approach for counselor and client feedback and promotes spontaneous responses to deviations and/or improvements in clinical care.

This being said, it is my opinion that the examinee might want to consider this overview as a modified attempt to meet aspects of treatment adherence for the new format.

Unit 2 in the supplement provides shortened and abbreviated information regarding instruments, monitoring, family treatment guidelines, efficacious evaluation standards, treatments, techniques and strategies, testing strategies, instrumentation, differential diagnosis, disorders, comorbidity, and treatment planning. Unit 2 will also provide brief information about 13 of 17 disorder categories, 31 disorders, and 3 other conditions that may be a focus of clinical attention involving 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 39 treatment definitions, discharging recommendations, counselor duties, supervision, and study suggestions.

It is exceedingly difficult to plan and provide treatment adherence over a reduced number of sessions. It appears from one NBCC example, the breadth and depth of client information might be narrowed or limited to shared intake assessment information that will require the examinee to recall knowledge of acquired counselor interactional skills for a countless number of observations from counselor training based on deviations and progress throughout a treatment contract.

For the examinee to demonstrate this knowledge and to adequately respond to those interactions over a longer set of sessions (online example), the amount of counselor and client dynamics is limited for any set of brief interactions. Treatment integrity, specificity, differentiability of treatment, and purity of clinical care will likely be abbreviated or non-existent.

Practicing for this type of formatted examination will differ in several ways. First, there is only one correct answer for NBCC's answer on the examination. Two, the course of the therapy may deviate based on the provided partial information for session one or two indicating changes have

taken place, or not (deviations). Deviations will require the treatment plan to be reviewed and changed according to influencing factors for compliance, alliance issues, internal or external symptoms, and documented disorder accounts of client behaviors (resistance, stigma, etc.). The case studies may include research-based observations; examinees may need to infer information based on their own clinical or learned knowledge in order to answer.

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