DR. ARTHUR'S STUDY OVERVIEW

for the

NCMHCE

NATIONAL CLINICAL MENTAL HEALTH COUNSELING EXAMINATION

New Case Study
Examination Formats

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Dr. Arthur's Study Overview for the NCMHCE

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Published by: Career Training Concepts, Inc.

Contact Toll-Free: 888-326-9229

Version 1.3

ISBN 978-1-877846-65-6

UNIT 1: INTRODUCTION TO THE NEW FORMATTED NCMHCE

The National Board for Certified Counselors in developing the National Clinical Mental Health Examination (NCMHCE) created 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, with 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 item), 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 (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.

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 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 how best to develop 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 verbally 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.

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 trust with the client?
    A. communication is often delivered with hesitation suggesting ambivalence
    B. client tends to go inward when he senses threat
    C. lack of understanding why he was referred for counseling
    D. hesitations in approaching adults and a history of abuse

Answer: d. hesitation in approaching adults and a history of abuse

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

2. The intake symptom 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: 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).

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 a. physical and mental abuse

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: a. The client does not involve himself with classmates (peers).

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

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

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

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. resists going to school

   C. prefers to take a written examination rather than an oral examination

   D. has an inward attentional shift

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.

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. irritation.

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).

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: 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."

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: a. functional analysis and imagery

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: a. psychoeducation

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: 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.

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 new format that each question will be headed with a domain and sub-domain that will be the focus of that question. The following 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.

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 each with yield a total of 130-150 questions. Ten of 11 case studies will count for 100 counting questions. The remaining questions are trial questions for future use. NBCC has not published a score report, but all indications appear that the examiner's report will be a listing of a raw number correct of the spread points published online. 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. Currently, the pass score is unknown.

Domain	**Your**	**Max Score**	**(Percent)**	**Percent Range**
Professional Practice and Ethics	11	16	16%	(10-20)%
Intake, Assessment, Diagnosis	19	25	25%	(29-30)%
Treatment Planning	13	16	16%	(10-20)%
Counseling Skills/Interventions	21	27	27%	(25-35)%
Counselor Attributes	14	16	16%	(10-20)%
Total	78 or 78%	100	PASS	Yes ____ No ____

The number of questions per domain fall within the spread percentages that NBCC has published in developing each case study. 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.

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

Communication interchanges between the counselor and client concerning:

1. Compliance issues: medication, homework, therapy attendance, personality dynamics Simpson, et al. (2011) reported on the importance of treatment adherence for considerations for treatment outcome. Homework compliance may be one observation for

early adherence. Non-compliance is a signal that the counselor may need to revisit the commitment to adhere to the treatment program.

2. Alliance ruptures: breakdown in communication, defense mechanisms, environmental influences, cultural differences, trust, lack of communication skills, intellectual deficits
3. 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 understands informed consent procedures. Consider disorders where this may be problematic (brief psychotic disorder, schizophrenia, memory issues, and psychoses.
4. 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, for a client with an eating disorder might use denial and minimization (Berg, Peterson, & Frazier, 2012).
5. 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 clients do not respond well to therapy, they refuse treatment (McGonigal & Dixon-Gordon, 2020; Caple & Schub, 2018; Messina, Wish, Hoffman, & Nemes, 2002).
6. 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, et al., 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 there are three emotional reactions to people with a mental disorder: pity, anger, and fear.
7. Interview styles: Interview style depends on function/purpose and includes 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

center on 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 want to change).
Solution-focused style emphasizes asking questions related to the client's counseling goals and following the miracle question to assess for the 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 wish 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, use 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.

8. Attribution training or retraining: Attribution training is a cognitive process used to change beliefs about causes of one's own failures and successes 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.
9. 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.

Counselor-client behaviors and symptoms:

1. Anhedonia: 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).
2. Relapse (disorders): Alcohol use disorder, bipolar I and II, obsessive-compulsive disorder, and major depression 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 protocol calls for safeguards that may include discontinuation of medication and prevent post-treatment failures to maintain healthy choices.
3. 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).

4. Residual symptoms: Residual symptoms follow directly from a psychotic episode (DSM-5-TR, Category A) and are collected prospectively (hallucinations/delusions).
5. Working memory: refers to reasoning and decision-making and includes 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, Piras, Vecchio, Banaj, Coull, & Spalletta, 2018).
6. 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.
7. 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 consist of five categories: cognitive and appraisal skills, defenses and coping mechanisms, temperamental and dispositional factors, interpersonal skills and supports, and external factors.
8. Monitoring for six 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.

9. 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, Video, Hoth, & Mold, 2010; Toenders, et al., 2020).
10. Blunted affect: refers to emotional indifference, a reduction emotional sensitivity, and a diminution in emotional responsiveness. 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, et al., 2005). Blunting refers to when individuals (clients) seek out distractions when confronted by a threatening situation (Mezo, et al., 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 the 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, 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.

    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). Six cognitive dimensions define the appraisals underlying emotions: pleasantness, anticipated effort, certainty, attention activity self-other responsibility/ control, and situational control agency (Smith& Ellswowrth, 1985)

11. 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, et al., 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.

12. 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).
    Women ruminate and men tend to use avoidance. Rumination is considered a risk-factor for several disorders. Two forms of rumination for children are sadness and aggression (Harmon, et al., 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).

13. 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.

14. 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. Alexithymia is a common symptom in somatoform disorder, panic disorder, obsessive-compulsive disorder, social phobia, and depression (Tapanci, Yildirim, & Boysan, 2018).

15. Bidirectional symptoms: refers to a relationship of symptoms. For example, generalized anxiety disorder (GAD) may involve sleep disturbance that exacerbates emotions, and the emotions, affect sleep.

16. Attentional scope: is the primary source of individual differences that determines the susceptibility to ruminate in response to negative affect. Those clients with narrow scope 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 (Fang, et al., 2018).
17. 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.
18. Emotional dysregulation: refers to "change or regulating emotional cues, experiences, actions, verbal, and behavioral response, and 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, et al., 2015, p. 25).
19. 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).
20. Soft and hard neurological signs: 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).
21. Perseverative cognition: refers to continuous (repetitive) thinking about negative events in the past or future. Worry and rumination are habitually dysfunctional coping strategies for major depression and social anxiety disorder (Bailey, et al., 2019).
22. 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). 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.

23. 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.
24. Mirroring: refers to a therapist's technique in mirroring what the client is projecting. Personality clients experience cognitive failure to see how they come across to others. The counselor can mirror that through listening and illustrations as it is displayed upon the therapist (Zanor, 2010).
    A second example of mirroring is parental behaviors for learned behaviors such as empathy development in children. The child learns and models the appropriateness in empathy delivery by the parent during interactions with others. Conduct disorder is an example where the client has been assessed with a deficit in empathy and develops a callous-unemotional response to those situations. Attribution training or retraining is an intervention.
25. Delay discounting: refers to a smaller preference for a reward versus larger delayed rewards. Treatment for ADHD is to promote, more often than controls, 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 are often the outcomes.
26. 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.
27. 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).

Programs, instruments, profiles for client application:

1. 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.

2. 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.

3. 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).

4. 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).
   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.

5. At-risk mental states: Disorders such as schizophrenia, psychosis, dementia and Alzheimer disease require assessment for the capacity to understand informed consent procedures.

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

7. 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 exist 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, Russell, Sadikaj, & Sutton, 2009).

8. 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, et al., 2021). It is further recommended the counselor assess three emotion regulation strategies (tolerating, adjusting, and concealing emotions).

9. DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure (DSM-5-TR, APA 2022, pp. 847-853): 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.

10. 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).
11. Severity levels (mild, moderate, severe, profound): 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.
12. 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.
13. Alliance ruptures: refers to interactions that break down between the counselor and client. There can be many 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, 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 and achieve some degree of emotional safety (Duffey & Trepal, 2016).
14. Attachment styles (relational view for influence in client disorders—ODD, CD): 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.

15. Symptoms: effects that are assessed for levels and for internal and external expressions (persistent depressive disorder, major depressive disorder, autism spectrum) and internal (depressive, anxiety, decreased self-esteem, self-image)
16. Adaptive behavior: definition (neurocognitive disorders) and definition/meanings for conceptual, social, and practical domains (intellectual development)
17. State and trait meanings: 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.
18. 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).
19. 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).
20. Dark triad (unhealthy lifestyle): This concept focuses on 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), Machiavellianism (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.
21. Strength: 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.
22. 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.
23. 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).

24. 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).
25. Metacognitions: refers to knowledge and beliefs about thinking and strategies used to regulate and control 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).
26. Response 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). 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).
27. 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).
28. Therapeutic process and alliance: 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).

Ethics: Ethical constructs are imparted throughout a treatment contract. Below are some key ethics-related concepts.

1. Stigma 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, et al. (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).

UNIT III: DSM-5-TR Core Features

Some of the treatment issues such as core features and client deficits will be addressed and some of this material will reappear in the Unit IV. Core features are considered to be those symptoms that have a high priority to appear in the majority of clients who are assessed with a particular disorder.

Neurodevelopmental Disorders

Attention-Deficit/Hyperactivity Disorder

Core features are social and academic impairment, behavioral disinhibition, impulsive errors, performance, social impact, drift, and genetic predispositions (Neece, Baker, & Lee, 2013).

Client deficits in need of treatment:

1. Behavioral benchmarking
2. Response inhibition: inability to suspend a response during an active moment-to-moment behavior
3. Set shifting or task shifting: redirecting one's focus away from one fixation point toward another fixation point.
4. Working memory: to encode, tore (separate into pieces), manipulate, and retrieve information in the face of interference.

Schizophrenia Spectrum

Schizophrenia

Moe and Docherty (2013) reported core features include sense of self (SOS)-disturbance of self, decoupling emotion-behavior avolition, and anhedonia. Core feature is a timing disturbance of the self-disturbance in the sense of self (SOS), anhedonia and avolition of negative symptoms. Two distortions of consciousness define consequences of abnormalities. They are hyperreflexivity and diminished self-affection (Moe & Docherty, 2013).

Deficits involve attention, learning and memory, information processing, and eye-tracking performance.

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

Emotion-behavior decoupling may be used (Lui, et al., 2016)

Brief Psychotic Disorder

Core features are hallucinations, delusions, and consciousness clouding (Cak, Kultur, & Pehlivanturk, 2007).

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), and updating (ability to incorporate relevant information and remove non-relevant information). If executive functioning is impaired, the result is rigidity (Ibanez-Casas, et al., 2013).

Bipolar Disorders

Bipolar disorders are marked by major fluctuations in an affect and activity and in perception and cognition.

Bipolar I Disorder

Core features are manic episode, cognitive inflexibility, working memory deficit, instability of interpersonal relationships, self-image, affect, and impulsivity.

Bipolar II Disorder

Core features include alexithymia, mood and hypomanic, and somatic complaints. An associated feature is impulsivity (Boen, et al., 2020).

Depressive Disorders

Major Depression (episode)

Core features include cognitive impairment, depressed mood, anhedonia, difficulty sleeping, weight and appetite changes, reduced energy, and subjective memory and concentration problems. Vegetative symptoms (VS) include fatigue, appetite and weight, cardiac arrhythmias, dyspnea, change in body temperature, altered sexual functions, and disordered salivation (Keyframer, et al., 2006).

Persistent Depressive Disorder

Core features are childhood trauma and maltreatment (Gunn, et al., 2021; Serbanescu, et al., 2020), interpersonal deficits, rejection sensitivity, loneliness and isolation, and deficient social support (Struck, et al., 2021; Wiersma, 2021).Anxiety DisordersGeneralized Anxiety Disorder (GAD): Core features are fear and chronic worry (Roemer & Orsillo, 2002; Stein, 2021), and three of 6 symptoms. Sleep is prominent and GAD symptoms are internalized (Tsypes, Adlao, & Mennin,

2013) . Intolerance of uncertainty is a risk factor in the development and maintenance for GAD (Ren, et al., 2021; Saulnier et al., 2021). Stigma does affect help seeking (Lakhdir, et al., 2021). History of childhood maltreatment/trauma may be present (Shafiei, Rezaei, & Sadeghi, 2021).

Anxiety Disorders

Generalized Anxiety Disorder (GAD)

Core features are fear and chronic worry (Roemer & Orsillo, 2002; Stein, 2021), and three of 6 symptoms. Sleep is prominent and GAD symptoms are internalized (Types, Aldao, & Mennin, 2013). Intolerance of uncertainty is a risk factor in the development and maintenance for GAD (Ren, et al., 2021; Saulnier et al., 2021). Stigma does affect help seeking (Lakhdir, et al.., 2021). History of childhood maltreatment/trauma may be present (Shafiei, Rezaei, & Sadeghi, 2021).

Panic Disorder

Core features are insecure attachment which leads to poor treatment outcome and conflict with autonomy and dependence (Lange, et al., 2021).

Social Anxiety Disorder

Core features are fear, worry, avoidance, attentional bias, social threat, scrutiny, and perseverative cognition. Client seeks out distractions when confronted with a threat (blunting, Mezo, et al., 2005).

Separation Anxiety Disorder

Core features include fear and worry related to separation, internalization of symptoms, physical symptoms, school refusal, loss of or harm to significant figure, and distressed when alone (Cooper-Vince, et al., 2014)

Obsessive-Compulsive Disorders

Obsessive-compulsive disorder

Core features include obsessions and compulsions, involving recurrent thoughts and behaviors that have to be carried out to control stress and anxiety. Doubt is created suggesting impaired memory. Alexithymia is a constellation of cognitive and affective characteristics observed in OCD. Response inhibition and use of stop-signal task are other features (Mar, et al., 2022).

Trauma-and Stressor Disorders

Posttraumatic Disorder (PTSD)

Core features are hallucinations and delusions, alternating episodes of avoidance and intrusions, memories, emotion regulation, and alexithymia (Oglodek, 2022).

Acute stress disorder

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

Adjustment Disorder: Core symptoms are preoccupation with the stressor (worry and distressing thoughts) and failure to adapt to the stressor/symptoms.

Somatic Symptom Disorders

Somatic Symptom Disorder

Core features include explained and unexplained symptoms, alexithymia, and impairment in affect perception and expression (Erkic, et al., 2017). Client behaviors include suppression of negative feelings, inability to identify and regulate emotions: cognitive impairment-regulation affective arousal. Trust is an issue for therapy. CBT restructuring is used to mediate/treat (modify automatic thoughts and distortions of perceived physical sensations and reattribute sensations to ordinary events rather than pathological causes (Looper & Kiemayer, 2002).

Feeding and Eating Disorders

Anorexia Nervosa Disorder:

Core feature is body image disturbance, and body image dissatisfaction (Grilo, Crosby, & Machado, 2019).

Bulimia Nervosa Disorder

Core feature is binging and purging. Development occurs in adolescent years. Other features include dietary restraint, body dissatisfaction, body image, and body disturbance. Integrative cognitive affective therapy for BN is recommended for treatment (Accurso, et al., 2016), and ecological measurement assessment (EMA) is recommended for assessment (Ebner-Priemer & Trull, 2009). Ethnic group culture is a consideration regarding values for food. Control deficits (Shapiro, et al., 2007), suicide ideation (red flag), and relapse prevention are major concerns (Leraas, et al., 2018).

Binge-Eating Disorder

Core feature is binging. Cognitive behavior therapy (the gold standard treatment) and acceptance and commitment therapy can improve symptoms (Juarascio, Forman, & Herbert, 2010); childhood maltreatment is linked to self-blame (Szabo & Nelson, 2019), body dissatisfaction, emotion dysregulation, rumination negative emotions, and suicide ideation (red flag) are concerning issues.

Disruptive, Impulse-Control and Conduct Disorders

Oppositional Defiant Disorder

Core features include anger and irritable mood component of emotion dysregulation syndrome (Doerfler, Volungis, & Connor, 2020). Attention scope is narrow and focus on information in the center (Fang, Sanchez-Lopez, & Koster, 2018). There is a failure to manage inhibitory control.

Intermittent Explosive Disorder

Core features are failure to resist affective aggression, impulsivity, emotional lability, and negative affect.

Conduct Disorder

Core features are lack of guilt, lack of empathy, and shallow effect (Hawes, Price, & Dudds, 2014). Also, very common are aggression, destruction, and deceitfulness (APA, 2022, p. 531).

Substance-Related and Addictive Disorders

Substance Use Disorder

highly stigmatized

Alcohol Use Disorder

Core features: vegetative changes, anergia, hypersomnia, increased appetite, craving for carbohydrates, and weight gain (Enggasser & Young, 2007). Other features include rumination, cognitive vulnerability, inhibitory control, and circadian rhythmicity.

Neurocognitive Disorders

Major and Mild Neurocognitive Disorder

Personality Disorders

Avoidant Personality Disorder (APD)

Core features include sensitivity to others' internal states and their emotions, sensitive to rejection, internalized shame, need to belong, anxious attachment, avoidance of close relationships, and adaptive defense mechanisms.

Schizoid Personality Disorder (SPD)

Core feature is mentalization, anhedonia, attachment (avoidant), rejection (indifferent to social feedback), empathy (lack capacity for mentalization), and defense style (maladaptive styles) are symptomatic issues.

Borderline Personality Disorder (BPD)

Core features include negative affectivity, disinhibition, emotional vulnerability, and antagonism. Stormy attachments are often characteristic of a child who grows up in an invalidating environment (Calvo, et al., 2016). APD shared common symptoms with BPD such as anger expression and emotion dysregulation. (McGonigal & Dixon-Gordon, 2020).

Antisocial Personality Disorder (ASP)

Core features include deception and manipulation (Knack, et al., 2021), failure to conform to lawful and ethical behavior, hostility and low self-control, and egocentric callous concern for others (APA, 2022). APD is an externalizing disorder. APD share common symptoms with BPD such as anger expression and emotion regulation (McGonigal & Dixon-, 2020).

Narsissistic Personality Disorder (NPD)

Core features include self-absorption (overly positive self-views, self-importance, and entitlement (Dehaghi & Zeigler-Hill, 2021). A key issue is lack of trust and a person with NPD suffers from relational disruptions.

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. Schzoid personality disorder (Miller & Davis, 2020)

c. Obsessive-compulsive disorder (Wahl, et al., 2021; Tapanci, Yildirum, & Boysan, 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, 2019), body dissatisfaction, emotion dysregulation, rumination, negative emotions, and suicide ideation (red flag) are concerning issues

a. Binge-eating disorder (Szabo, Nelson, & Lantrip, 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 (Gunn, 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, 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, Umpfenbach, & Alpers, 2014)
4. Anorexia Nervosa disorder: CBT, DBT (Gowens, 2006; Lenz, et al., 2004)
5. Binge-eating disorder: ACT, CBT (Juarascio, Forman, & Herbert, 2010), DBT (Kenny, Carter, & Safer, 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, et al., 2012)
11. Disruptive Mood Dysregulation disorder: Exposure-based CBT (Linke, et al., 2020), Social skills training, affect regulation (Barker, et al., 2012; Benarous, et al., 2017)
12. General Anxiety disorder: CBT, Integrating Mindfulness, acceptance and commitment therapy (ACT; Roemer, Orsillo, & Salters-Pedneault, 2008)
13. Major Depressive disorder: CBT

UNIT IV: 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 (Ole, Karkov, Hilde, & Esben, 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.

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, et al., 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 (Andries, Brixen, Bilenberg, & Hordeder, 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 (Gunn, 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, & Kuykenm, 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, et al., 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, et al. (2019) reported the role of the cient-counselor alliance may be a mechanism for the rapid changes. Newmann, et al. (2006) reported three important change mechanisms: accurate therapist interpretations themes, therapeutic alliance, and cognitive changes. 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 (Baby, et al., 2021; Singh, Pascual-Leone, Morrison, & Greenberg, 2021; Andrews, Hayes, Abel, & Kuyken, 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), generalized anxiety (Newman, Schwob, & Rackoff, 2022; Visual, Constantino, & Clucked, 2021; Present, et al., 2007), social anxiety (Thorisdottir, Tryggvadottir,

Saevarrsson, & Bkprmsspn. 2018), panic disorder, posttraumatic stress (Aderka, Applelbaum-Namdar, Shafran, & Giboa-Schechtman, 2011), and somatoform disorders (Heider, Kock, Sehlbrede, & Schroder, 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, Kock, Shehlbrede, & Schroder, 2018). Clients who improve quickly (generalized anxiety disorder, DBT; Newman, Schwob, & Rackoff, 2022), with sudden change, may be attributed to behaviors associated with suicidality, treatment expectations, previous psychotherapy, and the presence of specific symptoms (Heider, et al., 2018).

Client and therapist contributions or factors may account for some early change. Erekson, et al. (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; Tomaz, et al., 2006; Tang, et al., Tang,, et al., 2005) and confounding variables for cognitive changes may have been life events, and sudden physiological-psychological changes before the pregain sessions. The related or associated counselor role involved accurate interpretation of the pregain sessions.ons of relationship themes, therapeutic alliance, and cognitive changes (Tomasz, et al., 2006). 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, et al., 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, et al., 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, et al., 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, et al. (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

Core features: social and academic impairment, behavioral disinhibition, impulsive errors, performance, social impact, genetic, 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

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

Treatment

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

Techniques

1. social skills training and self-regulation (Fabiano et al., 2009)
2. behavioral benchmarking
3. improving communication skills
4. recognition of non-verbal messages

5. time management
6. anger management
7. impulse control measures
8. interactive rehearsal
9. modeling
10. in vivo
11. replacing negative messages with positive self-talk
12. contingency management (Grover, Huges, Bergman, & Kingery, 2006)
13. Structured Behavior Therapy (SDBT) techniques are goal setting, benchmarking, and redirection for ages 7 to 12 (Fabiano, 2009).
14. emotional self-regulation (Jarrett, 2016; Fabiano (2009) reported that inattention followed by hyperactivity/ impulsivity anxieties reflected a deficit in self-regulation of emotion and self-organization/problem-solving.
15. behavior management (positive reinforcement, response cost, programmed learning (Premack's Principle)
16. contingency management
17. improving communication
18. recognition of non-verbal messages
19. parent management of organization, time management, and planning for ADHD deficits (Sibley et al., 2006)
20. interactive rehearsal and parent management therapy (PMT)
21. 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
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: Stigma (da Silve, et al., 2021), compliance (homework, follow through)

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) reported core features include a timing disturbance of the self-disturbance in the sense of self (SOS), anhedonia and avolition of negative symptoms. Two distortions of consciousness define consequences of abnormalities, hyperreflexivity and diminished self-affection.

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, 2011,1996). 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 (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
7. Schedule for Affective Disorders and Schizophrenia (SADS)

Treatment

1. Medication is first line treatment
2. Interpersonal Social Rhythm therapy
3. Behavioral Activation system (BAS) involves behavioral charting such as mood and sleep charting (duration, frequency)
4. Family education, and maintenance
5. Family-focused psychoeducational (FFT; Miklowitz, 2008)
6. Interpersonal social rhythm therapy (Frank, 2007; Frank, 2005)
7. CBT depending on severity (Scott et al., 2006)
8. Supportive therapy if delusions are prominent
9. Compassion-Focused Therapy has an effect on self-reassurance and happiness (Ascone, Sundag, Schlier, & Lincoln, 2017; Gilbert, 2009)
10. Group and family therapy
11. Antipsychotic medication,

12. Cognitive Behavior therapy and social skills, family therapy (Wallace, Liberman, Tauber, & Wallace, 2000)

Techniques

1. psychosocial intervention
2. behavior therapy
3. social skills training
4. social support
5. group therapy
6. sleep dysregulation
7. sleep chart
8. psychoeducation
9. 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

2. Suicide (Lopez & Mamani, 2020)

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's 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 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. Erotomaniac 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 to 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'll 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, Piras, Vecchio, Banaj, Coull, & Spalletta, 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).

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, et al., 2014; Lim, et al., 2018; Denenny, et al., 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)

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, Sundag, Schlier, & Lincoln, 2017; Gilbert, 2009, a pilot study)

Techniques/Interventions

1. Medication, if delusions are prominent
2. Psychoeducation
3. Social skills training and maybe CBT
4. Imagery

Treatment Goals

1. Social skills deficit
2. Impoverished social network

Bipolar I Disorder (APA, 2022, pp. 139-142)

Criteria

Necessary to meet manic episode followed by hypomanic OR major depressive episodes.

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, working memory deficit, instability of interpersonal relationships, self-image, affect and impulsivity.

Differential Diagnosis: Major Depressive Disorder

Communication Issues: Suicide ideation

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): 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.
3. 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.
4. 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

1. Pharmacotherapy is the treatment of choice (Frank, 2009; Scott, et al., 2006; Sylvia, Peters, Deckersbach, & Nierenberg, 2013)
2. Cognitive Behavioral Therapy (CBT)
3. Interpersonal and Social Rhythm Theory (IPSRT) with medication (Frank, 2007)

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

1. restructuring
2. psychosocial intervention
3. relapse prevention
4. communication training

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

Criteria

The child grows with an invalidating environment where communication are not accepted as an accurate indication of his/her true feelings. 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: include alexithymia, mood and hypomanic, somatic complaints, and associated feature is impulsivity (Boen, et al., 2020).

Differential diagnosis: Depressive and bipolar disorders

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 Verheuol, 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)
2. Emotional Regulation Group Therapy (ERGT)

3. Interpersonal Psychotherapy (IPT)
4. Cognitive Analytic Therapy (CAT)

Techniques/Interventions

1. Mindfulness (Feliu-Soler et al., 2014), what and how communication skills
2. Attention regulation
3. Body awareness

Target Goals: irritability

Counseling Issues: Compliance (counseling & medication)

DEPRESSIVE DISORDERS

Disruptive Mood Dysregulation, 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) 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

Core features include irritability, angry mood, and cognitive control.

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. Cognitive Behavior Therapy and parent training
3. DBT to target mood dysregulation
4. Interpersonal Psychotherapy (IPT) to target depressive symptoms in an interpersonal context
5. Parent Management training

Techniques

1. psychoeducation
2. therapeutic alliance
3. social skills training
4. reward-based learning program
5. affect regulation and parent training

Target Goals

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

Communication Issues: stigma

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

Differential Diagnosis: Major Depressive Disorder

Instruments

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

Treatment

1. Interpersonal Psychological Therapy (IPT; Kriston, et al., 2014)
2. Cognitive Behavioral Analysis System of Psychotherapy (CBASP; Gunn, et al., 2021; Wiersma, et al., 2021), first choice therapy (Serbanescu, et al., 2020)
3. Metacognitive Therapy (Winter, et al., 2019)
4. Supportive Therapy (Serbanescu, et al., 2020)

Target Goals

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

Communication Issues

1. treatment resistance
2. childhood maltreatment
3. emotional safety

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. social withdrawal
2. sad, down, mood, decreased energy
3. hopelessness

Differential Diagnosis: Manic episodes with irritable or mixed episodes

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. Wakefied Self-Report Questionnaire

Treatment

1. Cognitive Behavior Therapy (DeRubeis, & Crites-Christoph, 1998; Martell, Dimidjian, & Herman-Dunn, 2010; Sturney, 2009; Weissman et al., 2000)
2. Behavioral Activation Therapy (BAT)

3. Behavior Therapy (Blieberg & Morowitz, 2008; DeRubeis & Crites-Christoph, 1998; Resick, Monson, & Rizvi, 2008; Sinha & Rush, 2006; Swartz. 2015)
4. Interpersonal Psychological Therapy (IPT)
5. Psychodynamic Interpersonal Psychotherapy (IPT; NCIE, 2004)
6. Emotion regulation
7. Family-based parent psychoeducation (Ale, Arnold, Whiteside, & Storch, 2014)
8. Emotion-Focused Therapy (Robinson, McCague, & Whissell, 2012) is an evidence-based treatment (depression and trauma).

Techniques

1. bibliotherapy
2. relaxation
3. Mindful-based Stress Reduction (MBSR; Williams, Teasdale, Segal, & Kabat-Zinn, 2007)
4. emotion regulation (Radkovsky, McArdle, Bockling, & Berking, 2014)
5. exercise

Target Goals: depressive episodes

Communication Issues

1. relapse prevention
2. denial
3. 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, fear, worry, loss of or harm to significant figure, alone (Cornacchio, et al., 2015; Cooper-Vince, et al., 2014).

Differential Diagnosis: Generalized Anxiety Disorder

Instruments

1. Separation Anxiety Scale for Children (SASC)-ages 8-11, measures worry about separation, distress for separation, and calm at separation
2. Separation Anxiety Avoidance Inventory (SAAI)
3. Separation Anxiety Assessment Scale (SAAS)

Treatment

1. Cognitive Behavior Therapy (APA Div 12 SCP, 2013)
2. Cognitive Behavior Therapy with exposure (Shikatani, Anthony, Kuo, & Cassin, 2014)
3. Acceptance-based Group Therapy (mindfulness)
4. Emotion-Focused Therapy (Shahar, Bar-Kalifa, & Alon, 2017; Shahar, 2014)
   Interpersonal Psychotherapy (IPT)
5. Coping Cat

Treatment (Children)

1. Cognitive behavioral therapy is the treatment of choice

2. Individual cognitive behavior therapy (ICBT)
3. Group Cognitive Behavior Therapy (GCBT), GCBT with parents, GCBT for social phobia (SOP)
4. SET-C for SOP probably efficacious using criteria for efficacious designs and protocols for Types I-V (Silverman, Pina, & Viswesvaran, 2008)
5. Coping Cat, (Kendall,2000; Southam-Gerow et al., 2021)
6. 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, Huges, Bergman, & Kingery, 2006)
   modeling
2. breathing techniques
3. relaxation
4. cognitive restructuring
5. contingency management
6. extinction methods such as active ignoring
7. social skills training (Grover, Hughes, Bergman, & Kingery, 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: resistance to separation

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:

Core features include fear, worry, avoidance, attentional bias, social threat, scrutiny, and perseverative cognition. Clients will use blunting and seek out distractions when confronted with a threat (Mezo, et al., 2005).

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. Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovex, 1990)
2. Penn State Worry Questionnaire—Adults (PSWQ-A; Hopko et al., 2003), a screener
3. Beck Anxiety Inventory (BAI; Beck & Steer, 1990a, b)
4. Social Phobia and Anxiety Inventory (SPAI; Turner, Stanley, Beidel, & Bond, 1989)
5. Social Phobia and Anxiety Inventory (SPAI-18; de Vente, Majdandzic, Voncken, Beidel, & Bogels, 2014)

6. Diagnostic Interview Schedule for Children (Costello, Edelbrock, Kalas, Dulcan, & Klaric, 1984)
7. Schedule for Affective Disorders and Schizophrenia for Children (Puig-Antich & Chambers, 1978)
8. The Anxiety Disorders Interview Schedule for Children (Albano & Silverman, 1996)
9. Social Anxiety Scale for Children-Revised (LaGreca & Stone, 1993)
10. Social Phobia and Anxiety Inventory for Children (SPAI; Beidel, Turner, & Cooley, 1993; Beidel, Turner, & Morris, 1995, 1999; Carleton et al., 2009)
11. Social Phobic Scale and Social Interaction Scale (SIAS; Mattick & Clarke, 1989, 1998)
12. The Social Avoidance and Distress (SAD) and Fear of Negative Evaluation (FNE; Watson & Friend, 1969)
13. The Interaction Anxiousness Scale (IAS; Leary, 1983)
14. Brief Social Phobia Scale (BSPS; Davidson, et al., 1991)
15. Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987)

Treatment

1. Cognitive Behavior Therapy (DeRubeis, & Crites-Christoph, 1998; Martell, Dimidjian & Herman-Dunn, 2010; Sturney, 2009; Weissman et al., 2000)
2. Behavioral Activation Therapy (BAT)
3. Behavior Therapy (Blieberg & Morowitz, 2008; DeRubeis & Crites-Christoph, 1998; Resick, Monson, & Rizvi, 2008; Sinha & Rush, 2006; Swartz, 2015)
4. Interpersonal Psychological Therapy (IPT; NCIE, 2004)
5. Family-based-parent psychoeducation (Ale, Arnold, Whiteside, & Storch, 2014)
6. Emotion-focused therapy (Robinson, McCague, & Whissell, 2014), evidence-based treatment (depression & trauma)

Techniques

1. bibliotherapy
2. relaxation
3. reframing
4. coping strategies
5. Mindful-Based Stress Reduction (MBSR; Williams, Teasdale, Segal, & Kabat-Zinn, 2007)

6. emotion regulation (Radkovsky, McArdle, Bockling, & Berking, 2014)
7. exercise

Target Goals

1. prosocial skills
2. fear, worry, anxiety reduction (social situations)
3. perseverate cognition (PC; Bailey, et a., 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 (Shikatani, Anthony, Kuo, & Cassin, 2014)
6. blunting
7. monitoring

Communication Issues: blunting

Panic Disorder (APA, 2022, PP. 236-237)

Criteria

Recurrent unexpected panic attacks, abrupt surge of intense fear or intense discomfort that peaks in minutes and 4 of 11 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, et al., 2021).

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
4. Interoceptive Exposure (IE)
5. Situational Exposure and Systematic Exposure
6. Acceptance and Commitment therapy (ACT)
7. Sensation-Focused Intensive Treatment (SFIT)

Techniques

1. in vivo (removal of safety features; Deacon, Lickel, Farrell, Kemp, & Hipol, 2013; Levit, Hoffman, Grisham, & Barlow, 2001)
2. psychoeducation (correct common myths, cognitive misappraisals, and overt avoidance behaviors)
3. cognitive restructuring (types of errors)
4. applied relaxation training
5. interoceptive exposure (induce feared physical sensations and correct misappraisal about sensations)

6. psychoeducation for physical sensation symptoms including shortness of breath, heart palpitations, sweating, and dizziness that are most distressing
7. breathing retraining (targets hyperventilation)
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

Agoraphobia Disorder (APA, 2022, P. 246)

Criteria

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

Core Symptoms

1. fear or worry
2. cognitive thoughts of something terrible to happen
3. demoralization

Differential Diagnosis: Specific phobia, situational type

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 features are fear and chronic worry (Roemer, Orsillo, & Salters-Pedneault, 2008; Stein, 2021).

Three crucial components contributing to worry are intolerance of uncertainty (IU), cognitive control, and attentional control (Sauilnier, 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

Instruments

1. Hamilton Anxiety Inventory (adults, adolescents, and children)
2. Mood and Anxiety Symptom Questionnaire (MASQ; Watson & Clark, 1991)
3. Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006)
4. Positive and Negative Affect Schedule (PANAS; Watson, et al., 1988)
5. Watson and Clark (1991) defined PANAS as the most widely used measure of affect, has two scales each with 10 adjectives (positive and negative). POSITIVE affect include: distressed (upset), hostile, irritable (angry), scared, guilt, afraid (fearful), ashamed, jittery, and nervous. The 10 NEGATIVE 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 et al., 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; DeRubeis & Crites-Christoph, 1998; Roemer, Orsillo, & Salters-Pedneault, 2008)
2. Acceptance and Commitment Therapy (ACT; Roemer, Orsillo, & Salters-Pedneault, 2008)
3. Mindfulness-Based Stress Reduction (Hoge et al., 2017)
4. Acceptance-Based Behavior Therapy (ABBT; Roemer, Orsillo, & Salters-Pedneault, 2008). ABBT targets experiential avoidance and worry as a means to escape or avoid internal thoughts, emotions, and physiological sensations.

Techniques

1. cognitive restructuring

2. recommended for children relaxation techniques (Grover, Hughes, Berman, & Kingery, 2006)
3. imaginal techniques
4. problem solving skills
5. habituation
6. mindfulness (Roemer & Orsilla, 2002)
7. progressive muscle relaxation
8. diaphragmatic breathing
9. psychoeducation
10. daily diaries
11. relapse prevention
12. regulate personal feelings
13. interoceptive exposure to bodily sensations (Velting, Setzer, & Albano, 2004)

Target Goals

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

Communication Issues

1. stigma (Calear, Batterham, Torok, & McCallum, 2021)
2. treatment resistant

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

Core symptoms include obsessions and compulsions, involving recurrent thoughts and behaviors that have to be carried out in order to control stress and anxiety. Doubt is created suggesting impaired memory. Alexithymia is a constellation of cognitive and affective characteristics observed in OCD.

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, 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

1. Cognitive Behavior Therapy (Schwartz et al., 2017)
2. Cognitive Behavior Therapy (CBT) and Exposure and Relapse Prevention (ERP; Whittal, Thordarson, & McLean, 2005)
3. Prolonged Exposure and Response Prevention Therapy is the treatment of choice. 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-Rush, 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).

4. Medication is recommended although it may take 6 to 10 weeks before changes appear (Franklin & Foa, 2008).
5. Metacognitive Therapy (van der Heiden, et al., 2016)
6. Conelea and Freeman (2015) reported four CBT models (habituation, inhibitory learning, cognitive, and acceptance and commitment therapy (ACT; Wiggs & Drake, 2016).
7. 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).
8. Exposure and Relapse Prevention (Foa et al., 2005; Simpson et al., 2011)
9. Acceptance and commitment therapy (ACT; Twohig, Hayes, & Masuda, 2006; Twohig et al., 2010)
10. Acceptance-based behavioral therapy (ABBT)
11. Stop-signal is the intervention for response inhibition (Mar, et al., 2022; Johnson, Kristensen, & Arendt, 2015).

Techniques/Interventions

1. behavioral activation and pharmacotherapy (Arco, 2015)
2. diaphragmatic breathing (APA, 2008; Van Oppen et al., 1995)
3. in vivo
4. relaxation training
5. muscle relaxation
6. cognitive restructuring (Ludvig & Boschen, 2015)
7. mindfulness (Ludvig & Boschen, 2015; Twohig et al., 2015)
8. reframing
9. Stop-Signal task-a measure of cancelation (Mar, et al., 2022)

10. cognitive restructuring and mindfulness techniques are useful for checking tasks (Ludvig & Boschen, 2015).
11. 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).
12. Exposure and Response Prevention (ERP) uses a feared hierarchy supported by a well-established efficacious finding (Chambless & Holland, 1998).
13. cognitive restructuring
14. psychoeducation
15. stress management (breathing retraining, progressive muscle relaxation, and structured problem-solving)
16. stress inoculation training (SIT)
17. relapse prevention
18. 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. working memory deficit (Angelakis & Gooding, 2021)
2. intolerance of uncertainty (IU)
3. response inhibition (Mar, et al., 2022)
4. lack of cognitive control
5. psychological flexibility
6. doubt
7. rumination
8. perception of negative social experiences
9. relapse prevention
10. quality of life
11. avoidance

Communication Issues

1. suicide ideation (Angelakis & Gooding, 2021)
2. stigma (Trompeter, et al., 2022; McCarty, et al., 20167)
3. childhood maltreatment
4. engaging in risk behaviors

Trauma-and Stressor-Related Disorders

Posttraumatic Stress (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, and alexithymia (Oglodek, 2022).

Differential Diagnosis: Adjustment Disorder

Instruments

1. Boal et al. (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 (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 et al., 1993)
5. M-PTSD Mississippi Scale for Combat-Related PTSD (Keane, et al., 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)

1. Prolonged Exposure Therapy (PET) is the gold standard treatment for PTSD (Bryant et al., 2008; Foa et al., 2005; Schnurr et al., 2007; Shaley, 2009; Foa, Keane, Friedman, & Cohen, 2009; Cooper, Zoellner, Roy-Byrne, Mavissakalian, & Feeny, 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, & Western, 2005; Lee, 2008; Makinson & Young, 2012; McLean & Foa, 2013)
4. Mindfulness-Based Cognitive Therapy (MBCT)
5. Cognitive Processing Therapy

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, Monson, & Rizvi, 2008)
4. stress inoculation (Gentry, Baranowsky, & Rhoton, 2017)
5. flooding
6. anxiety management
7. deep muscle relaxation
8. controlled breathing
9. cognitive restructuring
10. emotional self-regulation
11. imaginal exposure
12. stress inoculation training (SIT) has been effective treating rape victims for fears, anxiety, tensions, and depression (Falsetti & Resnick, 2001)

Target Goals

1. fear based re-experiencing emotional and behavioral symptoms
2. anhedonia
3. negative cognitions
4. arousal and reactive externalizing symptoms

Communication Issues: suicidal thoughts, attempts, and death (APA, 2022, p. 311)

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. memory
2. emotion regulation
3. alexithymia

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, 2011). 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. EMDR (Eye Movement Desensitization Reprocessing (EMDR) effectiveness studies are few in the therapy literature for acute stress disorder (Buyden, 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 et al., 2010)

8. bilateral stimulation (Amaco & Toichi, 2016)

Psychological First Aid (Solman, 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
1. 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, Dannenmann, & 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, et al. (2018) indicated that intrusions, ruminations, avoidance, and adaptive failure are central to adjustment disorder.

Differential Diagnosis: Major Depressive Disorder

Instruments: Adjustment Disorder New Model (ADMN-8): Two parts; 1) 17-life-stressors, and 2) 8 items of symptoms

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

Techniques

1. relaxation
2. time management
3. mindfulness
4. strengthening relationships
5. problem solving

6. miracle question (solution-focused therapy; deShazer, 1991)
7. bibliotherapy (helpful for preoccupation and posttraumatic symptoms)
8. psychoeducation
9. support groups
10. behavioral activation
11. stress inoculation training (Carta, Balestrieri, Murru, & Hardoy, 2009; Dannahy, & Stopa, 2009)
12. Solution Focused Therapy interventions include: 1. sense of self, 2. coping, 3. activation, and 4. relaxation (Bachem & Maerckem, 2016)

Target Goals

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

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 ~~is measured by~~
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

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. Emotional features are negative affectivity, desperation, and demoralization.

Differential Diagnosis: Other medical conditions

Instruments

1. Somatization subscale of Symptom Checklist-90
2. Patient Health Questionnaire-15
3. Beck Anxiety Inventory (BAI)
4. Beck Depression Inventory (BDI)
5. Short Form Health Survey (SF-36)

Treatment

1. Cognitive Behavior Therapy (Cetin & Varma, 2021; Looper & Kirmayer, 2002)
2. Eye Movement Desentization and Reprocessing (EMDR; Demirci, et al., 2017)
3. Mindfulness therapies (Tibben, et al., 2019)

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
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

Core feature is body image disturbance, and body image dissatisfaction (Grilo, Crosby, & Machado, 2019).

1. energy intake restriction
2. intense fear of gaining weight
3. disturbance in self-perceived weight or shape

Differential Diagnosis: Medical conditions, Major depression disorder

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, Forman, & Herbert (2010), mindfulness/acceptance
2. Family therapy

3. Cash's Body Image therapy
4. Cognitive Behavior Therapy Guided Self-care for binge eating
5. DBT (Eisler, 2005; Lenz, Taylor, Fleming, & Serman, 2014; Wilson & Fairburn, 1993)
6. Maudsley model, ACT (Juarascio, Forman, & Herbert, 2010)
7. Maudsley family-based
8. Multidisciplinary approach
9. Cognitive-behavioral therapy
10. Dialectical behavior therapy (DBT), group therapy
11. Transdiagnostic approach
12. Interpersonal psychotherapy and family therapy

Target Goals

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

Communication Issues: suicide risk

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

Criteria

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

Core symptoms are binging and purging. Development occurs in adolescent years. Dietary restraint, body dissatisfaction, body image, and body disturbance. Integrative cognitive affective therapy for BN (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. Control deficits (Shapiro, et al., 2007) include suicide ideation (red flag), and relapse prevention as major concerns (Leraas, et al., 2018)

Differential Diagnosis: Anorexia Nervosa, binge eating/purging type

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, 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)
   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; Fairburn, 2008; Grilo, Masheb, Wilson, Gueorguieva, & White, 2011; Linardon, Wade, Garcia, & Brennan, 2017; Wilson & Fairburn, 1993)
2. Dialectical Behavior Therapy (DBT; Lenz, Taylor, Fleming, & Serman, 2014; Linehan, 1993; Wilson, Grilo, & Vitousek, 2007)
3. Interpersonal Psychotherapy (IPT) targets personal stress and interpersonal relationships; Carleton, 2016a)
4. Exposure Response Therapy (ERP) has been useful when treating eating disorders and anxiety together.
5. Acceptance and Commitment Therapy (ACT), Cognitive Behavior Therapy (CBT), and Compassion-Based components (Heffner, Sperry, Eifert, & Detweiler, 2002)
6. Family therapy (adolescents; Eisler, 2005)
7. 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.

8. 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, 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, et al., , 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 (red flag)
3. relapse prevention is a major concern (Leraas, et al., 2018)

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

1. Distressed binge eating is present
2. Binge eating occurs, on average, once a week for 3 months
3. Not associated with compensatory behaviors

Core Symptoms

Childhood maltreatment is linked to self-blame (Szabo & Nelson, 2019), body dissatisfaction, emotion dysregulation, rumination, negative emotions, and suicide ideation (red flag).

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, Masheb, Wilson, Gueorguieva, & White, 2011; Linardon, Wade, Garcia, & Brennan, 2017; Wilson & Fairburn, 1993).
2. Dialectical Behavior Therapy (Lenz, Taylor, Fleming, & Serman, 2014; Linehan, 1993; Wilson, Grilo, & Vitousek, 2007)
3. Interpersonal Psychotherapy Therapy (IP) targets personal stress and interpersonal relationships (Carleton, 2016a).
4. Family therapy (adolescents; Eisler, 2005)
5. Exposure Response Therapy (ERP) has been useful when treating eating disorders and anxiety together.
6. ACT, CBT, and compassion-based components (Heffner, Sperry, Eifert, & Detweiler, 2002)
7. 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.
8. 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 strategies to change beliefs and attitudes about importance of weight and body shape on self-evaluation and approval of self
3. relaxation training (Kocovski, Flemming, Hawley, Huta, & Anthong, 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 (Kabat-Zinn, 1994)
6. Relapse prevention

Target Goals

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

Communication Issues

Suicide ideation

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

Core features include anger and irritable mood component of emotion dysregulation syndrome (Doerfler, Volungis, & Connor, 2020). Attention scope is narrow and focuses on information in the center (Fang, Sanchez-Lopez, & Koster, 2018). Failure to manage is a result of a lack of inhibitory control.

Differential Diagnosis: Conduct Disorder

Instruments

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

Treatment

1. parent management training,
2. anger control training,
3. Parent-child Interaction Therapy (PCIT), ages 2.5 to 6, efficacious studies
4. individual and group counseling,
5. family interventions (parent training)
6. 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.
7. Well-established efficacious was met for parent management training-Oregon mode (PMTO)
8. 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

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

Core features are failure to resist an impulsive aggression, impulsivity, emotional lability, negative affect, emotional dysregulation, and anger.

Differential Diagnosis: Disruptive Mood Dysregulation Disorder

Instruments

1. Intermittent Explosive Disorder Screening Questionnaire (IED-SQ)-Coccaro, Berman, McCloskey (2016)-used for adults
2. Barratt Impulsivity Scale (BIS-11)
3. Buss-Perry Aggression Questionnaire B(PA

Treatment

1. Cognitive Behavior Therapy
2. Behavior therapy
3. Family therapy
4. Group therapy

Technics/Interventions

1. social skills training
2. cognitive restructuring
3. anger management
4. emotion regulation
5. impulse control
6. distraction
7. habit reversal
8. problem-solving training

Target Goals

1. anger bursts (verbal and physical)
2. emotional regulation
3. decision-making
4. relationship issues

Communication Issues

1. Red flag for risk: threat to self-aggression, attempted suicide (Schub & March, 2018).

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

Core features are lack of guilt, lack of empathy, and shallow affect (Hawes, Price, & Dudds, 2014), very common are aggression, destruction, and deceitfulness (APA, 2022, p. 531).

Differential Diagnosis

Oppositional Defiant Disorder

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
2. Parent management training
3. Multidimensional treatment

4. Multisystemic therapy

Techniques

1. problem-solving skills training
2. dysregulation
3. impulsivity social skills
4. anger management
5. parent management

Target Goals

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

Clients demonstrate hyporesponsivity 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 (Tonyah, Goker, & Uneri, 2019). 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, et al., 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

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

Core features include vegetative changes, anergia, hypersomnia, increased appetite, craving for carbohydrates, and weight gain (Enggasser & Young, 2007).

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)

Treatment: Cognitive behavior therapy (Brooks, et al., 2021)

Target Goals

1. impulsivity (Haeny, et al., 2021)
2. rumination
3. cognitive vulnerability
4. inhibitory control
5. memory issues
6. judgment (decision making)
7. disorientation
8. inability to focus attention
9. circadian rhythmicity

Communication Issues

1. relapse (Durazzo, et al., 2016)
2. public stigma (Strzeleci & Waldron, 2021)

3. denial
4. suicide (Hsu, et al., 2022)
5. attachment styles
6. parenting attitudes

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).

Schizoid Personality Disorder (SPD)

Core feature is mentalization. Others are anhedonia, attachment (avoidant), rejection (indifferent to social feedback), empathy (lack capacity for mentalization), and defense style (maladaptive styles).

Antisocial Personality Disorder (ASP)

Social dominance (Stanton & Zimmerman, 2019), deception and manipulation (Knack, et al., 2021), failure to conform to social norms, deceitful, impulsivity, irritability (Caple & Schub, 2018), low self-control, deception, and manipulation are core psychopathic traits. Empathy deficits (Rhee, et al., 2021), egocentric callous concern for others (APA, 2022). Externalizing disorder. The client is subject to malingering/faking bad (Knack, Blais, Bagole, & Stevenson, 2021; Rogers, et al., 2002).

Borderline Personality Disorder (BPD)

Core features include negative affectivity, disinhibition, emotional vulnerability, and antagonism (Calvo, et al., 2016). Stormy attachments, unstable social relationships. Child grows up in an invalidating environment.

Narcissistic Personality Disorder (NPD)

Core features include self-absorption (overly positive self-views, self-importance, entitlement (Dehaghi & Zeigler-Hill, 2021). Issue is lack of trust. Suffers from relational disruptions.

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. It was difficult not to exercise that knowledge.

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, and provides ethical constructs at the onset. This may consume three to four 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 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 manual, 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.

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 such as 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 disorders (15 of 20 categories, 51 disorders), diagnostic needs (symptoms, comorbidity, and differentials), interviewing strategies (structured/unstructured interviews, clinical interviews, biosocial interviews), predispositions to disorders, treatment definitions, and recommendations. This unit also provides the examinee information about 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 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. Two, the course of the therapy may deviate based on the provided part 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 deviations 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 knowledge in order to answer.

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