DR. ARTHUR'S STUDY SUPPLEMENT for the NCMHCE

NATIONAL CLINICAL MENTAL HEALTH COUNSELING EXAMINATION

ONLINE SCENARIO SIMULATOR

DSM-5™ DISORDERS: DIAGNOSIS TO TERMINATION

GARY L. ARTHUR, Ed.D.

Dr. Arthur's Study Supplement

for the

National Clinical Mental Health Counseling Examination

DSM-5 Disorders: Diagnosis to Termination

A Companion to the
Arthur Online Scenario Simulator

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Unit 1. INTRODUCTION

How Best to Use This Supplement

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

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

UNIT 1:

Unit 1, Introduction, illustrates and provides information for those taking the NCHMCE. This unit includes a description of the testing format of the NCMHCE, along with suggestions for underlying features to consider during the examination. Unit 1 provides shortened and abbreviated information regarding instruments, monitoring, family treatment guidelines, efficacious evaluation standards, treatment, techniques, and strategy, testing strategy, instrumentation, differential diagnosis, disorder, comorbidity, and treatment planning. There are six traditional questions for each scenario (although NBCC indicates most scenarios will contain five to 10 questions). There are also suggestions about how to prepare for the exam and strategies for answering selections. Unit 1 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.

UNIT 2: DSM-5 Classification

Unit 2 provides detailed information about 51 disorders, with detailed information regarding disorder definition, incidence and interview, assessment, instrumentation, monitoring, treatment, and pharmacotherapy. If the examinee has had adequate experience understanding and providing treatment for clients with more commonly found disorders, he or she may prefer choosing material for those less frequent disorders rather than the more commonly found ones.

UNIT 3: References

There are two sets of references. The first set of references credits those authors whose material is paraphrased in the content of this supplement. The second set of references is for suggested readings located in the professional journals highlighting assessment, instrumentation, treatment, and monitoring.

UNIT 4: Appendices

The appendices include summary evidence-based treatments, techniques, and interventions published in professional journals about effectiveness and efficacious research outcomes for children and adults. Also, 40 or more definitions of techniques and interventions for 31 disorders, and techniques noted in treatment research, and therapy terms.

Developing Skills with Practice Scenarios

This study supplement has repeated material throughout the different units. Individuals preparing for the NCMHCE possess different levels of knowledge, degrees, and years of clinical experiences requiring different preparation. The author recommends all units for those recently completing a graduate degree and entering the professional counseling field. Professionals with advanced degrees (additional courses) and with years of clinical treatment experiences with a variety of client disorders may want to consider Unit I and 4. Units I and 4 provide brief statements for information pertinent for client care and literature support for effectiveness and efficacious treatment and interventions.

The Supplement has four units: Unit I contains an overview of the National Clinical Mental Health Counseling Examination (NCMHCE) as administered by the NBCC. Unit 2 contains disorders cited with high frequency in the population. Each disorder has an overview containing brief statements regarding comorbidity, differentials, instrumentation, treatments, and monitoring. Unit 2 contains an enlargement in information pertaining to the DSM-5 Disorder. Unit 3 contains references cited throughout the supplement. Unit 4, appendices contains literature supported summaries of evidence-based efficacious treatments for children and adults, theoretical theories for treatment, and techniques and interventions for the different disorders.

This study supplement is best used in conjunction with the Arthur Scenario Simulator, which is an online, interactive resource of 47 different practice scenarios similar to those comprising the NCMHCE exam. The 47 scenarios are designed to help the practicing counselor diagnose and treat individuals with mental health disorders.

While the DSM-5 contains some 300+ diagnoses, the information in this supplement has at least one, and sometimes two or more, disorders contained in 15 classifications, adverse effects of medication, and focus of clinical attention. The authors have chosen to develop 47 scenarios accounting for 36 different disorders. Some disorders are repeated, yet the scenarios are presented with different sets of circumstances.

DISCLAIMER

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

It is recommended that all users of this material periodically check with NBCC or APA for recent changes and specific information regarding the examination and material. Materials contained within this supplement relative to the DSM-5 are paraphrased, or credit is applied.

Scenarios – Practice Format

The 47 online scenarios are designed following a practice format similar to that utilized by the National Board for Certified Counselors (NBCC) for the National Clinical Mental Health Counseling Examination. These scenarios follow the standard protocol used to identify a mental health disorder for a simulated client case. Many of the 47 scenarios will provide adequate data to make only a single diagnosis; however, a few scenarios will provide data that point to more than one diagnosis.

In most cases, these scenarios will utilize a process that begins with the client's initial statement of a current problem, distress or chief complaint. The counselor, having accepted or been assigned the case, must then ask appropriate questions and gather the information necessary to formulate a tentative diagnosis. Sufficient information will be available to help the counselor make a provisional diagnosis. The next steps involve recommending collateral services or selection of appropriate instruments to gather additional diagnostic information for a tentative diagnosis and later questions requesting treatment procedures and initiating referrals.

For many of the simulations, the questions have been standardized in the form of information-deriving questions, methods or procedures to acquire additional and necessary information to form a provisional diagnosis, to validate a diagnosis (instrumentation), recommend treatment, techniques to treat symptoms, methods to monitor treatment, ethical consideration, and finally consideration of referral or case closure. Consider the following examples:

> During the first session, what information would be important to assess to formulate a provisional DSM-5 diagnosis?
>
> In completing the initial evaluation interview, what referrals or instrument selections would the counselor make?
>
> What instruments would be helpful in gaining additional information for a provisional diagnosis?
>
> Based on the information gathered, what provisional DSM-5 diagnosis is indicated?
>
> What treatment is recommended for the disorder?
>
> What techniques and interventions would be recommended treatment for the symptoms?
>
> What information or methods would be beneficial in monitoring the client's progress?
>
> In preparing for treatment termination, what recommendation(s), would a counselor make?

For the first two questions, if you make the right selection there is sufficient information to make a correct provisional diagnosis. When you reach the provisional diagnosis question that is a STOP question. The purpose of a STOP question is to make the correct provisional diagnosis before being permitted to respond to the final number of questions for the case. For some scenarios, you may be instructed to find a second diagnosis before going forward to the next question. Due to the brevity of the NCMHCE scenarios the request for two diagnoses might be the limit. It might be necessary to identify a primary differential diagnosis before or after identifying the provisional diagnosis. A recommended treatment question may follow the diagnosis question. A request for treatment goals might follow the determined diagnosis. When multiple diagnoses are identified, unless a specific diagnosis is requested, the treatment question should be answered with treatments for all designated diagnoses.

In addition to the 37 tutorial scenarios there are 10 additional exam scenarios that are formatted similar to the actual NCHMCE. These 10 scenarios are briefer in words and sentences and have no discussion boxes or explanations regarding positive or negative selections. The administration procedures are identical to the 37 tutorial scenarios. You can time yourself while taking the 10 scenarios regarding the NCMHCE three-hour limitation.

Sample Scenario

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

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

Note that Unit 2: DSM-5 Classification contains the *Disorder Overview*, which is the information portion of the supplement. Information is limited for many of the disorders but includes a definition of the disorder, interviewing strategies, assessment or diagnostic information, recommended treatment, instrumentation, a few commonly used medications, and references.

How to Approach the Scenarios

Because there are many different health providers, many of whom are trained at various degree levels, it will be important to approach these scenarios as though the counselor is trained at the Master's level of education, has completed a practicum/internship program, and has limited work experience. Also, many states are "practice" states, meaning a counselor is not allowed to practice beyond the limitations of his or her training. For the NCMHCE examination, even though the examinee may not be trained in certain treatments or instrumentation, one should answer all questions regarding best practice, not whether or not the examinee is trained in that treatment technique or using individual instruments. The examination requests knowledge regarding best practice, not selecting answers based upon the qualifications of the examinee (e.g., degree level, M.S., Ph.D.). An example may be to select the MMPI-2 as the best instrument of choice, even though the examinee has not been trained to administer or interpret the MMPI-2. The NCMHCE is seeking acquired knowledge. If the MMPI-2 contains the scale of the diagnosis under consideration, it may be selected. The examination is not determining if the examinee is qualified to administer the MMPI-2 or whether the examinee is ethical or unethical in making that selection.

The word provisional is used to convey that the diagnosis made by the counselor is subject to confirmation by a clinician trained in this assessment, such as a psychiatrist determining the purpose of prescribing medications, treatment planning, or hospitalization. In the treatment section, not all therapeutic recommendations will be within the capability or training of every counselor. For example, if a recommendation might be hypnotherapy, that might be a right choice for the client or a hypnotherapist but not for a professional counselor untrained in hypnotherapy. Nonetheless, making such a choice would be appropriate if the examinee believes evidence exists in the literature that this choice is the preferred response.

In reading many of the valued answers, you will recognize numerous references to specific medications. But the authors' intent is not to train you in how to identify, use, or monitor medications. It is unlikely the NCMHCE will ask for this knowledge, but it has been included as general information since many clients lack prior knowledge of medication or have been poorly informed and may ask questions about the psychoactive medications they have been prescribed.

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

National Board for Certified Counselors (NBCC)

The National Board for Certified Counselors (NBCC) sponsors the National Clinical Mental Health Counseling Examination (NCMHCE; http://www.nbcc.org/NCMHCE) for certified counselors. Those preparing to take the NCMHCE should visit this website for any changes made by NBCC. Testing time for the Clinical Simulation Examination (CSE) is three hours and fifteen minutes. You will only have three hours to complete the examination as 15 minutes are specifically for reading the instructions on how to take the examination. READ THE INSTRUCTIONS VERY CAREFULLY. If the paper-pencil version of the NCMHCE is to be administered, be sure you have a clear understanding regarding the latent pen, answers surfacing, asterisks (one or two), how many answers to select, scoring procedures and the problem-solving scenario. Today most states administer the online computer version of the NCMHCE.

The NCMHCE Exam

The NCMHCE consists of 10 clinical mental health-counseling cases. Some states use both the National Counselor Examination (NCE) and the National Clinical Mental Health Counseling Examination (NCMHCE) for the cognitive requirement for licensure. NBCC indicates that nine of the ten scenarios are calculated for a passing score. Case scenarios are presented with five to ten topical

segments (questions) during the entire scenario that include the different elements of assessment and treatment that are components of client care (NBCC, 2016).

The assessment behaviors begin with a question such as "what information would be important to assess to formulate a provisional DSM-5 diagnosis", followed by some options/answers. Further investigation may extend beyond inquiring about symptoms of various disorders to include questions about specific instruments considered helpful to acquire or validate symptoms or diagnoses.

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

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

The NBCC practice booklet does not appear to adhere to a strict set of questions for each of the two parts (Information Gathering—IG and Decision Making—DM), except acquiring information for and making a provisional diagnosis. In preparing for the NCMHCE note that questions can be geared to any client session and can include the necessary procedures or steps, tools, strategies, theories, treatment methods, counselor tasks or duties, supervision, in-session dialogue or dilemmas, ethics and consultation required to provide best client care.

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

Evaluating a client with one of these disorders means investigating cognitive, emotional, and behavioral symptoms by obtaining a complete history (present, past, social, family, medical, and occupational), performing a mental status examination, and often recommending further diagnostic

testing and consultations, while paying attention to ethical/legal issues. After making a diagnosis (es), a thoughtful treatment plan can be proposed or constructed.

Each of the Arthur scenarios is much like the NCMHCE in that it includes questions related either to Information Gathering (IG – usually two to four questions) or Decision Making (DM - usually four or more questions). IG includes questions such as, "What information would be important to make a diagnosis?" or "What information would be beneficial to monitor the client's progress?" DM includes questions such as, "After completing the evaluation, what recommendations would be recommended?" or "What is a recommended treatment?" or "What is the provisional diagnosis?" or "What is the rule in/out diagnosis?" or "What is the primary deferential diagnosis?" or "What are the rule out diagnoses?" Scoring is not provided for the NBCC three sub scores identified as 1) administration, consultation, and supervision, 2) counseling and psychotherapy, and 3) assessment and diagnosis.

The examinee should envision that the scenario and first question might resemble an initial interview unless otherwise instructed. The NBCC scenario is frequently a few brief sentences in length. The presenting scenario is typical of statements made by clients when asked what brought them to counseling. The statements likely contain a symptom or clue to the distress or discomfort. It is recommended to follow the words or symptoms presented in the scenario. There may be exact words located in a criteria or words with same meanings. Write these symptoms on the electronic scratchpad. Follow the words.

Morrison (1993) has delineated percentages of times devoted by an interviewer to specific tasks, as follows: chief complaint(s) (15%), specific symptoms—suicidal ideation or behavior, substance use, history of violence (30%), medical history (15%), personal, social and character pathology (25%), mental status evaluation (10%) and diagnosis and treatment discussion (5%). Although all of the options might provide some information, the efficient interviewer will want to maximize time seeking the most important information (symptoms) to establish a provisional diagnosis. A guide for the amount of spent for each question may be five minutes per question or 20 minutes for scenario to complete the 10 scenarios in three hours.

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

The interviewer's questions may be organized systematically (structured interview—clinical interview or biosocial) or they may be more open-ended (unstructured interview). In some cases, the interviewer would best follow the client's leads while not forgetting the task of utilizing the history of the client's presentation, motivation, and predispositions, which are those pieces of information that suggest that certain disorders need in-depth investigation, including issues related to medical, family, and social histories. Even though professionals are skilled in the use of a clinical or biosocial interview, the assessor would be advised to use an unstructured rather than a structured interview.

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

Predisposition may also be discovered in a family history of substance use, mood disorders, tics, and eating disorders. This does not mean that because any of these disorders were found in the family history they would necessarily be the cause of the disorder; rather, it may be that this person grew up in surroundings that predisposed them to such disorders. For this reason, choosing family history may gain positive points for the test taker in some scenarios but negative points in others.

It is recommended to order the choices before selecting them during the examination.

Strategy for Taking the Examination

It is important for the examinee to review the procedures for taking the test in the preparation guide for the 10 "Clinical Simulation Examinations" (CSE; NBCC, 2016). It is especially important to follow the directions as to whether one or more than one answer is required and to pay attention to the phrase "select as many," which appears in the first set of questions requesting the acquisition of relevant data.

The scoring system for NCMHCE includes varying values of minus 1 to a plus 3. For the 47 scenarios, assigned values vary for the answers, ranging from +2 to –2. Answers scored +2 are considered higher priority regarding best client care or choices, while those with +1 valuation are of lower priority regarding helpfulness. The author will assign a lesser value at different times because the answer may be acceptable but much lower on the list of best client care. Also, the scenario choices (words) are likely to be fewer or different than the options for the NCMHCE, even though certain choices may be preferable for the test. Points are taken away (-1, -2) if they are detrimental to the process (excessively expensive, unnecessary time spent, worsen the symptoms or even trigger a suicide attempt). NBCC may, in revealing an answer, use wording such as indicated, minimally acceptable, chosen, or plausible. These types of responses may suggest the answer receives some points but not the maximum.

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

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

Although the simulator modifies the test conditions to enhance learning, it is important to be aware of the real test conditions. In some states, when a paper-form of the NCMHCE is administered

the examinee will be asked to use a latent image pen to mark the correct answers and irrelevant or inappropriate answers will not only be devoid of helpful information but may also be given a negative score. In most states, the NCMHCE is administered online, a computerized form similar to this one.

In the actual test situation, you cannot undo what you have marked. However, you will be able to scroll back to previous questions and review the answers you selected for all questions. You will not be able to select additional answers. For each question select one choice at a time and read that response before making a second choice. You may mark more than one choice, but keep in mind that more answers might result in either a more positive or more negative score. In the NCMHCE place preferred answers in the electronic placeholder before submitting answers. There will be questions where only one answer is allowed. Read each set of instructions carefully.

Also, informational material is placed in discussion boxes about answers for different choices as a part of the Arthur tutorial scenarios. The actual NCMHCE does not provide discussion of their choices. It is important to be aware that discussion information is not revealed to test takers while working with a scenario. Information in the Arthur tutorial scenarios may add other information which may not be pertinent to that question but could be if some of the added information would be found in the NCMHCE question/answer.

The Arthur scenario format (six traditional questions) is similar to the actual NCMHCE, but be aware that the NCMHCE may contain a different number of questions per scenario, and recent information suggests five to 10 questions per scenario (NBCC, 2016). The reason for more questions compared to past years is that the NCMHCE has expanded the tasks a counselor performs to include knowledge and behavior required to work with different disorders counselor duties pertaining to ethical behaviors, consultation and supervision questions.

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

Another way in which the Arthur tutorial scenarios are different than the NCMHCE examination is of information received. When selecting an answer, you will receive more information in the form of sentences than you will find on the NCMHCE. **The NCMHCE scenarios and answers are much briefer.** If you purchased NBCC's packet, you would see fewer sentences and words, some of which are very brief and very short, such as 'not indicated.' We also provided shorter answers when we first started approximately 14 years ago but users wanted more information, so we decided to move

toward a more educational approach in question format, and we also chose to be more tutorial with our answers. As a result, our scenarios are more detailed than you will find on the actual exam.

Also, we have provided discussion boxes that contain our reasoning for our choices. The discussion boxes appear with the diagnosis and treatment. Frequently within the discussion box information may appear to contradict the scenario. It is not our intent to provide contradictory information, but rather to make suggestions that may be helpful in other situations.

The discussion boxes will not be found on the NCMHC examination.

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

The provisional diagnostic question is a STOP question. The correct diagnosis must be determined before the examinee is permitted to continue to the next question. There may be other questions that allow for only one answer so read the instructions carefully.

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

Question 1: Interview for symptoms

This question is a request for symptom gathering to formulate a tentative diagnosis. In doing so, a structured clinical interview may be helpful when the assessor sequences his/her questions to ask only those options that are likely to produce symptoms. Another approach is to use a more open-ended interview technique by identifying and pursuing keywords the client shared in the scenario that might be found on the DSM-5 disorder criteria, such as tired, fatigued, sad, down, loss of interest, inadequate sleep, lack of attention or focus, memory failing, etc. The DSM-5 has included in the manual four pre-interview rating scales (example: adults and parent/guardian for ages 6-17) designating domains rated on a 0 to 4 value (ordinal measurement) for the duration, frequency, and severity that can guide the interview during the assessment (APA, 2013, pp. 734-748). It is recommended to follow symptoms that contain affect, cognition, and behavior.

The DSM-5 included a cultural formulation interview (CFI) to assist in the assessment and treatment phases of the case. The purpose of the CFI is to assist counselors in understanding the cultural context of the client's illness experience (APA, 2013, pp. 749-759). Culture includes "language, religion and spirituality, family structure, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems" (p. 749). The CFI contains 16 questions that tap cultural identity, conceptualization of distress, psychosocial stressors and cultural features, relationships between the

individual and client, and overall cultural assessment. Cultural concepts of distress include cultural syndromes, cultural idioms of distress, and cultural explanations or perceived causes. Culture-bound syndrome has been replaced by cultural distress. Cultural distress has three components: culture syndrome, cultural idioms, and cultural explanation (explained causes).

Frequently an interviewer asks the client when the distress first started (time dimension) and what took place at that time (discontinued going to bridge group, stopped playing piano, spent even more money, no longer leaving the house, or started doing things perhaps in excess such as drinking more, angry outbursts, etc.). These increases and decreases (intensity) are contributing to the reasons the client is experiencing some degree of impairment and is seeking counsel. These statements or symptoms will be good for treatment, monitoring, and discharge but require more focus for symptom gathering. Perhaps some of these answers or information can be noted for later use. The scenario will likely contain symptoms, which may be written down on the piece of paper or the electronic scratch pad provided (on the computer) when entering the testing site. These symptoms might suggest one to three categories or classifications such as mood disorder, anxiety disorder, or risk behaviors that can provide a basis for helping guide the choice of additional questions to acquire more symptoms.

Develop a Strategy

It is recommended that the examinee, after reading the scenario, list the symptoms on the electronic "scratch pad" on the computer version or paper provided on the paper-latent pen version and add to this list as options are selected and opened. On the computer test version check the bubble referred to as a 'placeholder' while making the pre-choices before submission. Next, count the number of options available for question one in each scenario. For example, if there are ten options, divide that number in half (5) and subtract one (4). Now, before opening answers identify the four best choices or options that can be linked to the symptoms previously written on the scratch pad or sheet of paper that will likely provide an expansion for one or more of the symptoms developed from the scenario. Develop the choices that will provide symptoms and provide positive values. Ask yourself, "Why did I ask that question?" or "What do I expect?" Is there a link between the answer and symptoms and a knowledge base from the literature or clinical practice? If one can answer that question with a supportive reason, mark it on the placeholder or write the choice down and look for a second option using the same format or strategy from the option list. Can you connect your choice to a symptom or similar wording located in the scenario, predispositions, or validated questions found in the literature? Write the second identified option answer under the first identified choice. The computer version has a bubble to check for pre-selected answers (not the submission button). Do this until you have exhausted your knowledge or confidence base for making those choices.

When reaching an uncertain point in selecting a choice that will likely produce a symptom, draw a line under your first four choices and ask yourself, "If I select another answer (50% of the options), what would it be?" and write it under the line. On the computer version, the examinee will use the place marker for pre-selected answers.

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

If the selected answer is the best client choice, helpful information (symptoms or a duration) will be evident, and you will learn critical information that can be added to what was found in the scenario. Write it on the scratchpad with the other symptoms. Written words in the answer will likely be few but should contain a symptom or duration. Continue opening choices until you come to the choice that was uncertain or questionable. If you remain uncertain if that choice is a good one for a symptom and you have enough symptoms to provide a correct diagnosis you may want to consider less is more and move to the next question.

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

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

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

In reviewing the NBCC (2016) examination packet, and for those questions that indicate "Select as many as considered appropriate", the percentage of positive valued answers was 51 percent to 49 percent negative. This might suggest considering one less than half of the number of available choices or plus or minus one for the number of choices. The purpose of using this as a guide, not a golden rule, is to build confidence, order the options, and to avoid selecting too many or too few answers.

Question 2: Collateral services

This question is designed to determine the wise use of collateral services or to validate the considered diagnosis. This is the rule in/rule out decision. It might be wise to consider cost-effectiveness and efficiency when making these choices.

An area for review is instrumentations. A question such as, "What instrument would be helpful to gain additional information?" does not indicate what diagnostic instrument (such as the MMPI-2) to use. However, the choice of one of these or other short screeners, inventories or checklists instruments may be a good choice if the instrument includes a diagnostic scale (anxiety, depression, bipolar) or a behavior (aggression, hostility, withdrawn, etc.) for the disorder (depression) under consideration, such as the Beck Depression II, Beck Anxiety Inventory, or SASSI. Some instruments identify the scale in the title. When disorders or behaviors are not in the title of the instrument, it is recommended to learn whether the instrument is for adults or children and the specific disorder scale or behaviors. Frequently surveys of instrument use are literature supported, and these lists will be found throughout this supplement. The instruments on this list may be best choices. Several surveys have been conducted that identified 'most frequently utilized' instruments for different disorders or behaviors

and are included throughout this supplement. It is recommended for instrument preparation to first focus on these survey results for certain disorders. A reminder may be if the instrument question is on a scenario and the examinee received 'indicated' NCMHCE responses for selected choices and these same 'indicated' instruments appear on the monitoring question it is more than likely a good choice as it yields a pre-post measure of change. A likely purpose for the instrument question is to decide to select an instrument that will validate the assessed symptoms and disorder in the interview question.

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

Question 3: Diagnosis

Barlow, DiNardo, Vermilyea, Vermilyea, and Blanchard (1986) and Klerman (1990) described four terms and definitions for diagnosis. The first is primary diagnosis and is a temporary diagnosis. The second is causal secondary diagnosis referring to the disorder that is caused by another pre-existing condition. The third is symptomatic associated with the greatest distress. The principal is the fourth diagnosis established during admission and may be the focus of treatment.

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

Some disorders occur in childhood and continue into adulthood (homotypic continuity) such as ADHD, anxiety, depression and antisocial personality disorders. Other disorders are heterotypic patterns such as conduct/oppositional disorders and later anxiety, depression, antisocial personality disorder and substance misuse (Castagnini, Foldager, Caffo, & Thomsen, 2016). Also, early stages of brain development are involved in psychotic disorders (genetic) and towards schizophrenia (Costello, & Maughan, 2015; Rutter, Kim-Cohen, & Maughan, 2006).

Question 4: Treatment, technique, and strategy

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

It is recommended to consider treatments that provide immediate relief. Managed care or insurance companies approve a limited number of sessions and for that reason, the process of therapy, because of time limitations, may allow for establishing, collaborating and the teaching of skills to address identified symptoms, and begin the therapeutic process and treatment on the road to recovery rather than a cure per se. On the other hand, the presence of such time limitations may free up (or constrain) the examinee to select other therapies known to be helpful, such as brief psychotherapy, supportive therapy, psychoeducation, mindfulness, and solution-focused therapy. Since this question frequently states, "Select as many as appropriate," the list of options may include techniques and interventions that are matched to the disorder or treatment goals. This can be a time to use techniques or interventions that are contained in the symptoms list elicited in the initial question and activities the client was previously involved with but stopped during that period of the distress. An example might be recommending bibliotherapy if the person was an avid reader before the stressful issue was brought to therapy.

If one of the questions has requested selecting best short-term goals, then match from the treatment list a technique or intervention for each of the goals. An example might be recommending stress relaxation techniques, breath-inhalation, muscle relaxation, or even in vivo exercises for the client who stopped going to church or a social club because of anxiety associated with social interaction. A list of techniques, methods, and interventions will be located in the appendices for numerous disorders and theoretical orientations. In reviewing the NBCC examination packet, it appears more techniques and strategies are to be found on the list than theories.

The NBCC (2016) guide has the treatment question divided into two questions. The first question is a request for recommended global theories to treat the diagnosis (CBT, DBT, EMDR, IPT, ACT, etc.) and the second question is a recommendation for interventions or techniques. This portion of the treatment is to match from the case conceptualization those interventions or techniques that will decrease an increase or increase a decrease in those symptoms reported to be causing distress or dysfunction during the initial complaint.

A suggested treatment for a specific scenario may be to select a technique or intervention when paired with a symptom to reduce or increase a goal for symptom relief even though it might not be a technique for the overall treatment theory selection such as CBT, EMDR, IPT, and ACT yet is appropriate for that symptom. The treatment of choice for obsessive-compulsive disorder may be exposure and response prevention (ERP), and in vivo may be a selected technique. Some clients may reject the exposure component, and when this is the situation, CBT is recommended. CBT targets the recurrent and persistent thoughts, urges or images. Restructuring or reframing are commonly CBT techniques and may be good choices for those cognition symptoms. If no information is provided about client refusal for ERP than both choices would be selected.

If a treatment plan is effectively evaluated for implementation and the client fully participates and adheres to the treatment regimen monitoring can take place during the therapy sessions. Steps in collaboration with the client include establishing goal(s), client agreement, client practice, client rehearsal, client reporting and charting for feedback and increasing client assumption and responsibility yielding verbal recognition and specific behaviors for monitoring.

Southam-Gerow et al. (2016, pp. 73-74) provided an example of a treatment plan for child anxiety using individual cognitive behavioral therapy and Coping Cat to manage anxiety. Specifically, their plan based on the acronym FEAR includes interviewing and treating for feeling frightened (F), re-experiencing bad things to happen (E), actions and attitudes that can help by changing negative self-talk (A), and results and rewards to teach self-reinforcement (R). Monitoring for change and compliance is acquired using the Treatment Adherence Measure for Cognitive-Behavioral Therapy for Child Anxiety. A summary of the steps is abbreviated for deriving symptoms or activities to monitor treatment compliance with client skills and exposures:

1. client participates in homework related to anxiety
2. rapport-client participates or collaborates in therapy
3. psychoeducation-adherence to teaching material for anxiety, thoughts, feelings, and actions and understands the rationale behind the exposure
4. emotion-adherence to feelings, physiological response, associated with feelings; identify physical cues of feelings
5. fear ladder-creates an order of feared stimuli
6. relaxation-recognize and use exercise to maintain and encourage rehearsal
7. cognitive-practices rehearsal of role of thoughts in creating and maintaining, and reducing anxiety
8. problem-solving-rehearsal of missteps in a problem-solving model for coping with anxiety
9. self-reward-practices rehearsal of evaluating and rewarding oneself to cope with anxiety
10. coping plan to include:
    a. developing and practicing a coping plan that involves a combination of distinct anxiety management skills
    b. exposure preparation: develop an exposure task

c. exposure participation: client participates in one or more exposures

d. exposure debrief: client participates in the debriefing for praises, rewards, outcome discussions

e. maintenance: applies skills to future encounters

f. didactic teaching: receives didactic instructions from a therapist

g. modeling: participates in observational learning

h. rehearsal: client engages in behavioral enactments to practice CBT skills related to anxiety

Erford (2015) listed 40 techniques every counselor needs to know. The 40 techniques included scaling, exceptions, problem-free talk, miracle question, flagging the mind field, I-messages, Acting As If, spitting in the soup, mutual storytelling, paradoxical intention, empty chair, body movement and exaggeration, visual/guided imagery, deep breathing, progressive muscle relaxation training, self-disclosure, challenging/confrontation, motivational interviewing, strength bombardment, self-talk, reframing, thought stopping, cognitive restructuring, emotive imagery, bibliotherapy, journaling, systematic desensitization, stress inoculation training, modeling, behavioral rehearsal, role play, Premack principle, behavior chart (food chart), token economy, behavioral contract, extinction, time out, response cost, and overcorrection. Guided imagery and contemplative practices are recommended for some clients (Myers, 2017).

Counseling and Psychotherapy

The NBCC (2016) booklet for decision-making contains the words counseling and psychotherapy (subtest) for scoring the treatment questions. The treatment question may be two separate questions. The first question is a request for the overall psychotherapy (theory) portion of treatment (CBT, EMDR, DBT, IPT, ACT). Most likely, when there are to be found in the professional journals, rigorous scientific articles reporting significant evidenced-based data identified as effectiveness or efficacious treatments for certain disorders those choices are the higher point values and best options. An example might be CBT for major depression.

The accumulated points for the 'Counseling' portion of the accumulated treatment question would be the second question. The second question, counseling, refers to the weekly session a therapist is teaching specific skills using specific techniques to decrease those symptoms that increase or decrease symptoms that were increased and identified as client impairment or distress in question one. The question is likely to request what techniques or interventions are recommended for the particular disorder. A strategy for answering this second question is to start with the answers from the first treatment question, where the theory or theories chosen had an 'indicated' response. If the response CBT was indicated in the first question it is likely that techniques and interventions associated with CBT will be on that list such as restructuring or reframing, a cognitive approach or for the ACT, defusion or mindfulness. Secondly, consider the disorder and the specific symptoms that were identified in question one. The client symptoms increased or decreased and were identified for the severity or impairment/ dysfunction/distress expressed during the interview. If the disorder was social anxiety disorder, specific techniques or interventions for weekly therapy might include muscle

relaxation, breath-inhalation, and exposure and relapse prevention. These two treatment questions provide for half of the points on the decision-making NCMHCE. The second question sets the stage for the monitoring question, increases and decreases in symptom treatment.

Evaluation methodology for Efficacious (efficacy-effectiveness-outcome research) treatment:

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

Nathan and Gorman criteria:

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

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

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

Type 4 and 5: Secondary analysis articles

Type 6: Case reports

Chambless and Hollon (1998) criteria:

Well-established (WE):

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

b. single-subject design studies using strong designs and comparison to an alternative treatment

Probably efficacious:

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

1. Two strong group studies by the same investigator showing the treatment to have better results than no-treatment control group
2. Two studies showing better outcomes than a no-treatment control group
3. Three or more single-subject design studies that have a robust design and compare the intervention to another intervention.

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

Experimental treatment: treatments yet to be analyzed

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

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

Family Treatment Guidelines

Sexton et al. (2011) reported a more recent "best" method or design for the evaluation of evidence-based approaches for family therapy. This approach is three-leveled that reflects the complexities of family and couple-based practice.

Level I is based on psychological research. The research is not rigorous enough to warrant a higher level of sophistication yet draws attention to clinical treatment and well-validated models. Techniques have some supporting research.

Level II shows intervention promise in the research results. The strength of this level is based on the identification of techniques and interventions that are well specified and have the possibility of replication. Examples of such promising treatments for adolescents in families have been insight-oriented marital therapy and attachment-based family therapy.

Level III: Evidence-Based treatments

Level III treatments are specific and comprehensive treatment intervention programs demonstrating high-quality evidence.

The three categories are further classified for Level III to include:

Category 1 is defined as the strength of the evidence as compared with reasonable alternatives. The evidence is minimal and stated as two types of research with outcomes that are absolute and relative efficacy/effectiveness.

Category 2 is defined as the existence of validated change mechanisms for positive outcomes. The evidence is linked to relevant identifiable results, as theoretically expected. According to Sexton and Turner (2010) and Beach and O'Leary (1992) Behavioral Couple therapy for depression is such treatment.

Category 3 is defined with an ecological validity in which the approach has demonstrated validity. Contextual efficacy involves studies of specific clients, clinical problems, and service delivery systems for evidenced-based treatments. The treatment produces change and is effective for specific populations (Sexton et al., 2011).

Question 5: Monitoring

Monitoring is the process of observing the change in thought, feelings, and behavior of a client undergoing treatment. Monitoring may take many different forms, often in direct relation to what the client is experiencing and agreed-upon established goals for treatment. Monitoring is tracking of specific client changes in the treatment goals by the client, and the counselor's task is to help the client recognize change through record-keeping, regular goal assessment reporting, and feedback with the client. The client and counselor provide feedback via observations including self-reports, surveys, or behavioral reports. Improvement or lack of improvement information should be measurable, achievable, relevant and time-bound. Monitoring can be through idiographic and standard measures. Drapeau (2012) reported ten tools to measure progress in psychotherapy. Three methods are:

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

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

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

According to Prochaska, DiClemente, and Norcross (1992) change can be reflected in the process of counseling, such as stages of change or in the case of a specific theory treatment of choice. The stages of change include pre-contemplation, contemplation, preparation, action, maintenance, and termination (relapse prevention). All theories provide specific strategies, interventions, or the mechanism for initiating therapeutic change and steps for that change or experimentation to elicit or surface internal conflict. Interventions are procedures aimed at discovery. Although specific theories may not be a selected choice for NCMHCE scenarios, some Gestalt intervention strategies may be used

with other theories. Gestalt intervention examples include: location of feelings, confrontation, empty chair, making rounds, dream work, unfinished business, rehearsal, minimization, exaggeration, reversal, exposing the obvious, explanation or translation, retroflection, let the child talk, say it again, I have a secret, and stay with your feeling (Capuzzi & Gross, 2007, pp. 228-231). These types of interventions provide the groundwork and specific conflicts that are the pathways to the change elements but are also helpful to discern what resources the client uses to cope and engage in self-care. Paradoxical intention is both a theory and a strategy. As a strategy, the counselor may observe when the client gives up trying to be what they want to be and when the client stops struggling, and change occurs (Fernbacher & Plummer, 2005). The reverse of this concept is that the harder one tries, the more one stays the same.

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

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

Some examples of strategies for cognitive behavior are reinforcement (positive/negative) extinction, shaping (stimulus control, aversive control), all-or-nothing thinking, catastrophizing, and thought stopping. Symptoms observed during the intake if the frequency is known and recorded for accuracy are often good choices for monitoring.

Specifically, some examples include:

- Verbal reports or self-reports
- Instruments-screeners, monitors--pre/post measurements (BAI, BDI). The best report is a pre-post measure. If the instrument question is a part of the scenario and several instruments on the list and correct selections with 'indicated' appear that validate the interview (disorder), and the same instrument appears on the monitoring list that selection is an example of a pre-post measure for change.
- Level 1 Cross-Cutting Symptom Measure (Adult; Parent/Guardian for child age 6-17)
- Scales-rating scales such as those with solution or problem-focused therapies
- Compliance (medication, homework, working during counseling)
- Checklists
- Logging exercises such as emotion lists, frequency of angry feelings or acting out as long as this data is apparent during the pre-diagnosis or taught during the treatment become good selections
- Re-engagement in previous activities (running, music, crossword, etc.)
- Physiological measures (blood pressure, heart rate, pulse, galvanic response)

- This may depend on the diagnosis: ADHD (homework, compliance with medication, etc., boundaries)
- Children reporting--some disorders may be in question
- Global measures of outcome-measure across client diagnosis—the manual indicated that the SCL-90-R might be used as a monitoring tool, general symptoms derived from the nine subscales and Outcome Questionnaire-45 (Lambert et al., 1996), three subscales and composite score

A client may be experiencing difficulties in expressing him/herself socially in the form of interpersonal, verbal communication. Monitoring may take the form of observing that a client is meeting and talking with others. Monitoring observations can be behavior demonstrated or through self-monitoring. The specific behavior change monitored is dependent upon the treatment goals. For someone experiencing agoraphobia, improvement behaviors may be attending a social function, going shopping, mailing a letter, or other behavior whereby the client comes into contact with people. Client self-reports can be a strategy to determine improvement. The client reports tasks accomplished.

Self-reports from young clients are sometimes in question and may need validating observations from adults. A person experiencing an alcohol disorder will count the days of sobriety, attending AA meetings, meeting with a sponsor and meeting specific objectives of the 12-Step program. Relapse is another way to measure improvement, and in this case, it would be considered a lack of improvement.

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

Short screening instruments can be used to monitor improvement. An example might be someone experiencing a mood disorder. The Beck Depression II (BDI-II) can be administered at the initiation of treatment or during intake assessment and conducted again at a later time, thus a comparison (pre-post). The BDI is short and inexpensive and can be used to support self-reports, behaviors observed by the client or family members and mood charting by the counselor. The Coping Styles Questionnaire for Social Situations is a psychometric tool for measuring monitoring and blunting for social anxiety disorder. This tool observes for behaviors the client engages in to seek out information for threatening situations and for distractions.

Physiological instruments are used by medical professionals in a variety of ways for different disorders in specialized laboratories, hospitals, emergency rooms, or the private offices of medical specialists. Physiological indicators may include EKG, blood pressure, respiratory parameters, EEG, EMG, alcohol screening, body movements, body temperature, perspiration, eye movements, critical flicker frequency(CFF) and electrodermal activities, and neuroimaging. Individuals with chest pain and palpitations experiencing panic attacks are evaluated with EKGs, sphygmomanometers, and measurements of cardiac enzymes. Individuals with nightmares and sleep disorders are evaluated in sleep laboratories. Individuals with movement disorders, seizures, muscle weakness or loss of coordination are evaluated with EEGs, specialized exams, or EMGs. Individuals with chronic pain are

measured with dolorimeters. Individuals with changes in cognition may be evaluated with neuroimaging including procedures like CT scans, MRIs, Functional MRIs (fMRIs), PET Scans, and SPECT. Imaging is particularly useful to evaluate the possibility of space-occupying lesions but, as yet, is not useful for making psychiatric diagnoses. The MRI is increasingly found to be an effective tool for diagnosing central nervous system disease, including demyelization disorders, neoplastic disorders, and ischemic changes in the brain resulting from vascular insufficiency or occlusion.

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

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

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

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

Routine Outcome Monitoring (ROM):

Therapist routine outcome monitoring is essential to provide the client and therapist assurances that positive change and improvement is noted. A systematic plan is to provide session-by-session client feedback regarding the established goals to improve outcome. A few of these approaches include:

- Outlook Question-45 and a shorter version (OQ-30) is used to measure, monitor, and provide feedback to accurately predict treatment failure before the client leaves or has reached terminated. The OQ-45 is a self-report of 45 symptom occurrence for emotional states, interpersonal relationships and social role functioning (Lambert, 2015).
- Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrell & Brown, 2005): use the outcome rating scale (ORS) and session rating scale (SRS)
- Clinical Outcome in Routine Evaluation (CORE; Barkham, Mellor-Clark, & Stiles, 2015): CORE uses the Outcome Measure (OM) to measure the change in four domains; problems, life functioning, subjective well-being, and risk. The second instrument is CORE-A to measure severity.
- Treatment Outcome Package (TOP): Scales include depression, violence, social conflict, quality of life, sleep, sexual functioning, and work functioning, psychosis, panic, mania, suicidality, and the total score (Boswell, Kraus, Castonguay, & Youn, 2015).

- Counseling Center Assessment of Psychological Symptoms (CCAPS): Scales include depression, generalized anxiety, social anxiety, academic distress, eating concerns, family distress, hostility, and substance use.
- Behavioral Health Measure (BHM; Kopta, Owen, & Budge, 2015)
- A Collaborative Outcomes Resource Network (ACORN; Brown, Simon, Minami, & Cameron, 2015)

Psychologists use as the most common standardized and individualized outcome measures the Beck Depression II, Global Assessment Scale/Children Global Assessment Scale, Child Behavior Checklist, Structured Clinical Interview, Symptom Checklist 90-R, Beck Anxiety Inventory, and the Outcome Questionnaire-45 (Hatfield & Ogles, 2004).

The significance in pursuing a systematic measure in treatment outcome is to promote treatment effectiveness, client feedback, and goal attainment. In addition, Lambert and Shimokawa (2011) reported that an estimated 5%-10% of adult clients are worse off in clinical trials after they began treatment (Lambert & Ogles, 2004) and that an estimated 24% and 14% of children are worse off after treatment (Warren, Nelson, Mondragon, Baldwin, & Burlingmae, 2010). Feedback is essential for therapists to continue to improve in treatment outcome. Tracey, Wampold, Lichtenberg, and Goodyear (2014) contend that therapists do not improve, in fact, actually get poorer outcomes over time (Goldberg et al., 2015).

Question 6: Discharge

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

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

Be aware of recognized community resources such as self-help programs like AA, Al-Anon, Alateen, NA, grief recovery groups, rape support groups, eating disorder groups, spiritually sponsored programs, and other support groups known to have a good prognosis for sustaining the progress obtained through treatment.

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

Summary Information

1. Read carefully, as identifying information is provided in the clinical case scenario. Usually, you will know the age, gender and, at times, educational background, counseling setting, and the environmental setting, i.e., work and family.
2. Sensitivity to culture and race is critical because biases are known to exist throughout the literature, from assessment to treatment. Family communication, philosophical and practical issues related to treatment vary with client experiences with mental health services. Chavira et al. (2003), in researching diagnostic data for Caucasians, African Americans, Asian Americans, and Hispanic Americans reported different rates for four personality disorders. Important information for the clinician is to be aware of how the individual perceives and expresses a problem, the interaction between the clinician and the client, family philosophies regarding mental illness, and if the person decides to seek treatment. It is recommended that each preparer review the 2014 ACA Code of Ethics section on diversity, supervision, and the Cultural Formulation Interview in the DSM-5 (APA, 2013). Care is to be taken when assessing for ethnicity and personality disorders because the literature has noted boundary issues (characteristic features) are differentiation problems (Chavia et al., 2003; Graham, 2006)
3. Initially, focus on the chief complaint(s). Identify symptoms or clues in the scenario that will help you select the more important options. Some directional information will guide the questioning. Be alert to trigger words or phrases, such as "sleep," "appetite," "mood," "health," "concentration," "memory," "fatigue," "sudden change in behavior," "memory," and "duration of symptoms."
4. Select responses that will provide answers related to the DSM-5 disorders. Recognize the importance of acquiring information regarding frequency, severity (intensity), duration, and time frame of symptoms related to the chief complaint.
5. Pursue causative factors for the chief complaint(s). For example, if a client has memory loss, ask about accidents, falls, depression, and health problems, i.e., mini-strokes, etc.
6. It is important to be aware of medical conditions that appear to be associated with a diagnosis. The medical condition may not be the cause but should always be considered important and worthy of seeking additional information or referral. This information may suggest the counselor utilize appropriate referrals to gain best client care or to validate information. A list of these associations will be found at the conclusion of these suggestions.
7. The literature findings suggest that there are family predispositions with certain disorders that warrant history taking regarding medical, mental, family, work, social, and risk behaviors. For example, selecting family history can reveal important information about one or more family members who may have suffered from, or received treatment for, the same condition/disorder. Frequently clues may be found in the scenario to warrant family history to be important for data gathering. Some examples may be alcoholism, mood disorders, eating disorders, tics, etc. It is our opinion the family inquiry, as a selection, moves up the list of choices. A partial list will

follow the family, social, and medical associations. It is not possible to know if the NBCC scenarios award positive values for selecting predispositions choices.

8. The mental status examination (MSE) often confirms diagnostic questions about behavior, memory (short-term, intermediate and long-term), affect, and cognitive functioning. An MSE, whether brief or full scale, is important when the history and symptoms seem to be apparent for a major mood disorder, substance use, psychoses, and neurocognitive disorders.
9. Positive scores (+1, +2) will follow pertinent answers about duration and intensity of symptoms, with higher values reflecting greater importance. All values will be available to the user when the submission button is selected at the conclusion of the scenario except the NCMHCE. The Arthur scenarios use +2 to -2 values while the NBCC Examination booklet use +3 to -3 values (NBCC, 2016, p. 5).
10. Diagnostic instruments that assess for disorders that are statistically valid and reliable have been used to corroborate interviewers' data gathering of symptoms. Some instruments that have few items (time and cost concerns) may be good for monitoring client improvement. They may also be good choices, depending on the wording of the question. The question might state a diagnostic instrument or it might state what instrument would be helpful. The first request is for an instrument validated as a diagnostic instrument, such as the MMPI-2, while the second question indicates 'helpful', like the Beck Depression II (short in items but readily utilized). For diagnostic assessment, some instruments for mood disorders might be the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Beck Depression II (BDI-II), Burns Anxiety Inventory, and for personality disorders, perhaps the Millon Clinical Multiaxial Inventory-III.

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

First:	Beck Depression II (1st)
Second:	Myers-Briggs Type Indicator (2nd)
Seven:	Strong Interest Inventory (3rd)
Seven:	Wechsler Intelligence Scale for Children (7th)
Nine:	Beck Anxiety Inventory (9th)
Eleven:	Wechsler Adult Intelligence Scale Revised (WAIS-R; 11th)
Fourteen:	Wide Range Achievement Test (WRAT-3; 14th)
Fourteen:	Burk's Rating Scale (14th)
Fifteen:	MMPI-2 (15th)
Twenty-two:	Child Behavior Checklist (22nd)
Forty:	Thematic Apperception Test (40th)

Fifty-two:	Eating Disorder Inventory (52nd)
Not listed:	Holland's Self-Directed Search (not listed)
Not listed:	Eating Disorder Inventory (not listed)

This would suggest that these instruments were within the scope of a master's level curriculum course in the appraisal. When reviewing the list of instruments, the possible frequency of use and familiarity of these tools would be recommended for disorders such as contained in neurodevelopmental, anxiety, mood, feeding and personality categories (Youn et al., 2015).

The 2016 NBCC Examination Structure and Self-Assessment Directions and Explanation booklet of instruments list included Achenbach's Child Behavior, Minnesota Multiphasic Inventory-2-RF, Burk's Behavior Rating Scales, Wechsler Adult Intelligence Scale, Thematic Apperception Test, Beck Depression II-II, Holland's Self-Directed Search, Eating Disorder Inventory-2, Beck Anxiety Inventory, and the Wide Range Achievement Test.

When monitoring for client improvement using instruments, the clinician might consider using the Beck Depression II (BDI-II), Burns Anxiety Inventory or the Substance Abuse Subtle Screening Inventory (SASSI). The BDI contains 21 self-report items measuring the severity of depression in adults and adolescents. It assesses symptoms for depression contained in the DSM-5. It is inexpensive and can be administered and scored by the master level trained counselor. The instrument scale direction and cut-off scores have not been required for the NCMHCE. The use of instruments or scaling questions pre-post inquires best represent change. When medications are prescribed, it is essential the counselor monitor for compliance and adverse side-effects (Ashton & Young, 1998).

11. The provisional diagnosis question is a STOP question. STOP means the correct provisional diagnosis must be determined before the examinee is permitted to progress to the next question. The remaining questions are based on the correct provisional diagnosis. If one were to proceed to the next question with the incorrect provisional diagnosis, answers would likely be incorrect for treatment, to monitor and to refer.
12. This training supplement, in progressing to later scenarios, will be requesting for more than one diagnosis. If you select one correct diagnosis, you will be instructed to find a second or even third before proceeding to the next question. The NCMHCE may ask for multiple diagnoses but likely on only one or two scenarios. It is advisable to become familiar with the use of specified, unspecified and Z-codes with different diagnoses. When recording more than one diagnosis on the NCMHCE, one may find both disorders listed on the same option line. Normally, the diagnosis that requires the most professional assistance is listed first, followed by the second diagnosis, if it meets full criteria. Also, the disorder may contain the replacements for NOS, specified and unspecified. Specifiers and severity terminology may also be included for the disorder. Be sure to read NBCC's website for any up-to-date changes.
13. The treatment question usually pertains to the case conceptualization for the preferred theoretical approach with literature support or a session question regarding the counselor's task, ethical considerations, counseling steps or process for best client care. Sometimes more

than one treatment is valued. When multiple diagnoses are confirmed the treatment question can be approached by prioritizing the immediate need (safety, medication, mood), followed by decisions about treatment in order of priority. If this is not the case, do not select a treatment for one disorder that may not be at least somewhat helpful for the other. These types of questions are found in the Arthur later scenarios.

14. For recommended treatments, strategies, and techniques for different disorders found in the scenarios, the examinee should become familiar with the literature citing evidence-based research, which has been recommended by medical personnel and psychologists trained in scientific research to be a minimum of two independent randomized control trials for effectiveness. More recently the field has expanded this requirement to also include six levels of evidence. For a more in-depth understanding of effectiveness or efficacy studies, the examinee should consult Trinder and Reynolds (2000). One example of a research article reporting outcome research was reported by Gowers (2005), in which cognitive behavior therapy (CBT) produced significant change results for eating disorders. A controlled clinical trial refers to a study that meets the criteria for experimental design research in which the treatment or technique is exposed to rigorous research criteria. This type of research usually involves comparing the effectiveness of a particular therapy or intervention with a control group, waitlist or different technique/treatment. Levitt, Hoffman, Grisham and Barlow (2001) cited several controlled clinical studies in which the treatment for panic disorder was found to be effective using CBT in 8-12 treatment sessions. An effort has been made to include this type of recommendation in the supplement (appendices) as well as the online scenarios, whenever possible.
15. In addition to treatments that meet evidence-based outcome studies, consider treatment selections that provide immediate relief. Due to the limited number of sessions clients receive (insurance, finances, managed care, cost-effectiveness, transportation), effecting change for improved conditions is to be considered time-limited.
16. The third component of treatment includes techniques and interventions that are most appropriate for select disorders. Be prepared to select techniques such as bibliotherapy, journaling, stress inoculation, relaxation training, muscle relaxation, breath inoculation, in vivo, paradoxical intention, social skills training, empty chair, and reframing. An example might be stressing inoculation and the miracle question for adjustment disorder. Play therapy and sand tray therapies are appropriate for young clients. A technique list for selected disorders is located in the Appendix.

Medical Associations with Psychological Disorders

Counselors are not physicians and so are not expected to diagnose a physical problem. Limited medical information is provided so that when the interviewer is acquiring information, either in the

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

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

Heart Attack vs. Panic Attack

Symptoms of a panic attack often include chest pain or 'tightness,' shortness of breath, rapid pulse, and extreme apprehension, BUT a routine medical evaluation, normal electrocardiogram, and absence of abnormal laboratory findings rule out a heart attack.

Gastrointestinal and Varied Pain Complaints vs. Somatization Symptom Disorder

Symptoms of somatization symptom disorder may include gastrointestinal complaints such as vomiting, abdominal pain, nausea, bloating, diarrhea, intolerance of several different foods, nonspecific pain in back, joints, and pelvis, BUT the absence of objective medical and laboratory findings rules out a specific medical diagnosis.

Hypochondriasis, Sleep Disorder and Nonspecific Somatic Symptom Disorder Complaints and Chronic Posttraumatic Stress Disorder

Posttraumatic stress disorder is often overlooked by physicians whose clients, particularly women previously abused as children, seek medical attention for physical symptoms such as pelvic and abdominal pain, gastro-esophageal reflux disease, and noncardiac chest pain, gastrointestinal (GI) symptoms, and irritable bowel syndrome.

Cancer vs. Hypochondriasis

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

Multiple Sclerosis vs. Conversion Disorder

Symptoms of multiple sclerosis, an autoimmune demyelization disorder, may include difficulty swallowing, deafness, double vision, weakness, difficulty walking, or paralysis. Conversion disorder should be considered when one of these symptoms develops suddenly in a client with a history of psychological disorder and the psychological trauma. Multiple sclerosis should be suspected when symptoms of weakness or muscle paralysis recur 30 days or later but are different because demyelization occurs in a different anatomical location. An MRI sometimes provides objective evidence of demyelization.

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

Lyme Disease vs. Mood Disorders

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

Substance Withdrawal Symptoms vs. Anxiety Disorder

Symptoms of both disorders include sweating, rapid pulse, tremors, insomnia, gastrointestinal complaints, and occasionally transient hallucinations. These symptoms can occur after sudden withdrawal from alcohol, narcotics, marijuana, anxiolytics, certain prescribed psychoactive medications, and some muscle relaxants.

Substance Use Disorders

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

Physical Symptoms and Medication Side Effects

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

Diabetes and Bipolar Disorders

People with bipolar disorder are three times more likely to develop diabetes mellitus symptoms than are members of the general population (Hirschfeld, Allen, McEvoy, Keck, & Russell, 1999; Hirschfeld, Young, & McElroy, 2003; Krishman, 2005; Kupfer, 2005; Regenold, Thapar, Marano, Gavirneni, & Kondapavuluru, 2003). Dunne (2004) reported a 6.6% bipolar disorder and diabetes mellitus association in a study conducted in Canada.

Eating Disorders

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

Sleep-Wake Disorder

Sleep apnea disorder, circadian rhythm sleep-wake disorder, night terror disorder vs. sleep disorders secondary to another disorder (conditions such as depressive disorder and PTSD).

A diagnosis of a serious primary sleep disorder may require a sleep study such as a polysomnogram, multiple sleep latency tests, or multiple wake tests.

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

Twenty-five percent of chronically ill individuals develop a secondary depression, and five percent of those diagnosed with major depressive disorder subsequently are found to have another medical illness that caused their depression.

Organic Mood Syndromes vs. Medical Illnesses Causing Mood Disturbances

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

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

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

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

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

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

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

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

Mood Disorders Caused by Drug and Medication Side Effects

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

Mania may also be induced by cyclosporine, prescribed to prevent rejection of transplanted organs; levodopa for the treatment of Parkinson's disease; all antidepressants, including SSRIs and MAOIs; Lioresal, which is often used to treat multiple sclerosis and spinal cord injuries; stimulants used

to treat attention deficit hyperactivity disorder (ADHD); Synthroid, commonly prescribed as a thyroid hormone replacement; certain antibiotics, such as ciprofloxacin and gentamicin; antimalarial drugs, such as mefloquine and chloroquine; antineoplastic drugs, such as 5-fluorouracil and ifosfamide

Depression and Medication Side effects

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

Corticosteroids (including Prednisone and Cortisone) may cause changes in mood and cognition, are generally dose-related and can precipitate psychosis, hypomania, mania, depression, cognitive and memory problems.

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

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

Antibiotics: Penicillin, cephalosporins, quinolones such as Ciprofloxacin and Ofloxacin, chloramphenicol, and Isoniazid. The chronic use of broad-spectrum antibiotics (and excessive ingestion of meat products associated with antibiotic use) has been found to disturb probiotic bacteria in the intestinal tract. A small number of medical practitioners have written articles indicating their conviction that disturbed intestinal flora has caused a rising number of mental disorders in western nations. They recommended reducing sugar intake and taking probiotics to restore normal intestinal flora (Gucciardi, 2011).

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

Anabolic androgenic steroids are associated with mood and behavior changes.

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

Medications for reflux disease (omeprazole and lansoprazole) and H2 receptor antagonists (famotidine, nizatidine, ranitidine, and cimetidine) have been reported to cause serious

neuropsychiatric complications—including mental confusion, agitation, depression, and hallucinations—mainly in geriatric patients with impaired hepatic-renal function.

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

Antimigraine medications such as sumatriptan have been associated with fatigue, anxiety and panic disorder.

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

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

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

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

Family Predispositions

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

1. **Tourette's Syndrome**

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

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

2. **Eating Disorders**

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

3. **Alcohol**

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

4. **ADHD**

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

5. **Borderline Personality Disorder**

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

6. Social Anxiety

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

Instrumentation

This section will focus on the instruments that may be used for screening, monitoring and assessing (diagnosing) behaviors. Screening instruments are more likely used to derive a rough estimate of possible directions the assessor takes during the interview. Screening instruments often are short and provide direct questions in a self-report form. The instruments listed in this section for screening are not all defined as screeners in the supplement. Those that are considered screeners will

be identified. Screening is a rapid and rough estimate (Domino, 2000). It is a process of collecting data to decide whether the more intensive assessment is necessary. This is an initial stage in which a particular decision is sorted out from the general population (Salvia, Ysseldyke, & Bolt, 2007). An individual has a certain characteristic or does not have a certain characteristic. For example, the DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure-Adult may be considered a screener (pre-interview) for one or more of the 13 domains in the adult rating scale version. If the client was rated mild or greater on the Level 1 symptom measure, a Level II longer form might be administered.

A screening assessment is a relatively brief evaluation intended to identify individuals who are at risk of developing certain disorders or disabilities. Screening can be for preventive measures or to determine readiness for certain interventions. Some examples of screening instruments, if administered on a pre-post measure, that may be used as monitoring tools include:

1. SCL-90-R
2. PANAS Scales (PANAS-X is the expanded version-60 items)
3. Alcohol Use Disorders Identification Test (AUDIT)
4. Inventory of Interpersonal Problems (IIP-64; Horwitz, Alden, Wiggins, & Pincus, 2000) Screening for avoidant personality inventory measuring low in dominance and affiliation
5. Traumatic Events Screening Inventory (TESI-C; Ribbe, 1996), Children and TESI-P (Ippen et al., 2002)
6. Primary Care PTSD Screen (PC-PTSD; Prins et al., 2003)--past month

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

1. PROMIS Anxiety (Cella et al., 2010; PROMIS Cooperative group, 2010)
2. Mood and Anxiety Symptom Questionnaire (MASQ; Clark & Walton, 1991)
3. Generalized Anxiety Disorder Scale (GAD-7; Spitzer, Kroenke, Williams, & Lowen, 2006)
4. Positive and Negative Disorder Scale (PANAS; Watson, Clark, & Tellegen, 1988)

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

1. psychologists and addiction counselors (Hogan, 2005; Hogan & Rengett, 2008; Juhnke, Vacc, Curtis, Coll, & Paredes, 2003)
2. depression (children; Muller & Erford, 2012; Erford et al., 2011)
3. oppositional defiant disorder (Erford, Paul, Oncken, Kress, & Erford, 2014)
4. posttraumatic stress disorder for children and adults (Elhai, Gray, Kashdan, & Franklin, 2005)
5. substance instruments used by addiction counselors (Juhnke et al., 2003)

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

Peterson et al. (2014) surveyed 5,000 nationally certified counselors regarding the frequency of instrument use from a list of 174 instruments found within four textbooks. Of the surveys sent, 926

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

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

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

Many of these instruments are choices on different NCHMCE scenarios.

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

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

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

A rule out/in question may request selecting appropriate instruments that will gain additional information or validate the provisional diagnosis being considered after completion of the data

gathering question. It is likely to know the acronyms for different instruments may be helpful, as several instruments are identified by a disorder or the author, such as the Beck Depression II (BDI).

Diagnostic assessment is a detailed evaluation of an individual's strengths and weaknesses in several areas, including cognitive, affective, emotional, social functioning and behavioral. This type of assessment is to determine a level or degree of functioning or disorder. Decisions based on assessment should not be viewed as definitive and should be revised with new information or validated through other sources (Sattler, 2008). Instruments identified as screeners or diagnostic would be selected for a section of the NCMHCE where additional information is sought to validate or invalidate the data derived during the interview. It would be helpful to be aware of instruments that assess DSM-5 disorders. McHugh and Behar (2009) reviewed the readability of 105 instruments that included depression (14) and anxiety (91). The ninety-one instruments included GAD, panic and agoraphobia, specific phobia, social phobia, OCD, and PTSD.

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

The order of instrument importance in preparation for the NCMHCE is as follows:

1. First, those instruments that have been surveyed in the general population care centers and articles published in the literature. These survey reports will be fewer than found in classroom assessment textbooks.
2. Where surveys are not located in journal research for the frequency of use then those instruments with higher citations in the literature would be the second choice for knowledge acquisition. An example of citation frequency for acute stress disorder would include:

    Acute Stress Disorder (23 times)
    Clinician-Administered PTSD Scale (13)
    Acute Stress Disorder Interview (8)
    Beck Depression Inventory II (8)
    Impact of Event Scale (7)
    Glasgow Coma Scale (6)

3. Several instruments identified for specific disorders are located in the second-half of this supplement, unit 2. The exception will be those instruments listed from published research articles for the frequency of use. The listing in each disorder category from top to bottom has little significance to the frequency of use. Rather each instrument was identified from research articles published in professional journals in pre-post treatment studies. The order of the instruments on the list does not identify the most frequently used.

The order of these instruments in the Arthur supplement is not to suggest they are the best. These instruments and inventories are those likely to be used in the practice of screening, monitoring and supporting a diagnosis. No attempt is made to provide detailed information regarding validity,

reliability, norms and technical data. Rather, the focus is on identifying the purpose of the instrument, population served (children/adults) and scaled measured. For some instruments, additional information may be provided.

Although the following reported surveys are dated (1988 and 1989), the instruments were ranked according to the frequency of use in mental health centers (mhc), by counseling psychologists (cp), and for adolescents (a). It is recommended in preparing for the NCMHCE to become familiar with the instrument purpose, scales and appropriate for different population ages. The letters and digits following each instrument represents the ranking for mental health centers, psychologists, and adolescents.

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

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

DSM-5 Rating Scales:

The DSM-IV-TR was developed using a categorical approach; however, the DSM-5 added a dimensional approach to the measurement of distress, disability and severity (APA, 2013). Dimensional assessment measures for the frequency, duration, and severity of symptoms. The categorical approach was nominal in that the disorder was present or not present (met the full criteria). Three assessment issues in diagnosing were noted to be comorbidity, boundary issues, and an excessive use of not otherwise specified (NOS). Carpenter (2014) discussed boundary issues existing between schizophrenia and bipolar disorders, mood disorders and psychotic features, and anxiety disorders and neurodevelopment disorders. Added to the DSM-5 were pre-interview rating scales (APA, 2013; Jones, 2012).

The three rating measures are the 1) DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure — Adult, Parent/Guardian-Rated 2) DSM-5 Level 1 Cross-Cutting Symptom Measure — Child Ages 6-17, and 3) Clinician-Rated Dimensions of Psychosis Symptom Severity (APA, 2013; Jones, 2012). The

Clinician-Rated Dimensions of Psychosis Symptom Severity is included when cognitive symptoms are present that are suggestive of psychotic disorders. This rating scale has identified eight domains (hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression, mania) scaled on a 5-point (0-4) ordinal scale (APA, 2013). A final measure is the World Health Organization Disability Assessment Schedule 2.0 (WHODAS-2).

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

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

Instruments:

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

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

This self-rating is recommended for a pre-interview. The rating scale consists of 23 questions that assess for 13 domains including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance abuse (APA, 2013, p. 735). Each client response is rated on a 5-point ordinal scale (0-4), and each succeeding point is labeled as none, slight, less than a day or two, mild, moderate, and severe (every day). The client responds to how often and how much he/she was bothered by each problem during the past two weeks. The point values are summed for each of the 13 domains and identified as none, slight, mild, moderate, and severe. If a designation reaches mild or greater, the interviewer focuses the interview toward those domains and considers whether a Level 2 instrument is to be administered.

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

This pre-interview measure consists of 25 questions that assess for 12 domains including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, inattention, repetitive thoughts and behaviors, irritability, and substance abuse (APA, 2013, p. 736). Each client response is rated on a 5-point ordinal scale (0-4), and each succeeding point is labeled as none (0)-not at all, slight (1)-less than a day, (2), mild-several days, (3), moderate-more than half the days, and (4), severe-nearly every day .

Clinician-Rated Dimensions of Psychosis Symptom Severity

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

Neuropsychology II (NEPSY-II)

Purpose, Use, and Age:

The Neuropsychological II (NEPSY-II,) second edition, is used to assess neuropsychological development in preschool and school-age children, ages 3-16. It is useful for aiding in diagnoses and intervention planning for particular disorders including ADHD and LD (Kemp, Korkman & Kirk, 2000). The NEPSY-II is useful for general assessment, diagnostic assessment, selective assessment and a full assessment in a neuropsychological examination.

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

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

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

Bender Gestalt II (Bender Visual-Motor Gestalt Test)

Purpose, use, and age:

The Bender-Gestalt Visual-Motor Gestalt Test measures visual-motor integration skills in children and adults ages 4 to 85 (Branningan & Decker, 2003). The instrument is used in the educational,

psychological and neuropsychological assessment. The Bender Gestalt II is a clinical tool for measuring visual motor behavior.

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

Scoring:

There are several methods to score the Bender-Gestalt II such as the Pascal-Sutell, Hain, Koppitz Developmental, Brannigan and Brunner, Hutt Adaptation (Brannigan & Decker, 2003) and Canter's Background Interference (Canter, 1996).

Interpretation:

The majority of interpretations are directed at organic brain pathology.

Minnesota Multiphasic Personality Inventory-2

Purpose, use, and age:

Psychopathology and normal/abnormal function (18 years and older)

Validity Scales:

Include lie, infrequency, and correction.

Clinical Scales:

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

Minnesota Multiphasic Personality Inventory-Adolescent

Purpose, use, and age:

The MMPI-A is recommended for adolescents ages 14-18. Original research in behavior with the MMPI-A was conducted with borderline, depressed mood, eating disorders, homicidal behavior, manifest aggression, victimization by incest and sexual abuse, sleeping problems, physical disabilities, and schizophrenia. The MMPI-A has been researched in psychiatric settings, medical problems, alcohol, and drug treatment centers and correctional, juvenile programs (Butcher & Williams, 1992).

Clinical Scales:

Hypochondriasis (Hs)

Depression (D)

Hysteria (Hy)

Psychopathic Deviate (Pd)

Masculinity-Femininity (MF)

Paranoia (Pa)

Psychasthenia (Pt)

Schizophrenia (Sc)

Hypomania (Ha)

Social Introversion (Si)

Millon Clinical Multiaxial Inventory (MCMII-III)

Purpose, use, and age:

The MCMII-III provides support for the opinions of mental health professionals in clinical counseling, medical, forensic, and other settings. It was designed to measure personality traits and psychopathology and used for clinical decision making. There are 24 clinical scales clustered into four groups: personality scales, severe personality scales, clinical syndrome scales, and severe clinical scales. The MAPI is an adolescent and counseling inventory and recommended for age range 9-12; the pre-adolescent inventory (M-PACI), and the adolescent inventory (MACI) for age range 13-19 are additional forms.

Clinical Scales:

Anxiety, Somatic Symptom, Bipolar, Manic, Dysthymia, Alcohol Dependence, Drug Dependence, Posttraumatic stress disorder, Thought Disorder (Schizophrenia, Schizophreniform), Major Depression, and Delusional Disorder.

Personality:

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

Severe:

Schizotypal, Borderline, and Paranoid.

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

Positive Affect and Negative Affect Scales (PANAS Scales)

The PANAS is considered a mood questionnaire. The characteristics of positive affect (PA) are high energy, enthusiasm, and full concentration, active and alert. Negative affect symptoms may be distress in the form of anger, contempt, disgust, guilt, fear, and nervousness, as well as possibly a lack of coping skills (Crawford & Henry, 2004; Watson et al., 1988). The PANAS-X is the 60-item expanded version. The norms include adults and psychiatric population (Watson & Clark, 1994).

Clinician-Administered PTSD Scale (CAPS)

The CAPS is considered one of two instruments most commonly used for assessing PTSD diagnostic accuracy (Blake et al., 1995; Blake et al., 1990). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) is considered the gold standard (Weathers, Litz, Herman, Huska, & Keane, 1993). The CAPS assess for 20 DSM-5 PTSD symptoms. The items focus attention on the onset and duration of symptoms, subjective distress, and impact of symptoms on social and occupational functioning.

PTSD Checklist (PCL)

The PCL is the self-report checklist of 17 items measuring for symptoms in Criteria B, C, and D. There are three versions of the PCL: PCL-M (military), PCL-C (civilians), and PCL-S (specific). A critical review of the PCL was conducted by McDonald and Calhoun (2010) and Boal, Vaughan, Sims, & Miles, 2017), who found the PCL to be the most frequently used self-report. The self-report items are to be responded for the past month and on an ordinal scale of 1 (not at all) to 5 (extremely bothersome). Also, Bovin et al. (2016) reported psychometric properties for the PCL-5 establishing strong internal consistency, convergent and discriminant validity.

Beck Depression II (BDI-II)

Purpose, use, and age:

The BDI-II (Beck, Steer, & Brown, 1996 a; Erford, Johnson, & Bardoshi, 2016) is a 21-item self-report inventory that measures the severity of depression in adults and adolescents (13 and older). The inventory is composed of symptoms intended to assess the criteria for diagnosing depressive disorders. It is not an instrument strictly for diagnosing clinical depression; rather, according to the authors, it can be used for assisting in diagnosing disorders from panic disorder to schizophrenia.

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

Interpretation:

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

Wechsler Intelligence Scale for Children-Fifth Edition

The WISC is one of the most frequently used intelligence tests for children. There are 16 subtests, five first-order factors regarding verbal comprehension, visual-spatial, fluid reasoning, working memory and processing speed. Subtests include similarities, vocabulary, information, comprehension, block design, visual puzzles, matrix reasoning, figure weights, picture concepts, arithmetic, digit span, picture span, letter-number sequencing, coding, and symbol search (Canivez, Watkins, & Dombrowski, 2016).

Beck Anxiety Inventory (BAI)

The BAI is a 21-item self-report inventory designed to identify the symptoms of client anxiety. The items assess for cognitive and somatic characteristics (breathing difficulties, heart pounding, physiological symptoms) for the past month. Scores of 22 to 35 indicate moderate anxiety and scores above 36 indicate severe anxiety (Dozois, Dobson, & Ahnbert, 1998; Eack, Singer, & Greeno, 2008; Erford & Lutz, 2015).

Beck Hopelessness Scale (BHS)

The Beck Hopelessness Scale (BHS) is a 20-item self-report scale with three factors (affective, motivational, and cognitive). Boduszek and Dhingra (2016) found the BHS's three factors were associated with suicide-related constructs such as goal disengagement, brooding rumination, suicide ideation, and suicide attempts.

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

Purpose, use, and age:

The SCL-90-R measures change in outcome studies and screens for mental disorders and integrate data into the interview. Schmitz et al. (2000) indicated the SCL-90 is a widely-used symptom inventory. The SCL-R-90 has been researched with clinical trials. Norms are available for adult psychiatric outpatients, adult non-clients, adult psychiatric inpatients, and adolescent non-clients (age range 13-19). Frequently the client has provided stimuli of distress (why in counseling), unsure why they are there, and indicates a desire to free the self of the burden. The SCL-90-R elicits information regarding psychological distress and psychopathology. Caseness is based on the number of symptoms endorsed by the respondent. There is a shorter 67-item version of the SCL-90-R that has some advantages over the 90 -item SCL-90-R (Arrindell et al., 2017; Grande, Newmeyer, Underwood, & Williams, 2014).

SCL-90-R Scales:

Somatization (SOM)

Obsessive-Compulsive (O-C)

Interpersonal Sensitivity (I-S)

Depression (DEP)

Anxiety (ANX)

Hostility (HOS)

Phobic anxiety (PHOB)

Paranoid Ideation (PAR)

Psychoticism (PSY)

Global Severity Index (GSI)

Positive Symptom Distress Index (PSDI)

Positive Symptom Total (PST)

Interpretation:

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

Populations studied with the SCL-90-R:

Eating Disorders—(bulimic), psychopharmacology outcome-sensitive to drug vs. placebo anxiety and depressive disorders, stress, suicidal behavior, somatization, interpersonal sensitivity, paranoid ideation, and psychoticism, sleep disorders, drug and alcohol abuse, physical and sexual abuse, and sexual dysfunction.

Substance Abuse Subtle Screening Inventory (SASSI-4)

Purpose, use, and age:

The SASSI-4 is a structured self-report and screens for substance dependent disorder, ages 12-18 and adults. The SASSI-4 assesses for DSM-5 severity indicators mild, moderate, and severe for substance use disorder. Also, a new scale Rx measures for medication prescription likely being abused (Lazowski & Geary, 2016). The Adolescent SASSI-A2 (ages 12-18) is designed to provide a probability of substance use disorder. The SASSI-3 was the most widely and important used instrument by addiction counselors (Juhnke et al., 2003).

Scales:

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

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

The Structured Clinical Interview (SCID-I, SCID-II, and SCID-5PD)

Purpose, use, and age:

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

SCID-II was originally developed during the time of DSM-III-R and utilized for personality disorders, while the SCID-I was for clinical disorders such as those identified by the DSM-IV-TR. There is also a children's interview (DISC-2; Hodges, 1994). SCID-II has three components: an interview portion for 11 personality disorders, categories of depressive personality disorders, and passive-aggressive personality disorder. It can be used as a screening tool. The SCID-5PD includes five categories for the 10 Clusters A, B, and C personality disorders (First, Williams, Benjamin, & Spitzer, 2016).

Scales:

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

Bipolar Spectrum Diagnostic Scale (BSDS)

Purpose, use, and age:

Description: A narrative-based self-report developed by Dr. Pies and revised by Dr. Ghaemi in 2005. The results are designed to determine the presence or absence of bipolar disorder in individuals ages 5-17, and the Tri-Axial Bipolar Spectrum Screening Quiz is for individuals 18 and older. There are two separate parts. The first part is a story of positive statements in which the individual checks off whether or not he/she believes the statement is true for them. The second part of the instrument is a single multiple-choice question asking the individual to rate how well the story represents them overall (Ghaemi, Boiman, & Goodwin, 2000).

Mood Disorder Questionnaire (MDQ)-SCREENING

Purpose, use, and age:

Description: The MDQ is a single report. It is easy to use as a screening tool for the detection of bipolar I disorder. Hirschfeld et al. (2000) developed the MDQ. The MDQ has three questions, each of which is subdivided into additional questions, such as 13 for the first question. The authors indicate the MDQ is not used for monitoring for improvement. The signs and symptoms of bipolar disorder

include depressed, hyperactive, insomnia, mood swings, anxious, irritable, delusional/paranoid, low energy/fatigue, unable to focus, alcohol/substance abuse, legal problems, impulse-control problems, and no complaints. The clinician should inquire about past episodes of mania, hypomania, and mood swings. The MDQ can be administered to individuals from age 12 through adults. There is a parent version for bipolar I.

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

Purpose, use, and age:

Doctors and counselors, to determine if adults and adolescents are reflecting symptoms of an addict, often use the DAST. The DAST-10 (condensed from the DAST-20) and DAST-20 are screening tools for adults and adolescents involved with drugs (Skinner, 1982). The DAST-20 is specifically for the adult (Stevens & Smith, 2009). The SMAST attempts to identify individuals with drinking problems. The DAST has 28 items requiring the respondent to answer yes or no. A score of 5 or less indicates a normal score, while 6 or higher indicates a drug problem.

The Cage Questionnaire

Purpose, use, and age:

The CAGE was originally designed for adults and is used to screen for alcoholism during the intake interview. There are four questions: C for cutting down on alcohol intake, A for annoyance over criticism about alcohol, G for guilt about drinking behavior, and E for drinking in the morning to relieve withdrawal anxiety. Answering yes to two or three questions is considered a high alcohol suspicion Index (Ewing, 1984).

The Dissociative Experiences Scales (DES-D)

Purpose, use, and age:

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

Instruments for Children and Adolescents

NIMH Diagnostic Interview Schedule for Children (DISC):

Purpose, use, and age:

The NIMH DISC-IV assesses more than 30 psychiatric disorders. The age range is 9 to 17-year -old children and adolescents. The duration is the past 12 months and past four weeks. Administration time is approximately 70 minutes. Computer-assisted versions are available in English and Spanish (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000).

Stanford-Binet Intelligence Scale, 5th edition

Purpose, use, and age:

The Stanford-Binet age range spans 2 to 85+. The scales include fluid reasoning, knowledge, quantitative reasoning, visual/spatial reasoning, working memory and overall verbal, nonverbal and total intelligence quotient.

The Wechsler Intelligence Children Scales-5th ed., WISC-IV and WPPSI-III

Purpose, use, and age:

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

Depression

Muller and Erford (2012), identified through research the six most widely utilized depression instruments for school-aged children. The top-ranking instruments include:

1. Children's Depression Inventory (CDI; Kovacs, 2003)
2. Beck Depression II (BDI; Beck et al., 1996a, b)
3. Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960; Hamilton & Kobak, 1995)
4. Child Behavior Checklist Internalizing Scale and Anxious Depressed Subscale (CBCL-M-I; Achenbach, 1992; Achenbach & Rescoria, 2001)
5. Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977)
6. Reynolds Depression Scale-Second Edition (RADS-2; Reynolds, 2002)

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

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

Children's Depression Inventory (CDI 2)

Purpose, use, and age:

There are four versions of the CDI: a short form of 10 items, a teacher version of 12 items, a parent form of 17 items, and the original form of 27 items. The self-report form is designed for ages 7-17 and is translated into 23 languages (Kovacs, 2003). Scott, Clapp, Mileviciute, and Mousseau (2016) reported that the CDI is not only valid for White/Non-Hispanic youth but also for American Indian and Alaskan Native youth. The CDI can be used to assess and measure cognitive, affect, and behavioral depressive symptoms.

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

Revised Children's Manifest Anxiety Scale (RCMAS-2)

Purpose, use, and age:

The RCMAS-2 is a questionnaire and one of the most widely used in anxiety research. This questionnaire is used to assess the level and nature of anxiety in children ages 6 to 9. The major scales are worry, defensiveness, physiological anxiety and social anxiety (Reynolds & Richmond, 2008).

Achenbach System of Empirically Based Assessment (ASEBA)

Purpose, use, and age:

The ASEBA assesses behavioral and emotional disorders in children (ages 1.5 to 18), school age (6 to 18), and adults to age 90 (Achenbach & Rescoria, 2001). The scales on the ASEBA have been translated into 61 different languages. Factors assessed are withdrawn/depressed, somatic complaints,

anxious/depressed, social problems, attention problems, rule-breaking behavior, and aggressive behavior. Internalizing and externalizing scales are the two broad scales. Subscales include attention-deficit/hyperactivity problems, anxiety problems, oppositional defiant problems, affective problems, conduct problems, and somatic problems (Erford, 2013). Specific scales measured are competence and adaptive behaviors, including activities that are academic, social, work and school behaving. Empirically–based scales are anxious/depressed, withdrawn/depressed, somatic complaints, social problem, and thought problems. Rule-breaking behavior includes aggressive behavior, internalizing, externalizing and total problems. DSM-oriented scales are affective, anxiety, somatic and ADH, including oppositional defiant and conduct problems.

The Center for Epidemiologic Studies Depression (CES-D)

The Center for Epidemiologic Studies Depression (CES-D) is a 20-item self-report (Gonzalez et al., 2017). Major components assessed include depressed mood, feelings of guilt, hopelessness, loss of appetite, and sleep disturbance. There is also a shorter version the CES-D 10 to screen elderly. The CES-D is useful for diverse populations (Spanish translation for Hispanic/Latinos, Central American, Cuban, Dominican, Mexican, and South America). Muller and Erford (2012) conducted a frequency survey, and the CES-D was the fifth most frequently used instrument to assess for childhood depression.

Behavior Rating Inventory of Executive Function (BRIEF)

Purpose, use, and age:

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

Behavior Assessment System for Children, Third Edition (BASC-3)

Purpose, use, and age:

The BASC-3 can be used to evaluate the behavior and self-perceptions of children ages 2:0 to 21:11 and 6:0 through college age. There are two self-report scales, one for teachers and one for parents, a self-report scale (personality), structured developmental history and a form for recording classroom behavior (Reynolds & Kamphaus, 1992, 2004, 2015).

Burk's Behavior Rating Scale-Revised (BBRS)

Purpose, use, and age:

The purpose of the BHRS-2 is to diagnose children and adolescents (age range 4-18) with behavior problems. The BHRS scales include disruptive and emotional scales, social withdrawal, ability deficits, physical deficits, self-confidence, and attention and self-control problems. Parent and teacher forms are available (Burk, 1986; McCloskey, 2008).

Conners 3 (Parent, Teacher and Adolescent forms)

Purpose, use, and age:

Teachers and counselors use the Revised Conners Parent and Teacher Rating Scales (CPSR and CTRS-R; Conners, Sitarenios, Parker, & Epstein, 1998). The 2008 Conners 3 is in current use and has three versions: parent, teacher and adolescent self-report. Each version has a short and long form. There are three screening tools available, composed of a 12-item ADHD Index. Pediatricians in their practice frequently use the Conner forms.

The purpose of the Conners 3 is to screen and assess behavior problems. It is a clinical tool for obtaining parental, teacher and adolescent reports of childhood behavior problems. The content areas for the Conners 3rd edition include the following scales:

1. inattention, hyperactivity/impulsivity, learning problems/executive functioning, aggression, and peer relations
2. symptom scales including ADHD Inattentive, ADHD Hyperactive-Impulsive, ADHD Combined, Conduct Disorder, Oppositional Defiant Disorder)
3. screener items (anxiety, depression)
4. severe critical items (uses a weapon, cruel to animals, confrontation stealing, forced sex, fire setting, trouble with the police, breaking and entering)

The parent form contains 108 items, while the teacher form includes 113 items. These forms are typically used for parents, caregivers, and teachers when comprehensive information is needed. The CPRSR and CTRSR are often used in combination to provide observations of the child within the home environment and the school.

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

Factors:

Attention deficit hyperactive disorder (ADHD) and late disorders.

Reynolds Adolescent Depression Scale (RADS-2)

Purpose, use, and age:

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

Center for Epidemiologic Studies Depression Scale (CES-D)

Purpose, use, and age:

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

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

Purpose, use, and age:

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

Child Behavior Checklist (CBCL)

The CBCL consists of subscales for symptoms of withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behaviors, and aggressive behaviors. The eight subscale scores can be summed to represent the child behavior check list dysregulation profile (CBCL-DP (Kweon et al., 2016).

Child Behavior Questionnaire (CBQ)

The CBQ is considered the most widely used questionnaire for children ages 3 to 7. The questionnaire contains 195 items measuring 16 facets of temperament. The facets include activity level, anger/frustration, attentional focusing, attentional shifting, discomfort, falling reactivity, fear, intensity pleasure, perceptual sensitivity, positive anticipation/approach, sadness, shyness and smiling /laughter (Clark, Listro, Lo, Dollellan, & Durbin, 2016).

Parents are asked to report on their child's temperament. The effortful control dimension includes traits of attentional focusing, inhibitory control, low-intensity pleasure, and perceptual sensitivity. Negative affectivity includes anger/frustration, discomfort, sadness, fear, and soothability. Surgency includes smiling and laughter, high-intensity pleasure, impulsivity, shyness, and positive anticipation (Rothbart, 2011; Rothbart, Ahadi, Hershey, & Fisher, 2001).

Instruments: Disorders (Selected)

Oppositional Defiant Disorder

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

Substance Use Disorder

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

Posttraumatic Stress Disorder

Elhai et al. (2005) reviewed 102 inventories (81 adult, 21 child/adolescents) and reported that the four most widely used for clinical use include:

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

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

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

The DAP is a 104-item measure that assesses for trauma exposure and posttraumatic stress. The symptoms measured are for the intrusion, avoidance, and hyperarousal and associated features.

4. Combat Exposure Scale (CES, Keane et al., 1989)

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

Children:

Trauma Symptom Checklist for Children (TSCC) was the most popular and commonly utilized for children.

Suicide and Non-Suicide-Self Injury:

Hom, Stanley, and Joiner (2016) conducted a web-based online suicide and suicide-related symptoms for disclosing information for compensation study. The authors identified some instruments that cut across several of the risk factors associated with suicide and suicide self-injurious acts. Key factors and instruments include suicide capability, the involvement of alcohol, depressive severity symptoms, emotion regulation, suicidal symptoms, fearlessness of death, attitudes toward individuals who die by suicide, exposure to painful and provocative experiences, lifetime and past year suicidal ideation, stigma barriers for care, thwarted belongingness, and burdensomeness. The instruments identified as screeners by Hom et al. (2016) to assess for several of the risk factors include:

1. Acquired Capability for Suicide Scale: The Acquired Capability for Suicide Scale (ACSS; Ribeiro et al., 2014) is a 7-item self-report scale that assesses an individual's perceived fearlessness about death.
2. Alcohol Use Disorders Identification Test (AUDIT–C; Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998) is a 3-item self-report questionnaire used to screen for an alcohol use disorder,
3. Center for Epidemiologic Studies Depression Scale is a 20-item self-report depression scale (CES–D; Lewinsohn, Seeley, Roberts, & Allen, 1997) is designed to assess depression symptom severity.
4. The Depressive Symptom Inventory–Suicidality Subscale (DSI-SS; Joiner, Pfaff, & Acres, 2002) is a 4-item self-report assessment of suicidal symptoms.
5. The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) is a 36-item self-report measure designed to assess emotion regulation difficulties across six distinct domains.
6. The Stigma of Suicide Scale–Short Form (SOSS–SF; Batterham, Calear, & Christensen, 2013) is a 16-item self-report measure used to assess attitudes toward individuals who die by suicide.
7. The Painful and Provocative Events Scale (PPES; Bender, Gordon, Bresin, & Joiner, 2011) is a 26-item self-report scale designed to assess the frequency with which an individual was exposed to a range of painful and provocative experiences (e.g., physical abuse, car accidents, injuries requiring medical attention).

8. The Suicidal Behaviors Questionnaire–Revised (SBQ–R; Osman et al., 2001) is a 4-item self-report measure of lifetime and past-year suicidal ideation and future likelihood of suicidal behavior.
9. The Perceived Stigma and Barriers to Care for Psychological Problems Scale (PSS; Britt et al., 2008) is an 11-item self-report assessment used to investigate the degree to which various structural and stigma barriers for physical and psychological care might prevent an individual from seeking mental health treatment.
10. The Self-Injurious Thoughts and Behaviors Interview–Short Form (SITBI-SF) is a 72-item interview assessment used to capture information regarding the nature and timing of past and current suicidal ideation and behaviors as well as NSSI (Nock, Holmberg, Photos, & Michel, 2007).
11. The Interpersonal Needs Questionnaire (INQ) is a 15-item self-report measure of thwarted belongingness (INQ–TB; 7 items) and perceived burdensomeness (INQ–PB; 8 items; Van Orden, Cukrowicz, Witte, & Joiner, 2012).

Instruments (Suicide Self-Harm Injury or nonsuicidal self-injury):

1. Deliberate Self-Harm Inventory (DSHI; Gratz, 2001)
2. Self-Harm Inventory (SHI; Sansone, Wiederman & Sansone, 1998)
3. Self-Injurious Thoughts and Behaviors Interview (Nock, Holmberg, Photos, & Michels, 2007)
4. Attitudinal Familism Scale (AFS; Steidel & Contreras, 2003)

Differential Diagnosis

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

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

The diagnosis is based on accumulated symptoms derived from the interview, assessment instruments (tests), collateral services and environmental factors. Once a list is determined, it is narrowed down, and the process is referred to as a differential diagnosis. The interviewer begins the process of either confirming or ruling out (r/o) the disorders. A referral for additional data to correctly consider or rule out a diagnosis may be the next step since it is possible this diagnosis may not be the correct one.

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

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

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

Mood and Affect: Both depressed and demented clients can exhibit behaviors that typify depression. Dementia clients often look like they are depressed although they can also exhibit emotional lability (Kixmiller, 1991). Those who are severely depressed usually do not experience wide mood fluctuations.

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

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

Disorder, Comorbidity, Treatment Planning, Monitoring, and Instrumentation

It is important to have some basic preliminary information about techniques or treatment approaches recognized to be helpful for the assigned diagnosis. Be knowledgeable about the ethics and the use of particular techniques or treatment approaches (C.7.a). Informed procedures and client rights are central to the implementation of any treatment under the ACA Code of Ethics. Treatment questions are frequently about therapies, alternative treatments, techniques, and strategies known to be effective for many of the diagnostic disorders.

The recommendations for treatment and instrumentations have been compiled from research articles and the work of Seligman and Reichenberg (2012). The preferred treatments or treatments of choice are usually listed first, followed by other treatments found in the literature for that disorder.

Instruments listed are for assessment purposes, and occasionally one will be cited for monitoring. The treatment and instrumentation list is not comprehensive for the many disorders. At the conclusion of the treatment and instrumentation section is a brief definition of different therapies and acronyms.

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

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

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

1. Neurodevelopmental Disorders

Disorder: Intellectual Disability

Comorbidity:

ADHD, depressive and bipolar disorders, anxiety disorders, autism spectrum, stereotypic movement disorders, impulse-control disorders, and major neurocognitive disorders (APA, 2013, p. 40).

Differential:

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

Instrumentation:

Wechsler Intelligence Test and Stanford-Binet Intelligence Scales

Treatment:

1. Behavior modification is treatment of choice (for self-injury), parent training, and community-based treatment and individual psychotherapy
2. CBT and Behavior-Analytic (Parent, Birtwell, Lambright, & DuBart, 2016; for severe emotion dysregulation with Autism Spectrum Disorder)

Disorder: Autism Spectrum Disorder

Autism begins in early infancy with deficits in reciprocal social interaction, communication, and restricted and repetitive behaviors (Lord et al., 2006). Autism diagnosed at age two appears to remain stable through 9 years of age. Four disorders were combined in the DSM-5 to form autism spectrum (autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder). The three factors of qualitative impairments in communication, social interaction, and restrictive and stereotyped patterns of behavior (DSM-IV-TR) were combined into two factors, deficits in social communication and social interaction and restrictive, repetitive behaviors (King, 2013b, c).

Comorbidity:

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

Differential Diagnosis:

Rett Syndrome, selective mutism, language disorders and social communication disorder, intellectual disability without autism spectrum disorder, stereotypic movement disorder, ADHD, schizophrenia (APA, 2013, pp. 57-58)

Instrumentation:

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

Treatment:

1. Cognitive-behavioral therapy for anxious youths with ASD revealed promising effects (Storch et al., 2015)
2. Intensive behavior treatment (IBT; Odom, Hume, Boyd, & Stabel, 2012)
3. Snug Vest (Watkins & Sparling, 2014)
4. behavioral treatment (no single best behavioral treatment) is currently found in the literature)
5. floor technique
6. Pervasive Development Pivotal Response Training (PRI), response interruption and redirection (RIRD), differential reinforcement of other behavior (DRO; Ahearn, Clark, MacDonald, & Chung, 2007)

Parent et al. (2016) recommended a combination of CBT and behavior-analytic approaches for severe emotional dysregulation for ASD and ID. The combined treatment guides include the coping cat model and Think Good Feel Good.

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

Well-established

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

Possibly efficacious

None

Probable efficacious

Focused Parent Training (FPT): FPT is a caregiver-based intervention. A special childcare worker is assigned and the intervention is two years in which 15-hours of training are scheduled over 12-weeks focusing on communication development. The focus is compliance, mutual enjoyment, joint attention and language (Jocelyn, Casiro, Beattie, Cox, & Kneisz, 1998).

Relationship Development Intervention (RDI): Parent-training intervention (PTI): Home-based, parent-delivered developmental, and social communication intervention (Drew et al., 2002)

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

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

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

Disorder: Attention Deficit Hyperactive Disorder

Comorbidity:

Oppositional defiant disorder, conduct disorder, disruptive mood dysregulation disorder, specific learning disorder, anxiety disorders, major depressive disorder, intermittent explosive disorder (ACA, 2013, p. 65).

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

Differential Diagnosis:

Oppositional defiant disorder, intermittent explosive disorder, other neurodevelopment disorder, specific learning disorders, autism spectrum disorder, reactive attachment disorder, anxiety disorders, depressive disorders, bipolar disorder, disruptive mood dysregulation disorder (APA, 2013, pp. 63-64).

Instrumentation:

1. Achenbach Child Behavior Checklist is most commonly used (Erford et al., 2012)
2. Behavior Assessment System for Children, 2nd edition,
3. Conners Rating Scale-Revised and Conners Teacher Rating Scales-Revise
4. Individual Intelligence Instruments such as the Weschler or Binet scales

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)
7. Betchen (2003) recommended for adult ADHD treatment to include education, attention management training, behavioral management training, social skills training, anger management training, and problem-solving training.
8. Structured dyadic behavior therapy and Parent Management Therapy (PMT) are often combined to set goals, benchmark, and redirect behaviors (Curtis, 2014).
9. Stimulant medications

Jarrett (2016) reported that clients with diagnosed ADHD that inattention followed by hyperactivity/ impulsivity anxieties reflected a deficit in self-regulation of emotion and self-organization and problem-solving.

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

Techniques/Interventions:

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

Disorder: Tic Disorder

Assessment:

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

Comorbidity:

Medical and psychiatric conditions, ADHD, OCD

Differential Diagnosis:

Obsessive-Compulsive Disorder (OCD)

Instrumentation:

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

Treatment:

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

2. Schizophrenia Spectrum and Other Psychotic Disorders

Disorder: Brief Psychotic Disorder

Assessment:

One or more of delusions, hallucinations, and disorganized speech of 4 symptoms (delusions, hallucinations, disorganized speech, and grossly disorganized). An episode is to last at least one day but less than one month (APA, 2013, p. 94)

Comorbidity:

Schizophreniform and brief psychotic disorder share many symptoms and may resemble schizophrenia and delusional disorder. The brief psychotic disorder is considered rare; however, usually begins in adolescence (Sadock & Sadock, 2000, 2007).

Differential Diagnosis:

Other medical conditions, substance-induced psychotic disorder, depressive and bipolar disorders, personality disorders, Substance-related disorders, depressive and bipolar disorders, other psychotic disorders (APA, 2013, p. 96)

Instruments:

1. Brief Cognitive Assessment (BAC; Velligan et al., 2004)
2. Positive and Negative Syndrome Scale (PANSS; Kay, Fizben & Opler, 1987)

   The PANSS included two forms, an 18-item and 30-item models and were developed for use in schizophrenia, bipolar, and schizoaffective disorders (Anderson et al., 2017). Negative scales include blunted affect, emotional withdrawal, poor rapport, passive, apathetic social withdrawal, lack of spontaneity and flow of conversation, motor retardation, active social avoidance, and disturbance of volition. Positive scales include delusions, hallucinatory behavior, grandiosity, suspiciousness persecution, unusual thought content, and preoccupation.
3. Structured Interview for Psychotic Symptoms (SIPS; Miller et al., 1999)

Treatment:

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

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 et al., 2012) to reduce the severity of symptoms.

Techniques (symptoms-techniques):

1. sleep dysregulation
2. medication,
3. sleep chart,
4. psychoeducation
5. problem-solving skills
6. nutrient-based therapies (poor eating)
7. psychoeducation
8. social skills training

Disorder: Schizophrenia

Comorbidity:

Substance-related disorders, tobacco use disorder, anxiety disorders, and panic disorder, Schizotypical (APA, 2013, p. 103)

Differential Diagnosis:

Major depressive or bipolar disorder with psychotic features, schizoaffective disorder, brief psychotic disorder, delusional disorder, schizotypal personality disorder, OCD, body dysmorphic disorder, PTSD (APA, 2013, pp. 103-105)

Instrumentation:

1. Brief Cognitive Assessment (BCA; Keefe et al., 2004)
2. Independent Living Skills Survey (ILSS; Wallace & Liberman, 1985; Wallace, Liberman, Tauber, & Wallace, 2000)
3. Maryland Assessment of Social Competence (MASC; Bellack & Meuser, 1993)
4. Positive and Negative Syndrome Scale (PANSS; Kay, Feizbein, & Opler, 1987)
5. Structured Interview for Psychotic Symptoms (SIPS; Miller et al., 1999)

Treatment:

1. Granholm, Holden, Link, McQuaid, and Jeste (2013) reported that cognitive behavioral and social skills training are effective treatments for schizophrenia.
2. psychiatric management, antipsychotic medication
3. social skills training
4. family therapy
5. individual counseling

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.

Disorder: Schizoaffective

Comorbidity:

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

Differential Diagnosis:

Psychotic disorder due to medical condition, schizophrenia, bipolar, depressive disorders, bipolar disorder with psychotic features (APA, 2013, p. 109)

Instrument:

Hare Psychopathy Checklist-Revised (HCL-R; Hare, 1991) is a 20-item measure that assesses for dangerousness. The HCL-R is extensively used in the Criminal Justice Field. The four factors include interpersonal, affective, lifestyle, and antisocial (Blais, Forth, & Hare, 2017).

Treatment:

1. Psychoeducation and medication management; therapy is to be concrete and supportive, building social skills; family-focused therapy (Miklowitz, 2004).

2. CBT-Turlington, Dudley, Warman, and Beck (2006) recommended cognitive-behavioral therapy for treatment. Group therapy is not recommended because of lack of social skills.
3. Antipsychotics appear to be effective for schizophrenia, schizoaffective disorder and mood disorders with psychotic features. The atypical agents have a reduced risk for neurologic side effects, and it has been noted for better patient compliance (Bender, 2008).

3. Bipolar and Related Disorders

Disorder: Bipolar I

Assessment:

Mania is the core criterion for bipolar disorder, a positive affective disturbance (APA, 2013, p. 132).

Comorbidity:

Anxiety disorders, panic attacks, social anxiety disorder, ADHD, disruptive disorder, impulse-control disorder, conduct disorder, intermittent explosive disorder, oppositional defiant disorder, substance use disorder (APA, 2013, p. 132)

Differential Diagnosis:

Major depressive disorder, other bipolar disorders, generalized anxiety disorder, panic disorder, posttraumatic stress disorder, substance/medication-induced bipolar disorder, ADHD (APA, 2013, p. 131)

Instrumentation:

A screening instrument is recommended during the assessment of bipolar disorder. It is important because the DSM-5 added bipolar, mixed feature specifier for depressed individuals. Zimmerman (2014) recommended four screeners to assess for a lifetime history of manic/hypomanic symptoms. Cutoff scores identify balance percentages in sensitivity and specificity. 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 of 14 yielded a sensitivity of 80% and specificity of 51%.
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 targets 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%. Wang et al. (2015) in a meta-analysis study found the accuracy rate to be relatively good but cautioned when applied to clients without a previous bipolar diagnosis the accuracy rate was reduced (Clark et al., 2015).

5. Stanton, Gruber, and Watson (2017) evaluated four measures of mania because affective mania disturbance inventories have disparities in length, scope, and content. The four self-reports included:

    Hypomanic Personality Scale

    Altman Self-Rating Mania Scale

    General Behavior Inventory

    Mood Disorder Questionnaire

The outcome of the study of these four self-reports revealed that emotional liability factor was the strongest relations between neuroticism and depressive symptoms and measure mood volatility.

Other instruments (primarily children):

1. Child's Depression Inventory (ages 7-17)
2. The Washington University Schedule for Affective Disorders and Schizophrenia for school-age children
3. Young Mania Rating Scale (YMRS) distinguishes between bipolar and other disorders
4. Structured Clinical Interview (SCID) can be used to validate
5. Treatment Attitudes Questionnaire (limited research, better for planning, and the Hypomania Checklist 32 (HCL-32)

Factors helpful for Bipolar Disorder treatment:

Leahy (2007) reported eight factors to be known about bipolar disorder including: (1) know signs (symptoms) of bipolar disorder, (2) high genetic predisposition, (3) psychological treatment involves treating episodes for maintenance treatment, (4) pharmacological treatment is essential, (5) psychoeducation component to treatment, (6) collaborative work between therapist and psychiatrist, (7) life events, coping skills, and family environment contribute to the expression of mania and depressive disorders, and (8) integrative cognitive behavioral model is helpful.

Popovic et al. (2013) conducted a polarity index for psychological interventions. The authors reported that CBT, family-focused therapy (FFT) and psychoeducation predominantly were effective for antidepressive symptoms and caregiver support for antimanic symptoms.

Grabski, Maczka, and Dudek (2007) recommended psychoeducation as a technique to address the goals for bipolar disorder. The goals include information about the disorder, encouraging lifestyle regularity, enhancing medication compliance, and early recognition and management of relapse symptoms.

Treatment:

1. psychopharmacology is the treatment of choice (Popovic et al., 2013; Scott et al., 2006; Sylvia, Peters, Deckersbach, & Nierenberg, 2013)
2. Family-Focus Therapy (FFT; Miklowitz & Chung', 2016)
3. CBT, interpersonal therapy
4. interpersonal and social rhythm therapy with medication
5. combination family focused and CBT
6. psychoeducation (included in family-focused therapy, interpersonal social rhythm theory, and CBT; Grabski et al., 2007)
7. medication first line
8. interpersonal social rhythm therapy (ISPRT; Frank, 1999, 2005, 2007; Nusslock, Young, & Damme, 2014; predisposition to circadian rhythm and sleep-wake cycle abnormalities for the onset of hypomanic/manic and depressive symptoms
9. group therapy during recovery
10. family focused therapy (Morris, Miklowitz, & Waxmonsky, 2007)
11. other treatment recommended—DBT has some support as does nutrient-based therapies (poor eating and nutritional habits and increased risk of obesity; Sylvia, Peters, Deckersbach, & Nierenberg, 2013). Goldstein et al. (2015) reported that DBT in a randomized trial found DBT in comparison to a treatment as usual (TAU), an eclective psychotherapy approach over a one-year period had less severe depressive symptoms and improvement in suicidal ideation. DBT shows promise.
12. DBT: Fischer and Peterson (2015) reported on the effectiveness of DBT for reducing adolescent binge eating, purging, suicidal behavior and non-suicidal self-injury.

Combination treatment:

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

Techniques/Interventions:

Cognitive Analytic Therapy techniques(CAT; Evans, Kellett, Heyland, Hall, & Majid, 2017)

1. psychoeducation regarding treatment adherence
2. stress management and substance abuse
3. attention training for self-regulation (Fergus & Bardeen, 2016)

Monitoring:

Monitoring is usually done using scales such as the Beck Depression Inventory-II, the Manic-State Rating Scale, the Goldberg Mania and Depression Scales, the Young Mania Rating Scale and the Altman Self-rating Mania Scale and daily self-reports.

Disorder: Bipolar II Disorder

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 (ISRT; Frank, 2007; Frank, 2005)
7. CBT (Scott et al., 2006)

Techniques (symptoms-techniques):

1. dysregulation
2. medication
3. sleep chart
4. psychoeducation
5. problem-solving skills
6. nutrient-based therapies (poor eating)

Disorder: Cyclothymic Disorder

Comorbidity:

Substance-related disorder, ADHD, and sleep disorders (children-ADHD; APA, 2013, p. 141)

Differential Diagnosis:

Bipolar and related disorder due to medical condition, depressive disorder, substance/medication-induced, bipolar disorder I, disorder with rapid cycling, bipolar II with rapid cycling (APA, 2013, p. 141)

Instrumentation:

Hypomanic Checklist (HCL32) has been used to differentiate between unipolar depression and depression with hypomania symptoms (Angst et al., 2005). Zimmerman (2014) recommended taking a prior history taking for hypomanic or manic episodes and screening with four self-report questionnaires. The four screeners include The Hypomanic Checklist (HCL-32), Bipolar Spectrum Diagnostic Scale (good for bipolar I but less so for bipolar II), Mood Swings Questionnaire, and Mood Disorders Questionnaire (lifetime of mania and hypomania).

Treatment:

Two years are required when experiencing numerous episodes of hypomania and mild to moderate depression (one year for children, two for adults). Treatments proven to be helpful are IPT,

FFT, regulating sleep, circadian rhythms, and social rhythm. Supplements may be career counseling and interpersonal skill development. Group counseling may be useful. First degree relatives of people with the cyclothymic disorder have increased incidences of bipolar disorders, childhood history of being hypersensitive, hyperactive, and moody. Children with parents who have bipolar disorders are more likely to exhibit cyclothymic disorder compared with other children. Little research exists to regulate sleep, circadian rhythms, and social rhythms; thus, interpersonal and social rhythm therapy (IPSRT), family-focused therapy (FFT), and cognitive-behavioral therapy are recommended.

4. Depressive Disorders

Disorder: Disruptive Mood Dysregulation (DMDD)

Comorbidity:

Mood symptoms, oppositional defiant disorder, and ADHD. If children meet symptoms of oppositional defiant disorder or intermittent explosive disorder or disruptive mood dysregulation, only the disorder of disruptive mood dysregulation is to be assigned (APA, 2013, p. 160)

Differential Diagnosis:

Bipolar disorder, oppositional defiant disorder, ADHD, major depressive disorder, anxiety disorders, autism spectrum disorder, intermittent explosive disorder (APA, 2013, pp. 158-159)

Instrumentation:

1. Disruptive Mood Dysregulation Disorder
2. Child Behavior Checklist Dysregulation profile (CBCL-DP (Achenbach, 1991a; Achenbach, 1992)

Treatment:

1. Disruptive Mood Dysregulation Disorder is new; however, treatment recommendations include medication and psychotherapy until treatment research is available.
2. Behavior therapies appear to be helpful for improving cognitive functioning (Chen, Wang, & Fang, 2016).

Disorder: Major Depressive Disorder

Comorbidity:

Substance-related disorders, panic disorder, OCD, anorexia nervosa, bulimia nervosa, borderline personality disorder (APA, 2013, p. 168)

Differential Diagnosis:

Manic episodes with irritable mood or mixed episodes, substance/medication-induced depressive or bipolar disorder, ADHD, adjustment disorder with depressed mood (APA, 2013, pp. 167-168)

Instrumentation:

1. Beck Depression II
2. Hamilton Rating Scale
3. SCID
4. Behavior Activation for Depression Scale (BADS) long and short form

The BADS short form consists of 9-items and two scales, activation and avoidance. The BADS long form consists of 25 items and four scales, activation, avoidance/rumination, work/school impairment, and social impairment (Fuhr, Hautzinger, Krisch, Berking & Ebert, 2016). The BADS-25 can be recommended for use in clinical and community samples.

Instrumentation: Children

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

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

Treatment (Children and Adolescents):

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

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

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

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

Treatment:

1. CBT (DeRubeis, & Crites-Christoph, 1998; Martell, Dimidjian, & Herman-Dunn, 2010; Sturney, 2009; Weissman et al., 2000)

2. Behavioral activation therapy (BAT; Martell et al., 2010; Mazzucchelli, Kane, & Rees, 2009; Read, Mazzucchelli & Kane, 2016; Sturmey, 2009)
3. Behavior therapy (Blieberg & Morowitz, 2008; DeRubeis & Crites-Christoph, 1998; Resick, Monson, & Rizvi, 2008; Sinha & Rush, 2006; Swartz. 2015)
4. Interpersonal therapy (IPT) three randomized effectiveness control studies; Greenberg, 2010), low level of social functioning, clients perform best with interpersonal psychotherapy (Seligman & Reichman, 2012)
5. Psychodynamic, interpersonal psychotherapy (NCIE, 2004)
6. Family-based (parent psychoeducation (Ale, Arnold, Whiteside, & Storch, 2014)
7. Emotion-focused therapy (EFT)
8. Relapse prevention

A promising treatment for the major depressive disorder is emotion regulation skills and a skills-based model of adaptive coping with emotions (ACE) that have been found to be an effective way of coping with negative emotions.

Weissman, Markowitz and Klerman (2000) reported that CBT produces more rapid changes in depression than other psychotherapy strategies. Interpersonal psychological therapy is reported to be an effective therapy for depression when interpersonal issues are a component of the symptoms.

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

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

Techniques/Interventions:

1. bibliotherapy
2. relaxation
3. mindful-based Stress Reduction (MBSR; Williams, Teasdale, Segal, & Kabat-Zinn, 2007)

4. emotion regulation (Radovsky et al., 2014)
5. exercise

Disorder: Persistent Depressive Disorder

Assessment:

Depressed for the most of 2 years, mood present most of the time depressed and 2 or more of 6 symptoms.

Comorbidity:

Anxiety disorders, generalized anxiety disorder, and substance use disorders (APA, 2013, p. 171).

Differential Diagnosis:

Major depressive disorder, psychotic disorder, depressive or bipolar related disorder due to medical condition, substance/medication-induced depressive or bipolar disorder, personality disorders (APA, 2013, pp. 170-171)

Instrumentation:

1. Beck Depression II
2. Steen Happiness Index

Treatment

1. CBT
2. Interpersonal psychological therapy (IPT) and medication (Kriston, von Wolff, Westphal, Hōtzel, & Hãter, 2014)
3. Cognitive behavioral analysis of psychotherapy (CBAP; Kohler, Fischer, Brakemeier, & Sterzer, 2014)
4. Medication and CBT (Kriston et al., 2014) -a form of CBASP (cognitive behavioral analysis system of psychotherapy)

Techniques/Interventions:

1. social skills,
2. assertiveness, and
3. decision-making

5. Anxiety Disorders

Disorder: Agoraphobia Disorder

Assessment:

Mixed fear or anxiety, two of five symptoms. Criterion A: (a) using public transportation, (b) being in open spaces, (c) being in enclosed spaces, (d) standing in line or a crowd, and (e) being outside of home alone. Criterion B: finds ways to avoid symptoms, Criterion F: fear lasts at least six months (ACA, 2013, pp. 213, 217)

Comorbidity:

Anxiety disorders, depressive disorders, PTSD, alcohol use disorder (APA, 2013, p. 221)

Differential Diagnosis:

Disorders include specific phobia, separation anxiety, social anxiety, panic, acute stress/PTSD, major depressive, and other medical conditions. (APA, 2013, pp. 220-221)

Instruments:

1. Mobility Anxiety Inventory (Chambless, Caputo, Jasin, Gracely, & Williams, 1985; Chambless et al., 2011)
2. Agoraphobic Cognitions Questionnaire (Chambless, Caputo, Bright, & Gallager, 1984)

Treatment:

1. Exposure therapy for avoidance imaginal flooding
2. Panic control therapy (PCT; DeRubeis & Crites-Christoph, 1998)
3. Panic control therapy if panic attacks are a part of agoraphobia, if not, CBT (White & Barlow, 2002)
4. When panic episodes are a component of the assessment treatment includes:
    a. exposure therapy for avoidance features
    b. imaginal flooding, and panic control theory
    c. CBT and behavioral training are recommended when a panic episode is not a symptom of the assessment
    d. behavioral training consists of relaxation and assertiveness training

Techniques/Interventions:

1. situational exposure (Deacon & Abramowitz, 2004; White, Umpfenbach, & Alpers, 2014)
2. homework
3. systematic desensitization
4. relaxation training

5. assertiveness
6. thought stop
7. restructuring of negative thoughts
8. positive self-statements (Seligman & Reichenberg, 2012)
9. habituation (CBT technique)
10. specific habituation BAT techniques
11. thought stop
12. restructuring of negative thoughts
13. positive self-statements (Seligman & Reichenberg, 2012)
14. specific habituation techniques include thought stop, restructuring of negative thoughts, positive self-statements (Seligman & Reichenberg, 2012)

Monitoring:

Behavior avoidance tasks (BATs) can be used to evaluate individuals confronting a feared situation under controlled settings regarding approach and avoidance (Anthony & Barlow, 2010). Outdoor monitoring will provide a closer approximation to change behaviors.

Self-reports, physiological measurement (heart rate, tachycardia), heart rate increases with negative thought, behavioral avoidance tasks (BATs),

Disorder: Separation Anxiety (SAD)

Assessment:

The child has difficulty separating from attached figures. Three of 8 symptoms (excessive distress from major attachment (MAF) figures, worry about losing MAF, worry about getting lost, kidnapped and separation from MAF, refusal to go out, away from home, fear of being alone without MAF, nightmares with theme of separation, and complaints of physical symptoms (APA, 2013, p. 190-191)

Comorbidity:

PTSD, panic disorder, generalized anxiety disorder, social anxiety disorder, agoraphobia, OCD, and personality disorders (APA, 2013, p. 195)

Differential Diagnosis:

Generalized anxiety disorder, panic disorder, agoraphobia, conduct disorder, social anxiety disorder, PTSD, illness anxiety disorder, bereavement, depressive and bipolar disorder, ODD, psychotic disorder (APA, 2013, pp. 194-195)

Instrumentation:

1. Child's Depression Inventory (ages 7 to 17)
2. Washington University Schedule for Affective Disorders and Schizophrenia for school-age children

3. Young Mania Rating Scale (YMRS) distinguishes between bipolar and other disorders

Treatment:

1. Cognitive behavioral therapy is the treatment of choice for children
2. Individual cognitive behavior therapy (ICBT)
3. Group cognitive behavior therapy (GCBT), GCBT with parents and 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, 2008a)
5. Coping Cat (Beidas, Cooper, Peulo, & Edwards, 2010; Kendall 2000; Kendall & Hedtke, 2006; Southam-Gerow et al., 2016; Velting, Setzer, & Albano, 2004)
6. Separation Anxiety Family (referred to as TAFF)

Individual published evidence-based articles suggested that exposure therapy is highly effective, cognitive-behavioral most effective, and the Coping Cat model (manualized design).

Techniques/Interventions:

Children 7 to 9 years of age and Coping Cat 6-17-years of age:

1. modeling
2. relaxation and breathing techniques
3. cognitive restructuring
4. contingency management
5. extinction methods such as active ignoring (Grover et al., 2006)
6. social skills training (Schneider et al., 2013)
7. reframing
8. relapse prevention
9. TAFF techniques include psychoeducation, reframing, irrational beliefs, coping strategies and relapse prevention (Schneider, Unnewehr, & Margraf, 2009)

Coping Cat techniques (Kendall & Hedtke, 2006; Velting et al., 2004)

1. psychoeducation
2. exposure tasks
3. somatic management (relaxation of feelings)
4. cognitive restructuring
5. problem-solving
6. relapse prevention

Disorder: Generalized Anxiety Disorder (GAD)

Comorbidity:

Anxiety disorder, unipolar disorder (APA, 2013, p. 226)

Differential Diagnosis:

Unspecified anxiety disorder, anxiety disorder due to another medical disorder, substance/ medication-induced anxiety disorder (APA, 2013, pp. 225-226)

Instrumentation:

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

Treatment: (the main emphasis is meta worry)

1. CBT (DeRubeis & Crites-Christoph, 1998; Haby, Donnelly, Corry, & Vos, 2006; Herbert et al., 2009; Roemer & Orsillo, 2002; Roemer, Orsillo, & Salters-Pedneault, 2008)
2. ACT (Roemer et al., 2008)
3. Mindfulness-Based Stress Reduction (Hoge et al., 2017; Roemer, Orsillo, & Salters-Pedneaut, 1998)
4. Acceptance-Based Behavior Therapy (ABBT; Roemer et al., 2008) ABBT targets experiential avoidance and reports worry as a means to escape or avoid internal thoughts, emotions, and physiological sensations.
5. Coping Cat (Velting et al., 2004)

Techniques/Interventions (Borkovec, Newman, Pincus, & Lytle, 2002):

1. cognitive restructuring
2. relapse prevention
3. imagery training
4. problem-solving skills
5. relaxation techniques (breathing/muscle)
6. desensitization
7. emotional processing (in vivo exposure)
8. mindfulness training
9. mindfulness-based acceptance-based approaches (Roemer & Orsillo, 2002)

10. daily diaries
11. regulation of interpersonal feelings

Disorder: Social Anxiety Disorder (Social Phobia)

Assessment:

Symptoms of social phobia are a marked fear of one or more social situations in which the person is exposed to possible scrutiny. The person avoids those situations that provoke fear. For children, the fear must occur in peer situations (APA, 2013, p. 202). Adults and some children experience severe emotion-related difficulties (experiential avoidance, poor understanding of their emotions, shame, and self-criticism (Shahar, Bar-Kalifa, & Alon, 2017). Ranta, Tuomisto, Kaltiaja-Helno, Rantanunen, and Marttunen (2014) reported in their research that the most distressing situations include public speech (presentation, acting or playing an instrument before an audience) and meeting new people with an authority figure.

Hofmann (2007) reported a cycle of factors that maintain social anxiety. These factors include:

1. high perceived social standards
2. poorly defined social goals
3. heightened self-focused attention
4. negative self-perception
5. high estimated social cost
6. low perceived emotional control
7. perceived poor social skills
8. avoidance and use of safety behaviors
9. post-event rumination

Comorbidity:

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

Differential Diagnosis:

Shyness, agoraphobia, panic disorder, generalized anxiety disorder, separation anxiety disorder, specific phobias, major depressive disorder (APA, 2013, p. 206-207)

Instrumentation:

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

Treatment:

1. CBT (APA Div 12 SCP, 2013; Fresco & Richard, 2001; Rowa & Anthony, 2005)
2. CBT, with exposure (Shikatani, Anthony, Kuo, & Cassin, 2014)

3. Acceptance-based group therapy (mindfulness)
4. Emotion-Focused Therapy (Shahar et al., 2017; Shahar, 2014)
5. Interpersonal Psychotherapy (IPT)
6. Coping Cat (Velting et al., 2004)

Cognitive therapy with exposure is the most often treatment recommended and group cognitive behavioral therapy (GCBT). If the symptoms are severe caution is to be exercised in prescribing group experiences until the client has made sufficient progress. CBT is an empirically supported treatment for social anxiety.

Acceptance and Commitment Therapy (ACT), an alternative treatment based on a randomized clinical trial study, is recommended (Craske et al., 2014). Clark et al. (2006) recommended applied relaxation and cognitive therapy as the treatment for social phobia.

Coping Cat therapy has been used since 1990, and psychosocial techniques include diaries, behavioral observation, psychoeducation, somatic management, cognitive restructuring, problem-solving, exposure, and relapse prevention (Velting et al., 2004)

Emotion-focused therapy (EFT), a form of experiential therapy (combines person-centered and relational principles) uses interventions from Gestalt and experiential therapies (empty chair and to regulate emotions). EFT targets experiential avoidance, regulating emotions, and restructuring maladaptive emotions (Shahar et al., 2017). Also, the gestalt two-chair empty-chair is a technique to understand shame-based schemes that underlie the anxiety, regulate emotions, and to develop an understanding of emotional self -criticism. The underlying principle of EFT is to activate anger, grieving, and self-compassion (Shahar et al., 2012).

Techniques:

Specific techniques may target fear of negative evaluation, shame, avoidance, and strive for positive evaluation (Niles, Wolitzky-Taylor, Arch, & Craske, 2017; Kocijan & Harris, 2016).

1. cognitive restructuring
2. social skills training
3. exposure
4. mindfulness
5. self-focused attention
6. self-monitoring
7. visualization
8. relaxation training
9. progressive muscle relaxation
10. cognitive reappraisal
11. deep breathing
12. empty chair (Shahar et al., 2017; Shahar, 2014)

13. ACT techniques (psychoeducation, acceptance, valued action, mindfulness, cognitive defusion, behavioral exercises such as interoceptive, in vivo, and imaginal exposure)
14. CBT techniques (psychoeducation, self-monitoring, cognitive restructuring, breathing retraining, exposure to include in vivo, interoceptive)
15. relapse prevention

Cognitive Behavioral Therapy (CBT) Techniques

1. psychoeducation
2. self-monitoring
3. cognitive restructuring
4. breathing retraining
5. exposure to include in vivo, interoceptive

Acceptance and Commitment Therapy (ACT)Techniques

1. psychoeducation
2. acceptance
3. valued action
4. mindfulness
5. cognitive defusion
6. behavioral exercises such as interoceptive, in vivo, and imaginal

Psychosocial (Coping Cat)

1. diaries
2. behavioral observation
3. psychoeducation
4. somatic management
5. cognitive restructuring
6. problem-solving
7. exposure
8. relapse prevention (Velting et al., 2004)

Gestalt: empty chair (Shahar et al., 2017)

Disorder: Panic Disorder

Assessment:

Recurrent and sudden panic attack in minutes from a calm state. Four of 13 symptoms are required (APA, 2013, p. 208)

Comorbidity:

Anxiety disorders, major depressive disorder, bipolar disorder, mild alcohol use (APA, 2013, pp. 213-214)

Differential Diagnosis:

Unspecified anxiety disorder, specified anxiety disorder, substance/medication-induced anxiety disorder, specific phobia, separation anxiety disorder, social anxiety disorder, acute stress disorder, PTSD, major depressive disorder, other medical conditions (APA, 2103, pp. 212-213)

Instrumentation:

1. Panic Disorder Severity Scale (Shear et al., 1997; Shear et al., 2001) assesses for phobic avoidance, depression, general well-being and for other disorder; social anxiety, depressive disorder, PTSD, and alcohol use disorder.

Treatment:

Levitt et al. (2001) reported that panic disorder can be treated successfully in 8 to 12 sessions using cognitive behavioral therapy. Also, effective model outcomes include panic control treatment and cognitive therapy. Panic controlled treatment targets situational exposure and systematic exposure to internal sensations with psychoeducation. Physical sensations, body reactions, is the first-line goal for somatic sensations such as shortness of breath, sweating, dizziness, and heart palpitations. Psychoeducation is recommended to teach the fight/flight syndrome, body reaction to stress. Breathing training and later training in diaphragmatic breathing targets hyperventilation. Cognitive skills include restructuring to counter misinterpretations. Interoceptive training includes a series of exercises eliciting the physical sensations. Finally, the client learns that avoidance or escape of anxiety-provoking situations does not reduce the frequency and severity of a panic attack.

1. Pharmacotherapy and CBT has been first-line treatment (Addis et al., 2006; Levitt, Hoffman, Grisham, & Barlow, 2001)
2. Panic Control Therapy (PCT)
3. Cognitive Behavioral Therapy (Haby et al., 2006; Levitt et al., 2001)
4. CBT-exposure based and applied relaxation
5. Interoceptive exposure (IE)
6. situational exposure and systematic exposure
7. Newer treatments: ACT
8. Sensation-focused intensive treatment (SFIT)
9. Brief cognitive therapy (Clark et al.,1999; Clark et al., 2016)

    Specific interventions include:

    a. anxiety management

    b. psychoeducation

c. interoceptive exposure (IE)

d. cognitive reappraisal techniques

e. respiratory control (diaphragmatic breathing)

f. (visualization) in vivo exposure (Deacon, Lickel, Farrell, Kemp, & Hipol, 2013; Sanderson & Rego, 2001). IE does not work for all clients (Brown & Barlow, 1995).

Chambless et al. (2017) researched CBT; panic-focused psychodynamic psychotherapy (PFPP), panic control therapy (PCT) and relaxation therapy for parent and spouse/romantic perceived criticism. The study involved 130 clients of which 79 % were also diagnosed with agoraphobia. The study targeted self-perceived criticism, an expressed emotion (EE). The results reported that EE and perceived criticism measure (PC) would predict worse outcomes and recommended the perceived criticism as a treatment goal.

Techniques/Interventions:

1. in vivo (removal of safety features; Deacon et al., 2013; Levit et al., 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-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-observations)
10. attack record (cues, maximal distress symptoms, thoughts, and behaviors)
11. mood chart (situations avoided)
12. empty chair
13. relapse prevention

Monitoring:

Heart rate (HR) is a physiology measurement used for situations of exposure to threat and behavioral avoidance tasks.

6. Obsessive-Compulsive and Related Disorders

Disorder: Obsessive-Compulsive

Assessment:

The obsessive-compulsive disorder includes the presence of one or both obsessions and compulsions. Obsessions are recurrent and the persistent thoughts, urges, and images the client attempts to ignore. Compulsions are repetitive and mental behaviors or acts that are intended to reduce anxiety (APA, 2013, p. 237).

Six dysfunctional beliefs are the core domains for OCD that include: (1) over importance of thoughts, (2) need to control these thoughts, (3), perfectionism, (4) intolerance of uncertainty, (5) inflated personal responsibility, and (6) overestimation of threat (Alonso et al., 2013, p. 321.) Also, fear of self and unacceptable thoughts are reported symptoms during the interview (Melli, Aardema, & Moulds, 2016)

Comorbidity:

Panic disorder, social anxiety disorder, GAD, specific phobia, bipolar disorder, tic disorder, body dysmorphic disorder, trichotillomania disorder, excoriation disorder and possibly schizophrenia or schizoaffective disorder (APA, 2013, p. 242)

Differential:

Neurodevelopment disorders, psychotic disorder, another medical condition, substance-use disorder (APA, 2013, pp. 241-242).

Instrumentation:

1. Yale-Brown Obsessive Compulsive Scale II (Y-BOCS) is one of the most frequently applied tests (Lopez-Pina et al., 2015)
2. Obsessive-Compulsive Inventory-Revised (OCI-R; Foa et al., 2002). The OCI-R has 18 items with six subscales (washing, checking, ordering, hoarding, obsessing and neutralizing; Franklin, Ledley, & Foa, 2008).
3. Thought Fusion Instrument (TFI; Simpson et al., 2011; Wells, Gwilliam, & Cartwright-Hatton, 2001)
4. Obsessive Beliefs Questionnaire (OBQ) is recommended to assess for dysfunctional beliefs. The OBQ-44 contains three scales, responsibility/overestimated threat, importance/control thoughts, and perfectionism/intolerance of uncertainty (Frost & Steketee, 2002).

Treatment:

Treatment goals include increasing psychological flexibility and engaging in positive behaviors regarding teaching the processes of: 1) acceptance, 2) defusion, 4) self as context, 5) contact with presence thoughts, 5) values, and 6) commitment to action (Twohig et al., 2010).

1. CBT (Schwartz et al., 2017; Wilhelm, 2001)
2. CBT and ERP (Exposure and Relapse Prevention; Whittal, Thordarson, & McLean, 2005, 2008)
3. Prolonged Exposure and response prevention therapy is treatment of choice. If the client rejects ERP than CBT is a treatment of choice targeting thinking and is recommended when there is high emotional reactivity, poor insight, or difficulty comprehending the rationale of treatment procedures (Ben-Arush, Wexler, & Zohar, 2008; Conelea & Freeman, 2015; DeRubeis & Crites-Christoph, 1998; Franklin & Foa, 2008, 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). Should exposure and response prevention therapy (ERP) be rejected by the client because of distress (25% do reject; Woo & Keatinge, 2008), cognitive behavioral therapy (CBT) specifically targets errors in thinking and reframing and restructuring are techniques.
4. Medication is recommended although it may take 6 to 10 weeks before changes appear (Franklin & Foa, 2008).
5. Conelea and Freeman (2015) reported four CBT models (habituation, inhibitory learning model, cognitive model, and acceptance and commitment therapy (ACT), ACT (Wiggs & Drake, 2016).
6. Mindfulness-Based Cognitive Therapy (MBCT; Key, Rowa, Bieling, McCabe, & Pawluk, 2017)- MBCT skills teach for acceptance of internal experiences, decreases in depression 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.)
7. Exposure and Relapse Prevention (Foa et al., 2005; Simpson et al., 2011)
8. ACT (Twohig, 2009; Twohig, Hayes, & Masuda, 2006; Twohig et al., 2010; Twohig, Morrison, & Bluett, 2014)
9. Acceptance-Based Behavioral Therapy (ABBT)
10. Mindfulness, an acceptance and commitment technique, targets avoidance cues, sitting with hot thoughts to gain an awareness of inner experiences (Fairfax, 2008; Roemer & Orsillo, 2009).

Ben-Arush et al. (2008) recommended CBT when the client presents with high emotional reactivity, poor insight, and difficulty comprehending the rationale of treatment procedures. Conelea and Freeman (2005) recommended four CBT treatment models (habituation, inhibitory learning model-classical conditioning, cognitive model, and acceptance and commitment therapy (ACT).

The ACT has been used; however, is lacking research effectiveness as treatment for OCD. The strategy for ACT from an ERP perspective is mindfulness, acceptance, cognitive defusion, and values. The goal of the ACT is to help the client change how they relate their inner experiences and to view those experiences as what they are rather than what they present themselves to be (defuse from obsessional stimuli in practice viewing anxiety and obsessional stimuli (Towhig et al., 2015). Values provide a rationale for engaging in exposure techniques and resisting urges.

Medication is recommended although it may take 6 to 10 weeks before changes appear (Franklin & Foa, 2008).

Treatment Children:

1. Exposure-based ICBT (probably efficacious)
2. Family-focused ICBT
3. Family-focused GCBT (possibly efficacious). Treatment was derived from 21 literature studies by Barrett, Farrell, Pina, Peris, and Placentini (2008) using criteria for efficacious designs and protocols (Types I-VI).

Techniques/Interventions for children:

1. Exposure and Response Prevention (ERP) composed of a feared hierarchy supported by a well-established efficacious finding (Chambless & Holland, 1998)
2. psychoeducation
3. stress management (breathing retraining, progressive muscle relaxation, and structured problem-solving)
4. stress inoculation training (SIT)
5. relapse prevention
6. control thoughts (thought record, thought repression, a downward arrow for the meaning of negative thoughts, and cognitive continuum for ratings of beliefs (Wilhem, 2001)
7. in vivo, relaxation training
8. muscle relaxation training
9. reframing (thoughts)
10. defusion
11. behavioral activation targets negative affect and anxiety while doing, charting, and self-reports (Arco, 2015). Cognitive restructuring and mindfulness are helpful for checking tasks (Ludvik & Boschen, 2015).
12. behavioral activation and pharmacotherapy (Arco, 2015) Behavioral activation and pharmacotherapy were recommended from an evidence-based study when OCD and depression are comorbid (Arco, 2015).
13. diaphragmatic breathing (APA, 2008; van Oppen, de Haan, von Balkmon, Spinhoven, Hooqduin, & Van Dyck, 1995)
14. cognitive restructuring (Ludvig & Boschen, 2015)
15. mindfulness (Ludvig & Boschen, 2015; Twohig et al., 2015)
16. cognitive restructuring and mindfulness techniques are useful for checking tasks (Ludvig & Boschen, 2015).
17. ACT 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).

Disorder: Body Dysmorphic

Comorbidity:

Major depressive disorder, social anxiety disorder, OCD, substance-induced related disorders (APA, 2013, p. 247)

Differential Diagnosis:

Eating disorders, OCD, illness anxiety disorder, major depressive disorder, anxiety disorders, psychotic disorders (APA, 2013, pp. 245-246)

Instrument:

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

Treatment:

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

Disorder: Hoarding

Assessment:

Characteristic symptoms include (a) a persistent difficulty in discarding items with very little value, (b) a persistent need to save to avoid stressful feelings associated with discarding, (c) an accumulation of items that store up living areas, (d) a significant impairment socially, occupationally, in functioning, (e) a medical issue is not involved, and (f) no other mental disorder is noted (APA, 2013; King, 2014i).

Specifiers:

1. with excessive acquisition
2. with good or fair insight
3. with absent insight/delusional belief
4. with the excessive acquisition

Comorbidity:

Mood or anxiety disorder to include major depressive disorder, social anxiety disorder, generalized anxiety disorder, and OCD (APA, 2013, p. 251).

Differential Diagnosis:

Neurodevelopmental disorders, schizophrenia spectrum, major depressive episode, OCD, and neurocognitive disorders (APA, 2013, pp. 250-251).

Instruments

1. Saving Inventory-Revised (SI-R; Frost & Grisham, 2004)
2. Hoarding Rating Scale-Interview (HRS-I; Tolin, Frost, & Steketee, 2010)

Treatment:

1. Cognitive Behavioral Treatment (CBT) is considered the gold-standard although did not continue with further improvement post-therapy 3-12 after discharge (Steketee, Frost, Tolin, Rasmussen, & Brown, 2010). Family-based treatments are helpful for children and adolescents (Ale, Arnold, Whiteside, & Storch, 2014).
2. Cognitive-behavioral group (Moulding, Nedeljkovic, Kyrios, Osborne, & Mogan, 2017) Short-term cognitive-behavioral group therapy reduced beliefs and depressive symptoms (Mouding, Nedelijkovic, Kyries, Osborne, & Morgan, 2017)
3. Psychoeducation
4. Family-based (parent psychoeducation (Ale et al., 2014)

Techniques/Interventions:

1. psychoeducation skills training with reinforcement to shore up problem-solving,
2. imagined or direct exposure to distressing stimuli
3. cognitive-restructuring of hoarding-related beliefs (Kress, Stargell, Zoldan, & Paylo, 2016; Steketee & Frost, 2007), and exposure techniques are helpful to practice discarding items (Zoldan et al., 2015).
4. journaling
5. thought stop (Meyers, 2016)
6. relapse prevention

Monitoring:

Homework compliance was found to be lacking for treatment and further improvement after discharge (Muroff, Steketee, Frost, & Tolin, 2014).

Disorder: Trichotillomania (TTM; Hair-Pulling)

Comorbidity:

Major depressive disorder, excoriation disorder, mood disorders, anxiety disorders, substance use disorders, eating disorders, personality disorders in adults, disruptive behavior in youth (APA, 2013, p. 254).

Differential Diagnosis:

OCD-related disorders, neurodevelopment disorders, psychotic disorder, another medical condition, substance-related disorders (APA, 2013, pp. 253-254)

Instrument:

Harrison and Franklin (2012) list the following instruments for assessment:

1. Trichotillomania Diagnostic Interview (TDI; Rothbaum & Ninan, 1994)
2. MGH Hairpulling Scale (MGH-HPS)-assesses frequency, resistance, and control of hair-pulling behaviors
3. NIMH Trichotillomania Questionnaire (Swedo et al., 1989)
4. Trichotillomania Scale for Children (TSC-C, TSC-P, child and parent; Tolin et al., 2008)
5. Milwaukee Inventory of Subtypes of Trichotillomania (MIST-A and MIST-C for adult and child)
6. NIMH Trichotillomania Impairment Scale (NIMH-TIS)
7. The Premonitory Urge for Tics Scale (PUTS)
8. The two most common are the Massachusetts General Hospital Hair Pulling Symptom Severity Scale (MGH-HS; Keuthen et al., 1995)
9. National Institute of Mental Health Trichotillomania Severity Scale (NIMH-TSS: Goodman et al., 1989; Swedo et al., 1989)

Treatment:

There is no standard gold treatment for trichotillomania (McDonald, 2012). The first line of treatment would be brief behavior therapies such as CBT. There is a high rate of relapse due to the time and effort it takes to overcome the original cues associated with the habit. Treatment may be complicated because trichotillomania has many different complexities and is based on the various elements that fed into trichotillomania. Mansueto, Golomb, Thomas, and Sternberger (1999) and Penzil (2011) believed that the cause of trichotillomania might be biological and serves a grooming response to a need for balance in stimulation. Dr. Mansueto reported and identified internal and external factors that affect hair pulling. The internal factors include cognitive, affective, motoric, and sensory. The external factor is the environment. The behavior observed in hair pulling include tactile, visual, and oral (Falkenstein, Moulton-Odom, Mansueto, Golomb & Haaga, 2016; Mansueto, Golomb, Thomas, & Stermberger, 1999; Mansueto, Stemberger, Thomas, & Golomb, 1997; Penzil, 2011). Maas et al. (2017) reported primary difficulties in treating habit-related disorders such as skin picking, hair-pulling, and nail- biting is primarily influenced by giving way is rewarding, and resistance is impossible.

Cognitive behavioral is the treatment of choice. CBT is coupled with habit reversal (HR) and stimulus control (SC) to treat tics and nervous habits (Falkenstein et al., 2016). Treatment should be individually tailored to the client with an established baseline and to begin at the start of the response chain. Response interruption is another strategy to eliminate the hair pulling. Habit reversal is an empirically supported behavioral approach (Enos & Plante, 2001). The client is encouraged to self-monitor through record keeping of urges and emotions experienced. Cognitive therapy (Diefenbach, Reitman, & Williams, 2000; Gluhoski, 1995; Stein, 1995), group therapy (Diefenbach et al., 2000), and Acceptance-Enhanced Behavior therapy (Flessner, Bush, Heldeman, & Woods, 2008).

Habit reversal is the most researched and supported as the best intervention (Bloch et al., 2007).

Group therapy has been shown to be effective to increase awareness of internal and external cues for the urge to hair pulling (Diefenbach et al., 2000).

Techniques/Interventions:

1. habit reversal training (HRT; Bloch et al., 2007)
2. psychoeducation
3. stimulus control
4. relaxation training
5. cognitive strategies (dysfunctional thoughts precede pulling)
6. relapse prevention
7. self-monitoring
8. decoupling (Moritz, Treszi, & Rufer, 2011)

Excoriation Disorder

Treatment:

1. ACT, Acceptance-Enhanced Behavior Therapy (AEBT)
2. Cognitive Behavior Therapy (Jagger & Sterner, 2016)

Techniques:

1. cognitive restructuring
2. psychoeducation
3. habit reversal training (HRT)
4. intervention awareness
5. relaxation training
6. competing for response training
7. social support
8. generalization training (Gelinas & Gagnon, 2013)

7. Trauma-and-Stressor Related Disorders

Disorder: Posttraumatic Stress Disorder (PTSD)

Comorbidity:

Depressive, bipolar disorder, anxiety disorder, and substance use disorders (APA, 2013, p. 280).

Intermittent explosive disorder and PTSD are comorbid and associated with elevated levels of aggression, anxiety, anger, aggression, and impulsivity (Fanning, Lee, & Coccaro, 2016).

Differential Diagnosis:

Adjustment disorder, acute stress disorder, anxiety disorder, OCD, major depressive disorder, personality disorder, dissociative disorder, conversion disorder (APA, 2013, pp. 279-280)

Instrumentation:

Screeners:

1. Posttraumatic Checklist (PCL).

   The PCL, as a screener, is cited as the most widely used instrument for PTSD (Grubaugh, Elhai, Cusach, Wells, & Freuh, 2007; McDonald & Calhoun, 2010). The most recent version includes three additional items and a modification to align with the DSM-5 (Weathers et al., 2015). The PCL has 17 questions and can be administered by a clinician and in a short amount of time (Ruggiero, Ben, Scotti, & Rabalais (2003). According to MacDonald and Calhoun (2010), the PCL performs well as a screener. Screeners with 30 or fewer items lack a standard gold instrument.
2. Brewin (2005) conducted a systematic review of 13 DSM-IV–based PTSD instruments with fewer than 30 items.
   a. The Impact of Event Scale-Revised (Weiss & Marmar, 1997)
   b. PTSD Checklist-Civilian Version (Weathers, Huska, & Keane, 1991)
   c. Trauma Screening Questionnaire (Brewin et al., 2002)
   d. Hovens, van der Ploeg, Bramsen, Schreuder, & Rivero, 1994) had a 90% or greater level of diagnostic accuracy (Del Vecchio, Elwy, Smith, Bottonari &, Eisen, 2011)
   e. Self-Rating Inventory for Posttraumatic Stress Disorder (Hovens, Bramsen, & van der Ploeg, 2002)

Longer Versions

Del Vecchio et al. (2011) researched 41 assessment measures for PTSD (cognitive tests) and reported the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995) and the Structured Clinical Interview for DSM-IV, PTSD Module (First, Spitzer, Gibbon, & Williams, 1996) the gold standard instruments. A trained clinician is required to administer the CAPS to make judgments, rate symptom severity, and frequency and can take from 40 to 60 minutes to administer (Boal et al., 2017). Both instruments require a trained clinician for the administration and a lengthy period of interaction with the client.

Elhai et al. (2005) surveyed to determine the most commonly used instruments to measure event exposure and effects for PTSD. The survey was comprised of 41 inventories (10 clinically administered, 31 self-administered). The most popular instruments for adults in clinical use include:

1. Clinician-Administered PTSD Scale (CAPS)
2. Trauma Symptom Inventory (TSI)
3. PTSD Checklist (PCL)

4. PDS (Foa et al., 2016)
5. Keane PTSD Scale
6. Impact of Event Scale, and revised version (IES-R)
7. Checklist 90-R's PTSD Subscales

Elhai et al. (2005) found the most popular instrument for children was the Trauma Checklist for Children (TSCC).

Other instruments for children include: K-SADS PTSD section, Child Behavior Checklist (Achenbach, 1991b), Childhood Trauma Questionnaire (Bernstein & Fink, 1998), Psychometric Evaluation of the Children's Impact of Traumatic Events Scale-Revised (Chaffin & Shultz, 2001)

Treatment:

Three most popular trauma-focused therapies (TFT) include prolonged exposure, cognitive processing therapy, and EMDR (Lenz, Haktanir, & Callender, 2017). Gallagher and Resick (2012) presented evidence for cognitive processing therapy and prolonged exposure for effecting hopelessness and habituation change.

1. Prolonged Exposure Therapy is the standard gold 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. EMDR (adaptive information processing processes information related to traumatic and 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 (CPT)
6. Cognitive Behavior Therapy (Falsetti & Resnick, 2001)

Erford et al. (2016) reported that PTSD treatment support for trauma-focused and non-trauma focused therapies. Trauma-focused treatment exposes the client to triggers that are reminders of the traumatic event and include narrative therapy, in vivo, prolonged exposure and eye movement desensitization (EMDR). Sharpless and Barber (2011) reported that non-trauma-based approaches include supportive therapy, interpersonal psychotherapy, meditation, and dialectical behavior therapy (DBT). Lenz et al. (2017) reported the most popular of trauma-focused therapies (TFTs) include prolonged exposure, cognitive processing therapy, and eye-movement desensitization and processing (EMDR).

In summary, PTSD treatment has the best support for:

1. Emotion-focused cognitive-behavioral, trauma-focused CBT (sexually abused children), although Foa, Keane, and Friedman (2000) indicated prolonged exposure therapy is considered the best treatment of choice.

2. CBT, evidence-based prolonged exposure therapy is a treatment of choice (Bryant et al., 2006; Foa et al., 2005; Foa et al., 2009; Schnurr et al., 2007).
3. EMDR evidence-based meta-analysis (Bisson et al., 2007; Bradley et al., 2005; Lee, 2008; Makinson & Young, 2012),

Cognitive processing therapy (CPT) is recommended for survivors of sexual assault, and traumatic brain injury and PTSD. It has also been used for anxiety management training. Other treatments for PTSD include group, family therapy, and stress inoculation training.

Evidence-based Treatment (Child and Adolescents):

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

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

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

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

Techniques/Interventions:

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 the therapeutic relationship.

Stress inoculation training (SIT) is an effective intervention for treating rape victims for fears, anxiety, tensions, and depression (Falsetti & Risnick, 2001).

1. in vivo
2. exposure and response prevention (Resick et al., 2008)
3. stress inoculation (Gentry et al., 2017)
4. flooding
5. anxiety management
6. deep muscle relaxation
7. controlled breathing
8. cognitive restructuring
9. emotional self-regulation
10. imaginal exposure
11. prolonged exposure (McLean & Foa, 2003)

12. stress inoculation training (SIT) has been effective treating rape victims for fears, anxiety, tensions, and depression (Falsetti & Resnick, 2001)

Disorder: Acute Stress Disorder

Differential Diagnosis:

Adjustment Disorder, Dissociative Disorder, PTSD, OCD, Psychotic Disorder, Traumatic Brain Injury (APA, 2013, pp. 285-286)

Instrumentation:

1. Acute Stress Disorder Scale (ASDS; Bryant, Moulds, & Guthrie, 2000) is a 19-item self-report screener to identify ASD and predict subsequent PTSD.
2. Acute Stress Disorder Interview (ASDI; Bryant, Harvey, Dang, & Sackville, 1998)
3. Clinician-Administered PTSD Scale
4. Beck Depression II
5. Impact of Event Scale

Treatment:

1. Cognitive Behavioral Therapy (Bryant, Moulds, & Nixon, 2003a,b, 2005; 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
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).
6. Hypnosis

Cognitive Behavioral therapy (CBT). Bryant, Moulds, and Nixon (2003) reported a four-year follow-up of 80 survivors of a motor vehicle or non-sexual assaults study. Fifty patients received the CBT treatment while 39 received supportive counseling. Patients in the CBT treatment after four years reported less intense PTSD symptoms, less frequent and fewer avoidance symptoms than those receiving supportive therapy.

Psychological First Aid for adaptive coping includes feeling safer, calming and stabilization, connectedness to others, increasing self-efficacy and empowerment, and a sense of hope (Solomon, 2008).

Techniques/Interventions:

1. psychoeducation

2. breathing control
3. imaginal exposure
4. cognitive restructuring
5. anxiety management training
6. relaxation training
7. coping skills training
8. prolonged exposure
9. in vivo

Cognitive Behavioral Therapy techniques (Buyden et al., 2014)

1. prolonged exposure
2. imaginal
3. in vivo exposure
4. cognitive restructuring

Cognitive Processing Therapy techniques (CPT; Bryant, 2011)

1. exposure to the trauma in written form
2. cognitive restructuring exploring prior beliefs, rules, and experiences
3. psychoeducation and progressive relaxation (Feldman, Greeson, & Senville, 2010; Freuty et al., 2010)

Psychological First Aid for adaptive coping include feeling safer, calming and stabilization, connectedness to others, increasing self-efficacy and empowerment, and a sense of hope (Solomon, 2008).

Disorder: Adjustment Disorder (6 types)

Comorbidity:

Most mental disorders and medical disorders (APA, 2013, p. 289)

Differential Diagnosis:

Major depressive disorder, PTSD, personality disorders (APA, 2013, pp. 289-290)

Types of Stressors:

Types of acute or persistent stressors include the death of a loved one, divorce, moving, criminal act, accident, retirement, and termination of leisure activities. Chronic stressors include financial difficulties, family conflict, neighbor conflict, too much/too little work, illness/care of a loved one, unemployment, and pressure to meet deadlines (Einsle, Köllner, Dannemann, & Maercker, 2010: Lorenz, 2015; Lorenz, Bachem, & Maercker, 2016; Maercker, Einsle, & Kollner, 2007).

Instrumentation:

1. Adjustment Disorder New Module-20 is a 20-item screener and measures a six-factor module consisting of two core groups, preoccupations and failure to adapt. Also, responses to avoidance, depression, anxiety, and impulsivity and one item measuring impairment.
2. SCID (First, Spitzer, Gibbon, & Williams, 1996, 2002)
3. Diagnostic Interview Adjustment Disorder (DIAD; Cornelius, Brouwer, DeBoer, Groofhoff, and Van der Klink, 2014). The DIAD was based on the DSM-IV criteria. Criteria developed for the DIAD included stressors, first-time limit, distress, impairment, second-time limit, DSM-IV Axis 1/11, and bereavement. Time limit refers to recall and the identification of specific life event or clusters of stressors. The DIAD is a 17-item questionnaire with four-dimensional symptom scales including stressor and onset, distress and onset of distress, distress-stressor (relation) and impairment.

Treatment:

The major therapies include:

1. interpersonal therapy (IPT)
2. supportive therapy
3. psychoeducation
4. cognitive therapy

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. (p. 934)

Skruibis et al. (2016) reported psychotherapeutic interventions as the treatment of choice. Although there is no consensus as to which intervention is the most effective treatment those receiving support include:

1. supportive therapy
2. acceptance and commitment therapy (ACT)
3. psychoeducation therapy
4. cognitive behavior therapy
5. psychodynamic
6. interpersonal therapy (IPT)
7. ego-enhancing
8. problem-solving

9. eye movement desensitization and reprocessing (EMDR)
10. support groups
11. mirror image psychotherapy (MIP)
12. behavior activation therapy intervention (BAT)

Wiggs and Drake (2016) recommended Acceptance and Commitment Therapy (ACT) an evidence-based treatment for adjustment disorder with mixed anxiety and depressive symptoms.

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

The Internet-based modular program as a web-based intervention includes relaxation, time management, mindfulness, and strengthening relationships. This program is based on stress and coping research and evidence-based integrating CBT, mindfulness and body-mind practices, and exercises for enhancing social support (Shruibis et al., 2016; Spates et al., 2016).

1. Interpersonal psychotherapy (IPT; Casey, 2001)
2. Solution-focused therapy (Carta, Balestrieri, Murru, & Hardoy, 2009)
3. Mindfulness group therapy (Skruibis et al., 2016)
4. Internet-based modular program BADI for adjustment disorder

In summary, those theories and intervention that appear in several of the above research reports would be more likely choices for the NCMHCE.

Techniques or Interventions

Best therapeutic interventions include:

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 et al., 2009; Dannahy & Stopa, 2007)

12. solution focused therapy interventions include: 1. The sense of self, 2. Coping, 3. Activation, and 4. Relaxation; Bachem & Maerckem, 2016)

Self-Help Techniques:

Bachem and Maercker (2016) reported four categories of self-help interventions. The interventions include:

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

The Internet-based modular program is a web-based intervention that includes:

1. relaxation
2. time management
3. mindfulness
4. strengthening relationships

This program is based on stress and coping research and evidence-based integrating CBT, mindfulness and body-mind practices, and exercises for enhancing social support (Skruibis et al., 2016; Spates et al., 2016).

Psychopharmacology:

Note: The use of psychotropic drugs such as antidepressants in AD with anxious or depressed mood is not properly founded and should be avoided in less severe forms of this disorder

8. Dissociative Disorders

Disorder: Dissociative Identity Disorder

Comorbidity

PTSD, depressive disorders, avoidant and borderline personality disorders, conversion disorder, somatic symptom disorder, eating disorders, substance-related disorders, OCD, sleep disorders (APA, 2013, pp. 297-298)

Differential Diagnosis:

Major depressive disorder, bipolar disorder, PTSD, psychotic disorders (APA, 2013, pp. 296-297)

Instrumentation

Sue, Sue, and Sue (2006) indicated that diagnosis using instruments has been difficult with psychological and physiological tests (EEG, galvanic skin response, and cerebral blood flow). The following instruments and interviews are commonly used:

1. Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID)
2. Dissociative Disorder Interest Scale (DDIS)
3. Dissociative Experience (DES; Bernstein & Putnam, 1986)
4. Cambridge Depersonalization Scale (Sierra & Berrios, 2000) includes interview questions for the social role, gender identification, sexuality, and body
5. Structured Clinical Interview for Depersonalization and Derealization Spectrum

Treatment:

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

9. Somatic Symptom and Related Disorders

Disorder: Somatic Symptom Disorder (Briquet's syndrome)

Comorbidity:

Medical issues, anxiety and depressive disorders (APA, 2013, pp. 314-315)

Differential Diagnosis:

Panic disorder, GAD, panic disorder, depressive disorders, illness anxiety disorder, conversion disorder, delusional disorder, body dysmorphic disorder, OCD (APA, 2013, p. 314)

Instrumentation:

1. Anxiety Disorders Interview Schedule (ADIS-IV-L; Brown, DiNardo, & Barlow, 1994)
2. Trauma Symptom Checklist for Children
3. Beck Anxiety Inventory (neurophysiological, subjective, panic-related and autonomic)
4. Clinician-Administered PTSD Scale (CAPS; Blake et al.,1995)
5. PTSD Checklist (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996)
6. Affective Cognitive-Behavioral therapy (ACBT; Woolfolk & Allen, 2007)
7. Group and family therapy (forms include conversion, pain, hypochondriasis, and body dysmorphia). Treatment will vary depending upon form; for example, IPT-P and CBT for pain or HRT for skin scratching and picking.

Techniques:

1. social skills training
2. family psychoeducation
3. relaxation
4. stress-reduction
5. sleep hygiene
6. distraction techniques
7. cognitive restructuring

Disorder: Factitious Disorder

Comorbidity:

None in the DSM-5

Differential Diagnosis:

Somatic symptom disorder, malingering, conversion disorder, borderline personality disorders (APA, 2013, p. 326)

Assessment:

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

Instrumentation:

1. Clinical interview
2. Carter (2013) recommended instruments for malingering to include: Test of Memory Malingering (TOMM), Word Memory Test, Computerized Assessment of Response Bias, Portland Digit Validity Test, Victoria Symptom Validity Test, MMPI-2 (most scales), and Structured Interview Report Symptoms (SIRS)

Treatment:

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

10. Feeding and Eating Disorders

Comorbidity

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

Instrumentation:

1. Questionnaire on Eating and Weight Patterns-Revised (QEWP-R; Yanovski, 1993)
2. Eating Disorder Examination Questionnaire (Cooper & Fairburn, 1987; Fairburn & Cooper, 1993)
3. Development of the Body Checking Questionnaire (Reas, Whisenhunt, Netemeyer, & Williams, 2002)

Treatment:

1. CBT is considered the preferred effective treatment for bulimia nervosa (Fairburn, Cooper, & Palmer, 2009, Hay et al., 2014; Waller et al., 2007).
2. Emotion-focused therapy, multidisciplinary approach, cognitive-behavioral therapy
3. DBT for BED, active comparison group therapy (ACGT)
4. Fairburn (2008) has broadened the cognitive-behavior therapy to include an enhanced cognitive behavioral therapy (CBT-Ef) and a broad treatment (CBT-Eb) for all eating behaviors. The broad form includes modules for perfectionism, low self-esteem, and interpersonal difficulties considered maintenance factors for continued eating.

Disorder: Anorexia Nervosa

Comorbidity:

Bipolar, depressive and anxiety disorders, alcohol use disorder (APA, 2013, pp. 344-345)

Differential Diagnosis:

Medical conditions, major depressive disorder, schizophrenia, substance use disorders, social anxiety, OCD, body dysmorphic disorder, bulimia nervosa, and avoidant/restrictive food intake disorder (APA, 2013, p. 344).

Instrumentation:

1. Questionnaire on Eating and Weight Patterns-Revised (QEWP-R)
2. Development of the Body Checking Questionnaire (Reas et al., 2002)

Treatment:

1. Maudsley family-based
2. Multidisciplinary approach
3. Cognitive-behavioral therapy

4. Group therapy
5. DBT (Eisler, 2005; Lenz, Taylor, Fleming, & Serman, 2014; Wilson & Fairburn, 1993)
6. DBTG (group therapy)
7. Acceptance and Commitment Therapy (ACT; Juarascio, Forman, & Herbert, 2014)
8. Cash's Body Image Therapy
9. Transdiagnostic approach
10. Interpersonal psychotherapy (IPT)
11. Family therapy

Mann, Erford, and Minnich (2018) conducted a meta-analysis of anorexia nervosa using 92 counseling articles for effectiveness. Results for inpatient hospitalization, family counseling (no overall effect, more research needed), cognitive remediation therapy (more research needed), and CBT (can help clients but not superior) were reviewed.

Treatment (child and adolescent)

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

Well established (WE): Family therapy

Probably efficacious: None

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

Disorder: Bulimia Nervosa

Comorbidity:

Depressive symptoms, bipolar, depressive symptoms, and depressive disorders (APA, 2013, p. 349)

Differential Diagnosis:

Anorexia nervosa, binge eating disorder, Kleine-Levin syndrome, major depressive disorder with atypical features, borderline personality disorder (APA, 2013, p. 349)

Instrumentation

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

Sandberg and Erford (2013) in a meta-analysis study of 111 clinical trials isolated the frequency of use for bulimia assessment instruments. The most frequently used outcome measure instruments (first percentage) and in a bulimic study (second percentage) include:

1. Eating Disorder Examination (30.6 %, 37.8%l)

2. Eating Disorder Inventory (30.6%, 39.6%)
3. Eating Attitude Test (8.1%, 24.3%)
4. Bulimic Investigatory Test, Edinburgh (8.1%, 9.9%)
5. Body Shape Questionnaire (7.2%, 9.9%)
6. Three Factor Eating Questionnaire (7.2%, 7.2%l

Treatment:

1. CBT (APA, 2008; Linardon, Wade, de la Piedad Garcia & Brennan, 2017; NICE, 2004; Shapiro et al., 2007; Wilson & Fairburn, 1993)
2. DBT (Lenz et al., 2014)
3. Exposure and response prevention (ERP)
4. Nutritional, and stress management
5. IPT was reported to be effective for short and long-term clients (Treasure, Schmidst, & van Furth, 2003)
6. Family therapy (adolescents; Keel & Haedt, 2008; NICE, 2004)
7. ACT (Juarascio, Forman et al., 2014)
8. DBT and CBT focus on therapeutic alliance, reducing negative affect, modifying eating behaviors, and identifying situations that trigger eating behaviors (Maine, Davis, & Shure, 2009).
9. Manualized-based CBT treatment is the treatment of choice for bulimia nervosa disorder.
10. CBT-BN. Linardon, Wade, Garcia, and Brennan (2017) conducted a systematic review and meta-analysis of 97 randomized controlled trials (RCT) study of CBT-BN for bulimia nervosa. Findings from that report indicated CBT-BN treatment resulted in a significant reduction in behavioral and cognitive symptoms than did results for interpersonal psychotherapy (IPT).
11. IPT and CBT produce greater decreases in vomiting and restraint. (Weissman et al., 2000),
12. Medication (fluoxetine)-restraint, weight concern, food preoccupation improvement in nutritional management, decreases in binge eating and vomiting, and abstinence from binge eating. Shapiro et al. (2007), reported that trazodone decreases the frequency of binge eating, vomiting, and in fear of eating, and anticonvulsants. There is a greater reduction in the number of binge/purge days and body dissatisfaction, and often a drive for thinness.

Techniques:

1. homework
2. self-monitoring
3. cognitive restructuring
4. structured eating
5. routine weighing
6. monitoring food intake
7. exposure-based methods

8. psychoeducation about dangers of vomiting and purgative abuse
9. dietary management
10. identification of antecedents to loss of control
11. problem-solving
12. ERP
13. relapse prevention
14. body image
15. body exposure for body image treatment for increased cognitive-affective responses (Trentowska, Svaldi, Blechert, & Tuschen-Caffier, 2017)
16. habituation was examined with mirror image exposure

Disorder: Binge Eating

Comorbidity:

Bipolar disorders, depressive disorders, anxiety disorders, substance use disorders (APA, 2013, p. 353)

Differential Diagnosis:

Bulimia nervosa, obesity, bipolar and depressive disorders (APA, 2013, pp. 352-353)

Instruments:

Lydecker, White, and Grilo (2016) reported that the Eating Disorder Inventory (EDI) is considered the most prevalent and best-established interview method for assessment of eating-disorder psychopathology or a self-report measure.

1. Eating Disorder Examination (EDE; Fairburn & Cooper, 1993). The gold standard EDE measures for dietary restraint, eating, weight, and shape concerns. Also, the EDE measures for the frequency of binge eating, over-eating, and extreme weight compensatory behavior.
2. Binge Eating Scale (Gormally, Black, Daston, & Radin, 1982) 16-item self-report that measures binge eating symptomatology
3. Eating Disorder Examination-Questionnaire (EDE-Q; Fairburn & Beglin, 1994)
4. Eating Disorder Inventory-3 (EDI-3; Garner, 2004)
5. Eating Attitude Test -26 (EAT-26: Garner et al., 1982) most widely used screening self-report measure and differentiates those with and without an eating disorder. The EAT was developed to measure symptoms of anorexia nervosa and presently to measure eating disorders in general. Questions include demographic information of height, weight, and age to measure for body mass index (BMI) and five questions for frequency for engaging in behaviors associated with binging and purging.
6. BITE (Bulimic Investigatory Test (Edinburgh Bite; Henderson & Freeman, 1987)-self-report identifying those with symptoms of binge and bulimia.

Treatment:

Cognitive behavior therapy (Fairburn, 2008), interpersonal therapy (Weissman et al., 2000; Wilson, Grilo, & Vitousek, 2007), and DBT (Wilson et al., 2007). Treatment protocol may consider perfectionistic concerns as a vulnerability factor for binge eating (Smith et al., 2017). The perfectionism model of binge eating (PMOBE)-although the findings are uncertain if perfectionism is an antecedent or consequence or both for increased eating. Factors to consider for perfectionism include the tendency to demand perfection of oneself, unrealistic high personal expectations, to perceive others as demanding perfection, doubts about performance, and negative reactions to perceived failures.

Treatment includes:

1. CBT (gold standard; Fairburn, 2008; Grilo, Masheb, Wilson, Gueorguieva, & White, 2011; Linardon et al., 2017; Wilson & Fairburn, 1993)
2. DBT (Linehan, 1993a ; Wilson et al., 2007)
3. IPT (targets personal stress and interpersonal relationships; Carleton et al., 2015)
4. Family therapy (adolescents; Eisler, 2005)
5. Exposure-response therapy (ERP) has been used when treating eating disorders and anxiety together.
6. ACT, CBT, and compassion-based components (Heffner, Sperry, Eifert, & Detweiler, 2002)
7. BEfree program (a psychological program treating shame and self-criticism (Pinto et al., 2017). Befree is a newer approach, and this study supported symptom relief regarding less external shame, less depressed, less self-critical, and decreased flexibility related to body image but lacks in comparison research effectiveness.

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 the importance of weight and body shape on self-evaluation and approval of self
3. relaxation training (Kocovski, Fleming, 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

11. Sleep-Wake Disorders

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

Comorbidity or co-occurring

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

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

Instrumentation:

1. Sleep diary
2. Sleep Disturbance Questionnaire (Espie, Brooks, & Lindsey, 1989)
3. Sleep History Questionnaire (Edinger, 1987)
4. Sleep Impairment Index (Morin, 1993)
5. Beliefs and Attitudes about Sleep Scale (Morin, 1993)
6. Pittsburgh Sleep Quality Index (Buysse & Reynolds, 1990; Buysse, Reynolds, Monk, Berman, & Kuper, 1989),
7. Level 2 Sleep Disturbance Patient-Reported Outcome Measurement Information System (PROMIS) Short Form (psychiatry.org/practice/dsm/dsm5/online-assessment-measures)
8. Epworth Sleepiness Scale (Johns, 1991)
9. Sleep Disorders Questionnaire (Violani, Devoto, Lucidi, Lombardo, & Russo, 2004)
10. Sleep Condition Indicator (Espie, 2012)
11. The Composite Scale of Morningness (Smith, Reilly, & Midkiff, 1989)
12. Sleep timing Questionnaire (Monk et al., 2003)
13. Sleep Hygiene Index (Mastin, Bryson, & Corwyn, 2006)
14. A recent semi-structured clinical interview, laboratory analysis, sleep log or diary are components of the different questionnaires, except for polysomnography.

Treatment:

1. psychopharmacology
2. CBT
3. bright light therapy
4. sleep education
5. sleep hygiene, and sleep restriction
6. stimulus control
7. cognitive restructuring
8. paradoxical intention
9. relaxation, and relaxation therapy (Riemann, Fischer, Mayer, & Peters, 2003)

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

Disorder: Obstructive Central Sleep Apnea (OSAS)

Assessment:

OSAS requires evidence of five or more central sleep apneas (respiratory pauses) per hour assessed by polysomnography (APA, 2013). Symptoms include tiredness (sleepiness) during the day, awakenings during the night, headaches, poor memory, difficulty concentrating, and mood problems. If not treated there is an increased likelihood of developing hypertension, increased cardiovascular morbidity, and neurocognitive and mood dysfunctions (El-Ad & Lavie, 2005).

Treatment:

1. Continuous Positive Airway Pressure (CPAP)
2. CBT

Techniques/Interventions:

1. sleep education
2. sleep hygiene
3. sleep restriction
4. sleep charting
5. cognitive restructuring
6. relaxation exercises, progressive muscle relaxation
7. stimulus control procedures (physical activity, avoiding naps, avoiding caffeine late in the evening, setting room temperature at 19-20 C, bed for only sleep)
8. sleep diary (Danielsson, Jansson-Fröjmark, Broman, & Markström, 2016)

Disorder: Insomnia

Comorbidity:

Medical condition (diabetes, heart disease, chronic pulmonary disease, arthritis, fibromyalgia (APA, 2013, p. 368)

Differential Diagnosis:

Normal sleep variations, acute insomnia, delayed sleep, restless leg syndrome, breathing-related sleep disorders, narcolepsy, and parasomnias (APA, 2013, pp. 367-368)

Instruments:

1. Sleep History Questionnaire (Edinger, 1987)

2. Sleep Impairment Index (Morin, 1993)
3. Sleep diary, Sleep Disturbance Questionnaire (Espie et al., 1989)
4. Beliefs and Attitudes about Sleep Scale (Morin, 1993)
5. Pittsburgh Sleep Quality Index (Buysse & Reynolds, 1990)
6. Duke Structured Interview for Sleep Disorders (DSISD)
7. Structured Interview for Psychiatric Disorders
8. Patient Version (SCID-P)
9. Insomnia Symptom Questionnaire (ISQ; Spielman, Saskin, & Thorpy, 1987)

Treatment/Interventions:

1. Psychopharmacology (benzodiazepine; NICE, 2004)
2. CBT (first-line treatment)-breaks dysfunctional beliefs and attitudes about sleep that leads to emotional distress, medication (Riemann et al., 2003). The treatment includes stimulus control, sleep restriction, diaries, and common-sense interventions (McCurry, Logsdon, Teri, & Vitiello, 2007; Rieman & Perlis, 2009).
3. Cognitive therapy (CT) goals include reversing (a) dysfunctional beliefs about sleep, (b) sleep-related worry, (c) attentional bias and monitoring sleep-related treat, (d) misperception of sleep (Harvey et al., 2014; Wong, Ree, & Lee, 2016).
4. Cognitive Behavioral Therapy-Insomnia (CBT-I)
5. CBT (combination of behavior therapy and CT; Harvey et al., 2014)
6. Behavior therapy (BT) includes stimulus control and sleep restriction (use bed only for sleeping and limit time in bed (Harvey et al., 2014)

Milner and Belicki (2010) reported that treatment for insomnia includes physical and psychological approaches.

1. Physical approaches included pharmacology and bright light therapy.
2. Psychological approaches include CBT-I, bibliotherapy, sleep education, sleep hygiene, sleep restriction, cognitive restructuring, paradoxical intention, and relaxation therapy (standard technique). Pharmacological treatment using hypnotic and antidepressant medications are also common (trazodone and amitriptyline). There is no clinical evidence that relaxation therapy is effective (Edinger, Wohlemuth, Radthke, Marsh, & Quillian, 2001).

Techniques/Interventions:

1. bibliotherapy
2. sleep education
3. sleep hygiene
4. sleep restriction (Irwin, Cole, & Nicassio, 2006)
5. cognitive restructuring
6. relaxation therapy

7. sleep charting
8. exercise, CBT-I (stimulus control sleep restriction), psychoeducation, pharmacological, bright light therapy
9. pharmacological treatment (Milner & Belicki, 2010)
10. bright light therapy, sleep education (psychoeducation), stimulus control, and cognitive restructuring
11. paradoxical intention (paradoxical intention is to instruct a client to stay awake as long as possible (symptom prescription)
12. sleep scheduling (Irwin et al., 2006)
13. sleep diaries (estimated sleep onset latency, total sleep time, nocturnal wake periods, feeling of being refreshed), sleep hygiene (refrain from caffeine after lunch, alcohol, do not eat heavily in the evening, exercise regularly, use sleep ritual, do not check time (watch) during the night), relaxation, progressive muscle relaxation, psychoeducation (normal sleep-wake rhythms, sleep need, and sleep capacity, stimulus-control (bed equals sleep, bed only for sleeping, leave bed if not able to fall asleep, engage in something relaxing, get up regularly each morning at same time, do not sleep during the day), sleep restriction (stay in bed for specific time), cognitive techniques (paradoxical intention, thought-stop, problem-solving, restructuring (Riemann et al., 2003).
14. mindfulness (Wong et al., 2016)
15. thought stop-to interrupt ruminations

12. Sexual Disorders

Disorder: Female Sexual Interest/Arousal Disorder

Comorbidity:

Depression, thyroid problems, anxiety, urinary incontinence and other medical problems, arthritis, irritable bowel disease (APA, 2013, p. 436)

Differential Diagnosis:

Nonsexual mental disorders (depressive disorders), substance/medication use, another medical condition, interpersonal factors, other sexual dysfunctions, absent sexual stimuli (APA, 2013, p. 436)

Instrumentation:

1. Brief Sexual Checklist
2. Sexual Interest and Desire Inventory-Female (SIDI-F)
3. Sexual Opinion Survey (SOS; White, Fisher, Byrne, & Kingma, 1977)
4. Sexual Dysfunction Scale (McCabe, 1998)
5. Sexual Desire Inventory (Spector, Carey & Steinberg, 1996)

6. Early Sexual Experiences Checklist (Miller, Johnson, & Johnson, 1991) used to detect unwanted sexual experiences before age 16.
7. Interview for Sexual Functioning (DISF; DeRogatis, 1994, 1997) in five domains (sexual fantasy and cognition, sexual behavior and experiences, orgasm, sexual drive, and sexual arousal).

Treatment:

1. Psychoeducation
2. Eros clitoral therapy device (increases blood flow)
3. Emotion-focused therapy (EFT)
4. Couples and group therapy can be appropriate, relational therapy
5. 12-Step program modeled after Alcoholics Anonymous - approach lacks evidence-based practice (EBP)
6. Sex Addicts Anonymous, Sexual Compulsives Anonymous and Sex and Love Addicts
7. CBT (Cyranowski, Aarestad, & Andersen, 1999)

Techniques:

1. bibliotherapy (Arentewicz & Schmidt, 1983; Van Lankveld, 1998)
2. systematic desensitization (patients with pain)

13. Disruptive Impulse-Control and Conduct Disorders

Disorder: Conduct Disorder (CD)

The distinguishing features between conduct disorder and oppositional defiant disorder are that the oppositional disorder pattern includes a negativistic, defiant, disobedient and hostile behavior toward authority figures. The conduct disorder pattern is a violation of basic rights of others, or major societal norms or rules (Loeber, Burke, & Pardini, 2009). Also, aggressive behaviors and the emotion of anger and rumination are associated components to be assessed. Ekman (2003) reported that anger had associated emotions of fear, disgust, and guilt.

Searight, Rottnek, and Abby (2001) recommended five questions that target symptoms of conduct disorder. If answered yes to any one question a follow up question is asked for the circumstance and frequency: (1) Have you had any run-ins with the police, (2) have you been in physical fights, (3) have you been suspended or expelled from school, (4) have you ever run away from home, (5) do you smoke, drink alcohol or use other drugs, and (6) are you sexually active (p. 1583).

Comorbidity:

Antisocial personality disorder, specific learning disorders, anxiety disorders, depressive or bipolar disorders, substance-related disorders, academic achievement, especially reading and verbal skills (APA, 2013, p. 475).

Differential Diagnosis:

Oppositional defiant disorder, ADHD, depressive disorders, bipolar disorder, intermittent explosive disorder, adjustment disorder. Loeber et al. (2009) reported that research revealed a link exists among conduct disorder, mood disorders, and anxiety disorders (APA, 2013, pp. 474-475).

Instrumentation:

The following five instruments were ranked in a survey, and results were published in the Journal of Counseling and Development regarding the most frequently used (Erford et al., 2014)

1. Achenbach Child Behavior Checklist is most widely used
2. Behavior Assessment System for Children (2nd edition)
3. The Child Behavior Checklist Inventory
4. Behavior Assessment for Children
5. Conners Teacher Rating Scales-Revised (2nd ed.)

Treatment:

1. parent management training
2. multidimensional treatment
3. multisystemic therapy
4. the most effective treatment strategy is CBT involving combined parent and child or family and targets negative affect
5. anger coping intervention focuses on affective features of disruptive behavior (Lochman & Lenhart, 1993). Individual therapy should treat anger rumination
6. problem-solving skill training (PSST), dysregulation, impulsivity social skills, anger management, and parent management

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

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

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

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

Techniques:

1. problem-solving skills training
2. dysregulation

3. impulsivity social skills
4. anger management
5. parent management

Disorder: Oppositional Defiant (OD)

Comorbidity:

Conduct disorder, ADHD, anxiety disorders, major depressive disorder, and substance use disorder (APA, 2013, p. 466)

Differential Diagnosis:

Conduct disorder, ADHD, depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, intermittent explosive disorder, intellectual ability disorder, and social anxiety disorder (APA, 2013, p. 465)

Instrumentation:

Erford et al. (2014) conducted a meta-analysis regarding instruments that measure conduct disorder for children. The analysis contained 31 articles and reported the following five instruments were the most frequently utilized:

1. Child Behavior Checklist was used in 58% of the assessments
2. Eyberg Child Behavior Inventory in 35% of the assessments
3. Achenbach Child Behavior Checklist is widely used
4. Behavior Assessment System for Children, 2nd edition
5. Conners Teacher Rating Scales-Revised (Achenbach, 1991c)

Treatment:

1. parent management training
2. anger control training
3. parent-child Interaction therapy (PCIT)
4. individual and group counseling
5. family interventions (parent training)

Eyberg, Nelson, and Boggs (2008) conducted evidence-based randomized controlled design study 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.

Evidence-based efficacious studies include:

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

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

Individual studies with empirical support include family intervention.

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

Disorder: Intermittent Explosive Disorder (IED)

Comorbidity:

Depressive disorders, anxiety disorders, ADHD, conduct disorder, ODD (APA, 2013, p. 469)

Intermittent explosive disorder and PTSD are comorbid and associated with elevated levels of aggression, anxiety, anger, aggression, and impulsivity (Fanning et al., 2016).

Differential Diagnosis:

Disruptive mood dysregulation disorder, antisocial personality disorder, borderline personality disorder, delirium (APA, 2013, pp. 468-469)

Instruments:

1. The Intermittent Explosive Disorder-Screening Questionnaire (IED-SQ; Coccaro, Berman, & McCloskey, 2017) added seven-items to the Life History of Aggression (LHA) and is an effective screening measure for adults.
2. Multidimensional Anger Inventory (MAI; Siegel, 1986)
3. Dimensions of Anger Reactions (DAR; Forbes et al., 2004)
4. State-Trait Anger Expression Inventory 2 (STAXI-2; Spielberger, 1973, 1999)

Treatment:

Treatments effectiveness or efficaciousness have not been found. However, several authors have recommended the following:

1. CBT (McCloskey, Noblett, Deffenbacher, Gollan, & Coccaro (2008)
2. behavior therapy
3. family therapy
4. group therapy
5. behavior management with parental involvement (Olivera, 2002; Paone & Douma, 2009)

Techniques/Interventions

1. social skills training
2. cognitive structuring
3. anger management
4. emotion regulation

14. Substance-Related and Addictive Disorders

Disorder: Alcohol Use Disorder

Comorbidity:

Bipolar disorders, schizophrenia, antisocial personality disorder (APA, 2013, pp. 496-497)

Differential Diagnosis:

Nonpathological use of alcohol, sedative, hypnotic or anxiolytic use disorder, conduct disorder in childhood and adult antisocial personality disorder (APA, 2013, p.496)

Instrumentation (Screeners):

1. Substance Abuse Subtle Screening Inventory (SASSI)
2. Rapid Alcohol Problems Screen (RAPS4)
3. Michigan Alcoholism Screening Test (MAST)
4. CAGE (Screening for Alcohol Abuse)
5. Alcohol Use Disorders Identification Test (AUDIT)

Treatment:

1. CBT and social skills training (Ritvo et al., 2003)
2. Multidimensional family (MDFT)
3. Functional family therapy (FFT), group
4. Multisystemic therapy (MST), behavior family therapy
5. Cue exposure therapy
6. Cue exposure therapy plus coping skills training
7. Cognitive-behavioral relapse prevention model
8. Group (12-Step program)
9. Alcohol Anonymous (AA)
10. Insight-oriented Therapy
11. Supportive Therapy
12. Pharmacotherapy (Kaplan & Sadock, 1998)

Three theories are well known to be effective treatment. The theories include cognitive behavior therapy, acceptance and commitment therapy, and dialectical behavior therapy. Mindfulness is a technique used in each of the three therapies. Mindfulness helps to reduce stress, enhance regulation of the sympathetic nervous symptom (Jacques, 2017).

Individual published researchers recommended combined behavior interventions, motivation enhancement, cognitive therapy, social skills training, cognitive restructuring, relaxation training, stress management, twelve-step, and family therapy.

Techniques/Interventions:

1. social skills training (Tolin, Frost, & Steketee, 2007)
2. self-control training
3. brief motivational counseling,
4. stress management
5. behavioral marital therapy
6. community reinforcement)
7. cue-exposure (for dependence)
8. motivational interviewing is helpful in reducing anger and hostility

Children/Youth Treatment:

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

Well-established (WE):

1. Multidimensional family (MDFT)
2. Functional family therapy (FFT)
3. Group CBT

Probably efficacious:

1. Multisystemic therapy (MST)
2. Brief strategic family therapy (BSFT)
3. Behavior family therapy (BFT)

TECHNIQUES/Interventions (Adolescents):

1. Mindfulness is a technique used in each of the three therapies.
   Mindfulness helps to reduce stress and enhance regulation of the sympathetic nervous symptom (Jacques, 2017).

2. Individual published researchers recommended combined behavior interventions that include:
    a. motivation enhancement,
    b. cognitive therapy
    c. social skills training
    d. cognitive restructuring
    e. relaxation training
    f. stress management
    g. 12-Step
    h. family therapy

15. Neurocognitive Disorders

Disorder: Delirium

Comorbidity:

None provided in the DSM-5

Differential Diagnosis:

Psychotic disorders, bipolar and depressive disorders, acute stress disorder, diagnosis includes acute stress disorder, malingering and factitious disorder, other neurocognitive disorders (APA, 2013, p. 601)

Instrumentation:

1. Confusion Assessment Method (Inouye et al., 1990)
2. Mental Status Examination and neurology referral

Treatment:

1. Prevention is the treatment of choice (Fong, Iouye, & Jones, 2017)
2. Medication may target symptoms of depression, anxiety, psychosis, and aggressiveness
3. Support for caregivers and hospital elder program

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

Techniques:

1. support groups

2. relaxation
3. coping skills

Disorder: Major or Minor Neurocognitive Disorder (Dementia)

Comorbidity:

Age related diseases and delirium (APA, 2013, p. 610)

Differential Diagnosis:

Normal cognition, delirium, major depressive disorder (APA, 2013, p. 610)

Instrumentation:

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

Treatment:

Medication to slow the progression, support for caregivers

16. Personality Disorders

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

Treatment:

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

Group schema therapy is considered a long-term approach to treat borderline and Clusters B and C personality disorders (Nenadić, Lamberth, & Reiss, 2017). A pilot study by Nenadić provided evidence for short-term (ST) in-patient acute settings. Schema therapy is based on cognitive behavioral therapy although is extended to include emotional and experiential intervention techniques. A specific emphasis is reparenting with interpersonal difficulties (Sempertegui, Karreman, Arntz, & Bekker, 2013).

Instrumentation:

1. Millon Clinical Multiaxial Inventory

2. MMPI, Structured Clinical Interview, Level 2 DSM-5 Personality Cluster A: Appear Odd or Eccentric

Cluster A: Appear Odd or Eccentric

Disorder: Paranoid Personality Disorder

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Treatment:

1. Cognitive Analytic Therapy (CAT; Kellett & Hardy, 2014). A single case experimental design reported that CAT was an effective intervention for paranoid elements for clients diagnosed with paranoid personality disorder.
2. Minimal effectiveness studies available
3. Individual treatment preferred, cognitive therapy, group therapy rarely recommended

Disorder: Schizoid Personality Disorder

Treatment:

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

Instrumentation:

Millon Clinical Multiaxial Inventory, MMPI, Structured Clinical Interview

Disorder: Schizotypal Personality Disorder

Instrumentation:

1. Millon Clinical Multiaxial Inventory
2. MMPI-2
3. Structured Clinical Interview

Treatment:

1. Supportive therapy, lengthy and slow
2. Cognitive therapy
3. Behavior therapy for speech patterns

Cluster B: Appear Dramatic, Emotional or Erratic

Disorder: Antisocial Personality Disorder

Instrumentation:

1. Millon Clinical Multiaxial Inventory
2. MMPI-II
3. Structured Clinical Interview

Treatment:

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

Treatment:

1. Cognitive Behavioral Therapy (CBT; Gibson et al., 2010; Hofmann et al., 2012)
2. Interpersonal Psychotherapy (IPT)
3. Dialectical Behavioral Therapy (Newhill & Mulvey, 2002)
4. Schema Therapy
5. Agitation Therapy (Martens, 2001)
6. Psychopharmacology (mood stabilizers, anticonvulsants)
7. Social Skills Training
8. Psychoeducation

Techniques/Interventions:

1. imagery
2. empathic confrontation
3. homework
4. mentalization
5. mindfulness (Young et al., 2003)

Disorder: Borderline Personality Disorder

Instrumentation:

1. Millon Clinical Multiaxial Inventory
2. MMPI-2
3. Structured Clinical Interview

Treatment:

Emotional dysregulation is an emotional symptom of BPD. DBT and mindfulness technique are positively effective in reducing affective symptoms and enhancing emotions (Feliu-Soler et al., 2014).

Mentalization-based therapy, transference-focused therapy, schema-focused CBT, supportive psychotherapy, and STEPP group therapy are treatments found to be helpful. Group therapy can be more effective than individual therapy, especially schema-focused therapy (SFT) group (Farrell, Shaw, & Webber, 2009), and psychodynamic psychotherapy has one study equal to DBT. Giesen-Bloo et al. (2006) conducted a study composed of 44 borderline patients in a randomized trial comparison to 42 patients treated with transference-focused psychotherapy. Schema therapy proved to be helpful in reducing borderline personality disorder and general psychopathologic dysfunction over a three-year period.

Treatment:

1. DBT
2. CBT
3. Schema Therapy

Techniques/Interventions

1. mindfulness (Feliu-Soler et al., 2014)
2. attention regulation
3. body awareness

Disorder: Histrionic Personality Disorder

Instrumentation:

1. Millon Clinical Multiaxial Inventory
2. MMPI-2
3. Structured Clinical Interview

Treatment:

1. Long-term individual psychotherapy
2. Cognitive-behavioral therapy as the treatment of choice
3. Group therapy can be helpful (feedback)

Disorder: Narcissistic Personality Disorder

Instrumentation:

1. Millon Clinical Multiaxial Inventory
2. MMPI-2
3. Structured Clinical Interview

Treatment:

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

Cluster C: Appear Anxious or Fearful

Disorder: Avoidant Personality Disorder

Instrumentation:

1. Millon Clinical Multiaxial Inventory
2. MMPI-2, Structured
3. Clinical Interview

Treatment:

1. Randomized and control trials are effective for psychodynamic psychotherapy (Gottdiener, 2006).
2. Behavioral interventions
3. Schema-focused therapy
4. Group therapy
5. Family therapy may be helpful

Disorder: Dependent Personality Disorder

Instrumentation:

1. Millon Clinical Multiaxial Inventory
2. MMPI-2
3. Structured Clinical Interview

Treatment:

1. Psychodynamic
2. Cognitive-behavioral therapy
3. Schema therapy can be helpful

Disorder: Obsessive-Compulsive Personality Disorder

Instrumentation:

1. Dysfunctional Thought Record (active log)
2. Millon Clinical Multiaxial Inventory

3. MMPI-2
4. Structured Clinical Interview

Treatment:

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

Treatment Definition

Acceptance-Based Behavior Therapy (ABBT)

ABBT was designed by Roemer et al. (2008) to treat generalized anxiety disorder. It is a combination of CBT interventions, acceptance and commitment therapy, dialectical behavior therapy, and mindfulness-based cognitive therapy. Research indicates that ABBT targets experiential avoidance through awareness actions. Individuals negatively evaluate internal experiences (thoughts, emotions, and physiological sensations by avoiding (use worry) those experiences. Worry reduces autonomic reactivity and distracts from more topics or relationships. Outcome data in a randomized controlled trial study revealed that clients were meeting GAD criteria and ABBT treated clients sustained a significant reduction in depressive symptoms and at posttreatment 78% of subjects did not meet criteria for GAD and 77% achieved high functioning.

Acceptance and Commitment Therapy (ACT)

ACT's principles and techniques involve interoceptive exposure, mindfulness meditation, DBT, and ACT. These therapies target thoughts and combine acceptance, compassion, and commitments to achieve goals. ACT teaches acceptance of thoughts, choosing goals, and taking steps that are action-oriented. The therapy purpose is to help clients understand how they have become entrapped in their thoughts and the focus is on relational frame theory. A core skill learned is how to recognize and stop self-perpetuating and self-defeating emotional, cognitive, and behavioral avoidance routines (Seligman & Reichenberg, 2012). Eifert and Forsyth (2005) illustrated the acronym ACT in steps to accepting and embracing thoughts and feelings (A), choosing a direction that reflects who the client truly is (C), and taking steps toward action (T). The authors reported ACT effectiveness studies in published articles to include anxiety, substance abuse, and depression.

Acceptance and commitment therapy are often used in conjunction with exposure response prevention (ERP). For example, the processes for the ACT and ERP treatment for OCD is acceptance, cognitive defusion, awareness of the present moment, self as context, values, and committed action (Twohig et al., 2015). The client is taught to welcome unwanted obsessional thoughts, images, doubts, and anxiety. Acceptance is to remain open without attempting to change behavior.

Affective Therapy

Beck and Emery (1985) used a five-stage AWARE process (accept feelings, watch the anxiety, act with the anxiety rather than fight it in dysfunctional ways, repeat the steps, and expect the best).

Behavior Activation Therapy (BAT)

Emotions result in behaviors leading to rumination and avoidant behavior. The focus is on behavior activation without cognitive change, problem solving, long-term change and completion of the goal. Depression helps to overcome the urge to escape or engage in avoidance behaviors. BAT is a front-line intervention and evidence-based outcome for treating depression (Hopko et al., 2011). Spates et al. (2016) identified five computer web-based programs interactive BA and provider monitoring features, web-based BA interviewed with acceptance and commitment therapy (ACT), web-based BA targeting postpartum depression, web-based BA adapted to the smartphone, and web-based BA with momentary ecological sensing.

Cognitive Analytic Therapy (CAT)

CAT was developed as a short-term therapy to treat mental problems and personality disorders (Ryle, Kellett, Hepple, & Calvert, 2014). Therapy consists of 24 weekly sessions plus four follow-up sessions. It is a theory of personal constructs and object relations. Reciprocal roles have explored influences about how people anticipate, experience, enact and react to personal dynamics. Clients experience target problem procedures such as traps, snags, and dilemmas. CAT is a three-phase therapy; 1) narrative and diagrammatic reformulation of the presenting problem; 2) recognition in which the client becomes more aware of their roles and procedures via self-monitoring and 3) a revision phase in which change methods are designed (Ryle, 1995).

Cognitive Behavior Therapy (CBT)

Hofmann, Asnaani, Vonk, Sawyer, and Fang (2012) sampled 106 of 269 meta-analysis studies about the efficacious treatment for substance use disorder, schizophrenia disorder, depression, bipolar disorder, anxiety disorders, somatization disorder, eating disorders, insomnia disorder, anger, and aggression. Their review found strong support for anxiety disorders (front-line treatment), somatization disorder, bulimia disorder, anger control problems, and general stress.

The assumptions and basic model of CBT is that mental disorders and distress are maintained by cognitive factors. Treatment emphasis is through the use of therapeutic strategies change maladaptive cognitions that will alter or change emotional distress. Hofmann, Asnaani, Vonk, Sawyer, and Fang (2012) conducted a CBT meta-analytic efficacy study using 332 clinical trials for 16 psychological disorders. Results indicated for:

1. Addiction and substance use disorder-evidence for efficacy (highly effective) for cannabis and nicotine dependence
2. Schizophrenia and Other Psychotic Disorders-beneficial effect

3. Depression and dysthymia-effective but mixed when compared to psychodynamic, problem-solving therapy and interpersonal psychotherapy
4. Bipolar Disorder-small to medium overall effect
5. Anxiety Disorders-CBT is a first-line treatment
6. Somatic Symptom Disorder-more effective than other psychotherapies but no difference compared to waiting list/placebo at post-treatment (medium to large)
7. Eating Disorders-medium effect although behavior therapy was greater than CBT; more effective than other psychotherapies for bulimia
8. Insomnia Disorder-more efficacious (superior) than control treatments

Cognitive Processing Therapy (CPT)

Resick, Schnicke, and Markway (1991) are the theory developers of cognitive processing therapy for treating PTSD. CPT combines exposure therapy, anxiety management training and cognitive restructuring. Traditional CPT integrates information processing theory to cope with and interpret traumatic events (Resick, Monsoon, & Chard, 2007; Resick & Schnicke, 1992; Resick, Schnicke, & Markway, 1991). CPT is considered to be helpful in treating rape victims and survivors of sexual assaults. CPT is a 12-session structured model where exposure is combined with cognitive restructuring. Caution is exercised to not re-expose the client to the trauma when exposure is utilized as a part of the treatment. Lenz, Bruijn, Serman, and Bailey (2014) reported evidence-based outcome for CPT and PTSD evaluated with the Chambless benchmarks for efficacious research.

Coping Cat

Coping Cat is a manualized approach that prescribes 16 to 20 sessions, the first half of which focuses on psychoeducation, emotional awareness, relaxation and cognitive restructuring, while 111 latter half focuses on facing fears through exposures (Beidas, Cooper, Puelo, & Edwards, 2010; Kendall, 2000; Kendall & Hedtke, 2006). Child behavior therapy program ("copying cat") was designed to target anxiety disorders in children but especially SAD (Flannery-Schroeder & Kendall, 2000). Strategies or techniques for treatment include psychoeducation, cognitive restructuring, changing self-talk, somatic management, problem-solving, exposure tasks to feared stimuli using FEAR acronym. FEAR represents feeling frightened (F), expecting bad things to happen (E), actions and attitudes (A), and results (rewards) or situations. Strategies include using developed plans for anxiety coping skills and homework assignments. Also, graduated exposure tasks and role-playing are techniques (Southam-Gerow et al., 2016). Social reinforcement is used by the therapist during the recommended 16 sessions. Eight of the sessions are training sessions, and in the final eight sessions, the child practices new skills in imagery and real-life situations.

Dialectical Behavior Therapy (DBT)

Marsha Linehan reported that DBT theory development started with her research and interest in suicide and eventually borderline personality disorder. The theory includes support, insight and

Eastern philosophy. It is further based on CBT. Client work is with eating disorders, antisocial and borderline personality and substance use-comorbid with a borderline personality disorder. The goal for DBT is to develop a balance in tensions existing between dependency versus independence, and emotional control versus emotional tolerance, and trust versus suspicion. Behavior targets or goals include: decreasing suicidal behaviors, decreasing behaviors that interfere with therapy and a quality of life, increasing behavioral skills, and decreasing behaviors related to posttraumatic stress (Friedel, 2004). DBT integrates mindfulness and acceptance with behavior change to reduce emotion dysregulation and maladaptive behaviors. The protocol includes weekly skills group, individual therapy, weekly therapist consultation, and the use of telephone coaching (Fischer & Peterson, 2015; Linehan, 1993a, b).

Skills training involves emotional regulation, distress tolerance, interpersonal effectiveness and mindfulness (Treasure et al., 2003).

Emotion-Focused Therapy for Depression (EFT) and Social Anxiety

Sharha (2014) reported that EFT had been demonstrated to be efficacious with depression, interpersonal trauma, and marital discord. The current study for social anxiety treatment was to target shame as a maladaptive emotion. Results indicated that EFT offered an alternative approach to treat shame and self-criticism as SAD component symptoms.

Greenberg and Goldman (2008) developed a person-centered therapy approach including gestalt principles involving narrative and emotional expressions through the use of lived stories that can be re-evoked and reconstructed through recollection and memory. Three interrelated pathways are developed with emotion and narrative processes with the goal that the client can access and articulate a meaningful understanding of emotional processes evoked from personal stories. The three guiding principles are emotion awareness, emotion regulation and emotion transformation (Goldman et al., 2006; Greenberg, 2002, 2004, 2010). Emotion-focused therapy is a dialectical-constructivist model with focused attention on personal meaning that is built on the concept of self-organization and one's own emotional experience involving reason and emotion.

A fundamental understanding is that emotional schemes are composed of responses and experiences that are stored in memory and become a part of the lived experiences of clients. Some emotions are maladaptive and may be rooted in attachment responses where a client was met with criticism or rejection. Criticism or rejection may be experienced later in life, resurfacing earlier emotions of fear or shame (Greenberg, 2002, 2004). The client, in re-experiencing this story that is heavily laden with emotions, attempts to make sense by symbolizing it into a story. The counselor often hears these stories repeatedly during therapy. Singer and Blagov (2004) suggested that these expressions of stories of past events are the pathway through which is revealed the client's identity, emotion, behavior, and personality for a change process. The story is revealed as a bodily-felt, expressed feeling. Key terms in EFT include:

1. Emotion assessment: Different types of emotions
    a. Primary emotions: most fundamental direct initial reactions to a situation

b. Secondary emotions: responses to prior thoughts and other, more primary internal processes and may be defenses against feelings (hopeless when angry; Greenberg, 2004, p. 7).

c. Maladaptive emotions: old familiar feelings that occur repeatedly and do not change

2. Goals for EMFT
   a. Increasing awareness of emotions (primary emotion and primary adaptive response), feeling the feeling
   b. Enhancing emotion regulation (overcoming avoidance of emotional arousal and the promotion of emotional processing)
   c. Transforming emotion
3. Emotion Regulation: the emotions to be regulated are secondary emotions, and those primary emotions are maladaptive. The goal is to teach clients to tolerate and to self-soothe by allowing the feelings to come and go with regulating breathing.
4. Emotion Transformation: changing emotion with emotion, which is undoing a maladaptive emotion, which helps to transform it. Another method is to shift attention, as the emotion may be present non-verbally in the tone of voice or manner of expression.

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

Eye Movement Desensitization Response (EMDR)

Shapiro is the founder of eye-movement desensitization and reprocessing (EMDR). There are various EMDR protocols developed since the original EMDR created by Shapiro. These treatments include the Standards EMDR Protocol, EMD Protocol, Recent Traumatic Episode Protocol (R-TEP), and EMDR-PRECI, a single session for the recent traumatic event (Buydens, Wilensky, & Hensley, 2014). The goal of EMDR is to transform dysfunctional memories into adaptive resolution, fostering psychological healing (p. 9). Psychological first aid followed by the critical incident is the initial response for adaptive coping. Psychological first aid strategies are to promote feeling safer, calming and stabilization, connectedness to others, increasing self-efficacy, and empowerment, and a sense of hope (Solomon, 2008). EMDR is a technique that combines imaginal exposure with eye movement and has been researched as a treatment for trauma-related anxiety. EMDR pairs visual stimulation, kinesthetic stimulation, and auditory stimulation with a focus on the traumatic memories. EMDR's approach to trauma is to focus on distancing and free association. The aim of this process is to transfer memories and information from an implicit (body sensing) to explicit cognitive memory systems (Stickgold, 2008). This approach differs from exposure therapies that focus on exposure to reliving crucial aspects of the trauma. EMDR places a greater emphasis on distancing. It is a duo focus in which the client maintains focus on the trauma material and also is present with the therapist in the room, and the trauma memory is to be observed not relived. The process is to desensitize (Lee, 2008).

Family-Focused Therapy (FFT)

Miklowitz and Chung' (2016) reported a study of 30 years of research that FFT is an evidenced-based treatment for bipolar disorder. Bipolar disorder clients experience symptoms that include expressed emotional (EE) negative interactions with others, increased levels of expressed hostility, parental self-sacrificing and emotional overinvolvement (over-concern, overprotective, exaggerated emotional responses to emotional unclear boundaries, anger). The overall goal for FFT is to teach and recreate adaptive responses for blaming, stigmatizing parents and to restructure family dynamics and relationships (reduce conflicts and improve communication).

FFT is a combination family-oriented treatment approach focusing on psychopharmacotherapy, psychoeducation, communication-enhancement, and problem-solving.

Counselor skills include expressing positive feelings, active listening, making positive requests for change in another's behavior, communication clarity, and expressing negative feelings. The authors outlined six objectives for FFT. The objectives include 1) integrating experiences associated with mania or depression, 2) recognizing and accepting vulnerability to future episodes, 3) accepting medication for mood-stabilizing for symptom control, 4) personality and bipolar disorder distinctions, 5) recognizing stressful events and learning to cope, and 6) reuniting functional family relationships after events (page 488).

Psychoeducation includes defining mania and depression, symptom handouts, episode sharing, stress prompting suicidal ideation, genetic or biological predispositions (disorder runs in families), brain circuity, medications for control, and sleep/wake cycles.

Problem-solving emphasizes identifying family conflicts and developing solutions, evaluating advantages and disadvantages for each solution, choosing one or more solutions, and creating a plan. Communication-enhancement includes improving family relationships through interrupting negative patterns of interactions, encouraging active listening for empathy, balancing praise versus criticism, and clear agenda while speaking. The skills include expressing positive feelings, active listening, making positive requests for change in another's behavior, communication clarity, and expressing negative feelings (p.

Habit Reversal Training

The therapist assists the client in identifying situations, stressors and other factors that trigger habits such as skin picking or nail-biting. The task is to find other activities to do instead of the habit, such as squeezing a rubber ball. The developed task will help ease and occupy the hands. The therapist will attempt to alter the environment to help curb the behavior. Habit reversal and stimulus control are components of treatment for tics and nervous habits. Four steps include:

1. Step one is an awareness of the repetitive behavior that precedes the habit. The client recognizes the circumstances and feelings regarding the urge or tension before the habit. A self-monitoring sheet is provided to the client to record the situation and emotional state.
2. Step two is to teach progressive muscle relaxation.

3. Step three is teaching diaphragmatic breathing exercises.
4. Step four is acquiring a muscle tensing activity (Penzil, 2011).

Maudsley Family-based therapy

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

Medication

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

Be alert to client issues involving medication such as positive and negative psychiatric effects of antiepileptic drugs especially for clients with seizure disorders (Ketter, Post, & Theodore, 1999). Even though the prescribing psychiatrist may not be working with the counselor, it is helpful to establish good communication (with the client's permission). The counselor needs to be aware of medication issues, indications/contraindications, and possible side effects. He/she may see the client more regularly than the psychiatrist or prescribing physician and should be alert to issues such as non-compliance or complaints about medication effects.

In summary, the evaluation process includes some important aspects. The counselor must make an empathic contact with the client and begin a process of gathering information, including What is (are) the chief complaint(s)? When did each begin? What may have caused the symptom(s)? How long (history) has each symptom gone on? Has the symptom(s) gotten worse? What alleviates or makes the symptoms worse?

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

Meditation

Three forms of meditation are focused attention, mindfulness, and compassion. Focused attention is to concentrate on the in-and-out cycles of breathing. The mind tends to wander so focused attention is to regain the focus. Mindfulness (open-monitoring) is observing sights, sounds, and other sensations, including internal bodily sensations and thoughts. Compassion is feelings of benevolence toward other people, whether friend or enemy (Ricard, Lutz, & Davidson, 2014a, b). The goal of meditation is to achieve a clear mind, emotional balance, a sense of mindfulness, and compassionate caring. Neuroscientists believe that meditation can rewire the brain circuits and aims to tame and center the mind. Also, it is believed that the brain can experience growth.

Mentalization-based Therapy (MBT)

MBT is a psychodynamic approach, and central to the therapy is attachment theory. It is a manualized approach. The goal is to assist clients to understand their own and others' mental states, faulty thinking about relationship problems which triggers abandonment fears and reduce impulsivity, self-harming and suicidal behaviors (Bateman & Fonagy, 1999, 2006a, 2008). The four elements of MBT include: (1) focusing on the client's current thoughts, feelings, wishes, and desires; (2) avoiding discussions that are not connected to a subjectively felt reality, a more conscious awareness mentalization; (3) developing a climate whereby thoughts and feelings are available to be considered; and (4) an enhanced or enlightened understanding of the feelings and thoughts prior to an engagement of behaviors in the future.

Metacognitive Theory (MCT)

Metacognitive theory focus is about "the information that individuals have about their thinking, thinking style, and strategies that affect the thinking, and the thinking style that regulates the maintenance and change" (Hjemdal, Hagen, & Nordahl, 2013, p. 301). Clients with psychological disorders present with biased thinking styles involving negative thoughts and beliefs, and maladaptive cognitive processing. Worry is at the forefront of several psychological disorders controlling the thinking style referred to as cognitive attentional syndrome (CAS). The thinking style prolongs and intensifies the negative thinking and emotions, and worry and rumination. Treatment strategies aim to alter and change persistence or perseveration of self-held ideas that maintain interpersonal problems. Because the thinking style is inflexible and self-focused attention, the goal is to implement self-observation and monitoring of the thought processes. Detached mindfulness and worry postponement experiments are two techniques aimed at awareness of control and change. The treatment consists of 10-12 sessions including (1) shaping meta-awareness between thoughts that act as triggers and worry response; (2) challenging beliefs about uncontrollability of worry; (3) challenging beliefs about the danger of worry; (4) modification of positive beliefs about worry; and (5) relapse prevention. MCT shows promise as an effective approach for generalized anxiety disorder. Wells and King (2006) and Fisher (2006) research cited 87.5% recovery rate and 75% at 6 to 12-month follow-up and 80% and 70% respectively. MCT is a recommended treatment for GAD in the NICE guidelines (NHS Evidence, 2012).

Mindfulness-based Therapies

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

Spates et al. (2016) presented research for five computer mindfulness-based therapies, and previous research indicated effective outcomes in treating depressed cancer patients, posttraumatic stress disorder, depressed obese individuals, and anxiety disorders.

Mindfulness-Based Stress Reduction (MBSR)

MBSR, developed by Jon Kabat-Zinn, is a technique or strategy that, when combined with meditation, teaches clients how to quiet the mind and to become aware of the present moment. During 2012, there were 477 scientific journal articles published on mindfulness practices (Pickert, 2014). Training of the brain to focus is a way to cope emotionally and behaviorally with the stressors encountered on a daily basis. Jon Kabat-Zinn believed the mind could be rewired to allow the client to pause and reset. MBSR has been recommended for anxiety issues. The common program is once a week for eight weeks, meeting two-and-half hours. The concept is based on the fact that the mind can adapt and rewire (neuroplasticity). The strategy is to de-stress through meditation and mindfulness practice. Research tends to support that mindfulness practice does lower cortisol levels and blood pressure and increases the immune response.

Multicomponent CBT (sleep)

Multicomponent CBT includes a combination of sleep hygiene education, stimulus control, sleep restriction, and relaxation training (McCurry et al., 2007). Stimulus control is to strengthen the cue that the bed is to sleep in and not for other activities such as reading or watching television. McCurry and associates reported seven studies supporting evidence-based therapy (EBT)

Neuroscience

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

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

Panic Control Theory (PCT)

Panic control theory is a cognitive-behavioral approach that focuses on addressing mistaken beliefs people have about the meaning of physical sensations (Craske & Barlow, 2008). The approach is psychoeducation, relaxation, cognitive restructuring, and interoceptive exposure exercises shown to reduce panic attacks.

Panic-Focused Psychodynamic Psychotherapy (PEPP)

PEPP is a short-term, transference-based symptom-focused therapy. The therapy is designed to uncover unconscious meanings of panic symptoms and to resolve core conflicts. Attention is given to recognizing, managing, and expressing anger and guilt about conflicts over separation and autonomy (Chambless et al., 2017).

Parent-Child Interaction Therapy (PCIT)

The Parent-Child Interaction Therapy (PCIT) is a family-centered evidenced-based clinic and in-home delivered treatment (EBT) for childhood disruptive disorders (Chase, et al., 2019; Galanter…et al., 3012; Zisser & Eyberg, 2010). Neglect and physical abuse are the two most prevalent maltreatments (Barth et al.; Whitaker, et al., 2005). PCIT is designed for children 2.5 to 6-years of age although some clinics offer treatment for ages 8 to 10 (Self-Brown, …et al., 2012). The treatment is for children with serious behavioral problems and who have experienced trauma due to child abuse or neglect. PCIT is the only evidence-based treatment for both child and parent together. Mac (2019) reported that PCIT has been used successfully for children with symptoms that include attachments, social learning, emotional disorders, ADHD, anxiety disorders, social phobia, and agoraphobia.

Effective treatment decreases antisocial behavior, externalizing behaviors and increases child compliance. Parent and child combined improvements in child internalizing symptoms, parenting stress and locus of control (Chase & Eyberg, 2008). PCIT strengthens attachment and builds resilience in at-risk families demonstrated through improved ways for parents to listen to, talk to, and interact with their children (McNeil & Hembree-Kigin, 2010).

The overall treatment goals are to modify maladaptive and ineffective parenting styles and behavior, teaching or modeling relationship-enhancing adaptive skills, develop positive disciple and encourage compliance skills. The treatment approach consists of two phases, child-directed interactions (CDI) and parent-directed interactions (PDI).

The quality of the parent-child relationship is improved by the use of play in a positive, nondirective way (Nixon, Sweeney, Erickson, & Touya, 2003). Enhancing skills include praise, reflection, imitation, description, and enthusiasm (PRIDE). Each PRIDE skill is designed for corrective direction. Parents are taught to give good commands and act with reasonable time-out sequence (Galanter, et al., 2012). The in-home treatment settings when compared to clinical settings enable live coaching for observing behavior time outs, rapport development with other housemates and grandparents to establish consistency and congruency in the acquisition of parental responses. Immediate feedback in different therapy setting is achieved through the use of in vivo training, telephone interchanges, self-instructional manuals, videotape modeling, bug-in-the-ear, and a one-way mirror.

Therapist training consists of 40 hours of didactive training, participation in biweekly consultation, two clinical case reviews, and submission of video-taped sessions.

Assessment symptoms target stressful interaction using a combination of a semi-structured interview identifying strengths, needs and instrumentation. Instrument scales are coded for problematic interactions between the child and parent(s). Instruments may include the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) and coding system (Eyberg & Robinson, 1983), Child Behavior Checklist (CBCL; Achenbach & Rescoria, 2001), Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg, Chase, Fernandez & Nelson, 2014), and the Parenting Stress Index-Short Form (PSI-SF; Abidin, 1990).

Pivotal Response Training (PRI)

PRI is a home-based behavioral intervention. Early work was with autism, targeting motivation and initiation. Parents are trained to intervene while at home with their child. As such, improvement is noted in communication skills, decreased disruption behaviors and increased generalization of treatment gains (Koegel, Koegel, Vernon, & Brookman-Frazee, 2010). A similar approach in working with parents is Floor Time (Greenspan, 1999).

Polyvagal Theory: Vagus Nerve Therapy (VNS)

A device is implanted in the chest that sends electrical impulses to the vagus nerve to activate the brain, leading to improvement in mood (Feder, 2006). Stephen Porges developed the neurophysiological foundation of emotions, attachment, communication, and self-regulation (Porges, 2011).

Prolonged Exposure Therapy

This therapy is the creation of Dr. Edna Foa and is frequently recommended for anxiety and depression disorders and specifically for PTSD. The goal is to decrease distress regarding a trauma. The client learns to interact with feared stimuli in new and more functional ways. The client approaches thoughts, feelings, and situations that are being avoided because of the distress. The client is exposed to repeated thoughts, feelings, and situations to reduce the control the client has allowed due to the distress. The therapy includes education, breathing-relaxing exercises, real-life practice through an in

vivo experience, thus reducing the distress gradually and creating more control, and talk during the therapy about the trauma. Several evidenced based outcome studies exist (Bryant et al., 2008; Bryant, Moulds, Guthrie, Dang, & Nixon, 2003a, b; McLean & Foa, 2013; Schnurr et al., 2007).

Psychodynamic Psychotherapy

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

Psychoeducation

Psychoeducation consists of several sessions (6-12) providing formation regarding the disorder's etiology, treatment, length and expected outcome, strategies to identify early warning signs of relapse, and illness-coping strategies (Colom et al., 2004; Swartz & Swanson, 2014).

Rapid Resolution Therapy

The client is asked to describe the traumatic experience while intending to remain emotionally connected to what is happening. The therapist explains that he or she will also intend to remain emotionally connected to what is happening and will help the client if necessary. The therapist and client are collaborating on a project, which is an improved quality of life. The idea is to overcome the intrusive, sensorimotor elements of the trauma and is to be a transformation of the traumatic memory into a personal narrative in which the trauma is experienced as a historical event that is a part of the person's autobiography. The purpose is to tell the story of a shocking event without re-experiencing it. The client is to remain emotionally present while telling the story as if it happened to another person.

Referral and Monitoring

Monitoring is the process of observing changes in thoughts, feelings, and behaviors of clients undergoing change treatment. Monitoring can take many different forms, often in direct relation to what the client is experiencing or the disorder. Monitoring is tracking of specific client changes of treatment goals by the client and counselor through record-keeping, regular goal assessment reporting and with the client and counselor observations via self-reports, surveys, or behavioral reports. Improvement information should be measurable, achievable, relevant and time-bound.

A client may be experiencing difficulties in expressing him/herself socially in the form of verbal communication. Monitoring may take the form of observing that a client is meeting and talking with others. Monitoring observations can be behavior demonstrated or through self-monitoring. The specific behavior change monitored is dependent upon the treatment goals. For someone experiencing agoraphobia, improvement behaviors may be attending a social function, going shopping, mailing a letter, or any behavior whereby the client comes into contact and interacts with

people. Self-reports are an effective method to determine improvement. The client reports tasks accomplished. Self-reports from young clients are sometimes in question and may need validating observations from adults. The cross-cutting symptom measures, if administered during the initial contact, can be effective for monitoring on a pre-post measure. A person experiencing an alcohol use disorder might count the days of sobriety, attending AA meetings, meeting with a sponsor and meeting specific objectives of the twelve-step program. Relapse is another way to measure improvement and would be considered a lack of improvement.

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

Short screening instruments may be used to monitor improvement. An example might be someone experiencing depression. The Beck Depression II (BDI) can be administered at the initiation of treatment or during intake assessment and administered again at a later time. The BDI is short and inexpensive and can be used to support self-reports, behaviors observed by the client or family members and mood charting by the client and counselor.

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

Schema Therapy

Schema therapy is a combination of psychodynamic, supportive, and cognitive behavioral therapies. Treatment focuses on organized patterns of behavior, cognition, and feelings that were most commonly, but not necessarily, established during childhood. The schemas include abandonment, anger/impulsivity, primitive parent, and detached protector (patterns in childhood).

Other examples of schema beliefs are: "I'm unlovable, I'm a failure, people don't care about me, something bad will always happen, and I will never be good enough." The therapist probes for four environmental contributors to the themes and maladaptive behaviors: unstable or unsafe home environment, overly punitive parents, emotional negation or deprivation, and an environment where the child's needs are subjugated to the needs of the parents (Rafaeli, Bernstein, & Young, 2011). Schemas are categorized into five modules and include: (1) abandoned and confused child, (2) angry and impulsive child, (3) detached protector, 4) punitive parent, and (5) healthy adult. The elements of change include: (1) limiting re-parenting, (2) emotion-focused work involving the use of imagery and dialogues, (3) cognitive restricting and education, and (4) behavioral pattern breaking (Friedel, 2004)

Sensation-Focused Intensive Treatment (SFIT)

This approach combines treatments for panic and avoidance in an intensive self-study format over eight consecutive days. Treatment includes exposure to the most feared situations without teaching techniques for reducing the anxiety.

Social-effectiveness Therapy (SET-C)

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

Sleep Restriction Therapy

Sleep restriction therapy is based on compressing the time spent in bed for the time sleeping. If the client reports spending 10 hours in bed but sleeps six hours, the schedule is to remain in bed six hours thus creating a deprivation. The compression is designed to assist the client to fall asleep easier and to stay asleep. McCurry et al. (2007) reported three evidence-based studies supporting sleep restriction therapy.

Supportive Therapy

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

Supportive Psychoanalytic Psychotherapy (SPP)

Supportive psychoanalytic psychotherapy was developed by Applebaum (2006, 2008) and Carsky (2013) with an emphasis on psychoanalytic concepts, less the therapists' interpretations of the relationship between the client and the therapist. The therapist assists the client in attending to his or

her emotional reactions, and the relationship is the change agent for a safe place to learn and experiment with change. According to Applebaum SPP does not use homework, systematic teaching, or group therapy methods.

Social Effectiveness Training

Social effectiveness training is designed to decrease social anxiety, improve interpersonal skills, improve social performance, and increase participation in social activities (Turner et al., 1994).

Strength-Based Principles

Strength-based principles include eight practice principles of the integrative system in creating solutions (Davidson, 2014). The acronym STRENGTH refers to S (solution focused), T (trajectory preview), R (resource development), E (exceptions analysis), N (noting positives), G (goal setting), and H (human capacity development).

Structured Dyadic Behavioral Therapy (SDBT)

SDBT is a behavioral approach for psychosocial ADHD treatment for children ages 7 to 12. The goal is to promote self-regulation and social learning. SDBT is highly structured and aims to establish clear, consistent, and predictable guidelines. Contingency management is the primary intervention to represent modeling, interactive rehearsal, and peer feedback. Setting goals, establishing benchmarks (also for monitoring), and redirection are components of contingency management. The overall task is to improve the performance of the child through modeling engagement as a more effective self-regulation and social management rather than to suppress them. A simple goal for a session might be to instruct the child to show paying attention or show not interrupting a peer (goal, benchmark, and redirection). The SDBT is more of a solution-focused approach teaching adaptive skills. When involving parent management therapy (PMT) with SDBT in vivo techniques can be employed (Curtis, 2014).

Transference-focused Therapy

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

Supervision

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

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

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

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

There is also a difference between supervision and consultation insofar as consultation is usually a one-time experience when the counselor requests a seasoned professional to help the client better

understand how to process through a severe case (skill level). Teaching, counseling, and consultations are specific roles yet overlap in supervision.

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

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

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

Ethical considerations and issues for supervision may include due process, informed consent with clients, supervision, supervisees, HIPAA requirements, technology, and multiple relationships between supervisees and clients, preventing supervisee transgressions, competence, monitoring supervisee competence, and confidentiality. Legal issues include malpractice, duty to warn, direct liability and vicarious liability, and to prevent claims of malpractice. Direct liability is the direct negligence of supervisory practices and is likely to include allowing a supervisee to practice outside the scope of practice, not providing sufficient time for supervision, lack of emergency coverage and procedures, not providing a supervisory contract, lack of appropriate assessment of supervisee, lack of sufficient monitoring of practice and documentation, lack of consistent feedback, and violation of professional boundaries in the supervisory relationship (Haynes et al., 2003, p. 190, Paniagua, 2001).

Models (Selected)

Most clinicians are recipients of supervisors who adhere to a supervision model of choice. Some of these models include psychodynamic, developmental, and social models. A primary goal of most models in the training of supervisees is to teach and assist in decision-making for application and ensuring treatment fidelity. The literature is scant when it comes to evidence-based supervision. Evidence-based supervision tracks outcome and teaching principles of change. Feedback has always been an aim of supervision to teach and encourage the counselor to redirect and refine the selection,

implementation, and efficacy of interventions (O'Donovan, Halford, & Walters, 2011). Also, evidence-based supervision emphasizes using standardizing objectives and outcomes of supervision and the level of client impairment.

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

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

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

Cognitive behavioral models emphasize developing skills to develop and manage agenda setting, to problem solve and providing formative feedback (Cummings, Ballantyne, & Scallion, 2015). Skills for cognitive behavioral supervision are similar to the theory of CBT treatment. The step-by-step process is one of advancing the supervisee from socializing to the supervision experience to managing time (organize) and to establish a purpose for the agenda. The supervisor uses a collaborative approach emphasizing independence and communicates a genuine, empathic, listening and responding style as a facilitator of change and acceptance. Cummings et al. (2015) likened the process of problem-solving to that of Vygotsky's scaffolding where new learning is based on past learning in a relationship with a mentor (supervisor). Supervisee feedback is in the form of a trainee developing self-evaluation and reflection skills.

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

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

Training and Routine Outcome Monitoring (Evaluation for Supervision Integration)

Supervision research provides an empirical base for supervisee growth, treatment effectiveness, and an effective method to monitor treatment in the process and for the outcome. A key component of supervision is the relationship between the supervisor and supervisee and the supervisee's client. The effectiveness of this relationship has a direct bearing on the treatment objectives and the relationship between the supervisee and the client. Monitoring and providing objective feedback requires a methodology implemented at the beginning of therapy and session-by-session assessment of client change.

Routine outcome monitoring (ROM) tools are used to acquire treatment feedback for client change (positive and less so). Specific objective measures to determine client change and to assist clinician decision-making can be based on the pattern of progress or lack of progress. Supervisors introduce and integrate outcome programs to develop an effective method to obtain and use objective client feedback, use outcome monitoring to inform discussions of specific clients in agenda setting, use patterns of outcomes across clients to facilitate supervisee growth and development (problem-solving), and to track and predict client treatment change or failure (Wampold, 2015).

Alliance-Focused Training (AFT) focuses on therapist's skills for negotiating problems or ruptures in the alliance (brief relational therapy; BRT). The goal of AFT training is to increase the therapist's ability to recognize, tolerate, and negotiate alliance ruptures by enhancing supervisee self-awareness, affect-regulation, and interpersonal sensitivity (Eubanks-Carter, Muran, & Safran, 2015; Friedlander, 2015). Three skills are used interdependently; self-awareness, affect regulation, and interpersonal sensitivity (Safran & Muran, 2002). Self-awareness is the supervisee's ability to attune to his or her immediate experience and better detect strains in the alliance. Affect-regulation is responding empathically and resisting the urge to answer client hostility with a counter hostile response or to avoid behaviors to reduce one's anxiety. Interpersonal sensitivity is the ability to communicate with the client about what is taking place without worsening the rupture.

AFT training begins with readings, definitions, and an approach for rupture resolution. When an alliance rupture is severe clients often drop out of therapy, and a less severe rupture may be caused by inadequate negotiation of the goals and tasks of treatment (Friedlander, 2015). Friedlander reported that therapist responsiveness is required when the counselor describes the client behavior as a troubled alliance. A supervisor task is to become responsive to the treatment and to respond to the supervisee's reactions to the therapeutic rupture. Three training tasks included in the AFT model are a videotape analysis of challenging moments, use of awareness-oriented role-plays, and mindfulness.

Holt et al. (2015) offered an evidence-based supervision model to track outcome and to teach principles that are used in clinical supervision. The measures include the STS Clinician Rating Form (Fisher, Beutler, & Williams, 1999) and the Therapist Process Rating Scale (TPRS; Malik, Beutler, Alimohamed, Gallagher-Thomas, & Thompson, 2003) to assess therapist competence and the exactness in details of the quality of treatment. Eight principles for supervision include impairment (clients with weak social support systems), three relationships (strong working alliance, therapist relates to a client in an empathic way, resolve alliance ruptures), resistance (use directive therapeutic interventions), two coping principles (externalizing clients, internalizing), and readiness.

Supervision Instrumentation:

Therapist competence and fidelity of treatment application instruments include:

1. STS Clinician Rating Form (Corbella et al., 2003)
2. Therapist Process Rating Scale (TPRS; Malik et al., 2003)

Possible questions

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

Some possible supervision questions may appear similar to the following:

Question

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

a. share the treatment plan with the client
b. adhere to all policies of the counseling agency
c. 3,000 hours of clinical experience
d. 30 continuing updating hours each year
e. reveal all personal information about yourself
f. meet over lunch to discuss particulars of the situation

Answers: a, b

Question

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

a. frequency, location, length, and duration of supervision meetings
b. type of notes
c. supervision models and expectations
d. fee structure
e. liability and fiduciary responsibility of the supervisor
f. the evaluation process, instruments used and frequency of evaluation
g. therapy techniques required for treatment
h. emergency and critical incident procedures

Answers: a, c, e, f, h

Group Supervision

Group supervision has many of the same purposes as individual supervision. The group composition is four to eight supervisees coming together to present and receive assistance with cases.

The supervisor is to monitor the quality of the therapeutic work and understanding of a counselor's responsibilities during the therapeutic processes. Some advantages of group supervision are the economics of time, cost, and expertise, vicarious learning, breadth of client exposure, feedback with greater quantity and diversity, comprehensive picture of the client and supervisee, learning supervision skills, normalizing experiences and mirroring interventions (Bernard & Goodyear, 2009).

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

Question

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

a. confidentiality
b. economics of time, costs, and expertise
c. vicarious learning
d. breadth of client exposure
e. group phenomena issues
f. isomorphic
g. feedback of greater quality

Answers: b, c, d, f, g

Explanations:

a) No. Confidentiality is less secure, especially the privacy of fellow supervisees.
b) Yes. Time, costs and expertise are considered advantages especially when compared to individual supervision.
c) Yes. Vicarious learning through observing other counselor supervisees present case conceptualizations, techniques utilized and issues related to ethics.
d) Yes. Broader ranges of clients are presented during group supervision thus providing a breadth of client exposure.
e) No. Supervisee competition, scapegoat, and group dynamics may impede focusing on client care.
f) Yes. A supervisor and supervisee can set up a group format that mirrors the treatment being supervised (isomorphism or parallel process).

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

Question

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

a) develop a descriptive metaphor
b) develop and review critical points in a theoretical orientation
c) develop homework for the client
d) request the client to take a different perspective
e) consider a referral to another counselor
f) this is a situation that calls for case consultation

Answers: a, b (f is a possibility; however, the complexity of the case is not provided)

Question

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

a) a bug in the ear (BITE)
b) asking the client
c) in vivo exercise
d) phone-ins
e) client relapse
f) employing an empirical study

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

Question

For eight weeks, the counselor provided a client diagnosed with delirium treatment consistent with psychoeducation and supportive therapy. During the seventh week of a 14-week therapy commitment, the client informed the counselor that he/she didn't think he was getting better or had

benefited from the counselor's efforts to help. During supervision, the counselor requested what the supervisor might recommend he provide to the client (Select as many as you consider helpful)

a. offer the client the truth that there is no treatment for dementia
b. seek consultation from a hypnotherapist
c. try CBT
d. continue psychoeducation and supportive therapy
e. ask the client for specific suggestions that would be helpful
f. survey the literature for treatments that are helpful for specific aspects of dementia

Answer: e, f

Question

The counselor decided to seek supervision for a client's treatment. In selecting a supervisor, the counselor would want to consider which of the following? (Select as many as you consider appropriate).

a. supervisor's clinical experience
b. supervisor is listed on the approved supervisor registry
c. supervisor is within a 5 to 15-minute travel time of the cite
d. supervisor theoretical orientation
e. supervisor training

Answers: a, e

Explanations:

a) Clinical experience would be helpful.
b) This might be useful; however, is not required by law or ethics.
c) Not indicated
d) Travel time could be helpful but not necessarily a determining selection factor for this case.
e) Training would provide the counselor with the supervision knowledge and exposure to different supervision models, elements for a contract (stating the scope of supervision, role of a supervisor, methods and theoretical orientation for supervision, client counseling experiences, expectations for supervision and insurance coverage).

Question

Supervision is sought for treatment for a client experiencing a social phobia. The supervisor asked the supervisee what target (specific) behaviors should be addressed during treatment. (Select as many as you consider appropriate)

a. controlling adrenalin-mediated stress reactions

b. anger
c. behavioral laboratory
d. selective mutism
e. facial hyperhidrosis
f. self-esteem
g. internal critical script
h. sympathectomy
i. sugar intake

Answers: a, e, f, g, i

Explanations: The supervisor may want to gauge the counselor's developmental progress by reversing a normal procedure in which the supervisor identifies or points primary target goals for social phobia. The counselor's ability to identify goals might reflect the counselor's preparation in identifying symptoms and in treating a client who has social phobia.

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

a) Yes. It can be helpful to provide anxiety-disordered clients with education about the mind-body connection, including the role of the limbic system and the adrenalin-mediated fight, flight, and freeze reactions to stress. Also, it can be useful to train clients diagnosed with a specific social phobia to use techniques such as relaxation training or biofeedback training to control the physiological components of stress.
b) No. Anger is often associated with clients who have social anxiety or phobia. If anger surfaces during session work, it would be appropriate for the counselor to seek supervisory assistance to understand the process and appropriate therapeutic techniques.
c) No. This is a form of pro-active teaching and treatment and is not a target behavior requiring change. However, during treatment, it would be helpful to teach clients how to recognize and accept the physiological symptom of blushing caused by increased blood flow in the face.
d) No. This is not recommended unless inability to talk is apparent during the interview. In cases where mutism is an issue, parents should learn they may be contributing to the child's failure to speak by doing such things as 'enabling' by finishing their child's sentences and creating over-dependence. Rather, they should do such positive things as empowering initiative to speak, avoiding pleading or forcing speech, attentive listening and learning to be patient.
e) Yes, this concern is present in many situations where others are involved. During treatment, it could be helpful for clients to practice learning how to recognize and accept the physiological symptom of hyperhidrosis (increased sweating) caused by the adrenalin mediated anxiety response to stress and possibly learning to control or modify it.

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

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

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

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

In summary, it is recommended to review the ACA 2014 Code of Ethics to become aware of different tasks, duties, and relationships with a supervisor and counselor. Specifically review Sections F.2., F.3., F.4., and F.5.: Counselor Supervision Competence, Supervisory Relationships, Supervisor Responsibilities and Counseling Supervision Evaluation, Remediation and Endorsement. Also, see consultation services provisions in Section D.2. Consultation.

There are numerous supervision questions that can be posed when reviewing the ethical code. Some ideas may be gathered from the following (ACA, 2014):

1. Records (A.1.b.): Required by law, timely documentation, documentation is accurately placed in the chart, client progress, services provided, and errors in the record
2. Client records not to be kept. Wheeler (2013), a licensed attorney, recommends that the counselor should not comply with this type of request (Standard A.1.b, ACA, 2014).
3. Client requests their counseling records. Wheeler (2013) recommended records to be based on HIPAA regulations. Copies may be given to the client but not the original records. There is a difference in copies and originals. If under a subpoena consult with your attorney for release.
4. Informed Consent (A.2.a.): Review in writing and verbally with client rights and responsibilities and regarding process and counselor

5. Information needed (A.2.b.): Purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services, counselor qualifications, credentials, relevant experiences, confidentiality, records, a continuation of services regarding death or incapacities, implication of diagnosis, use of tests and reports, fees and billing.
6. Fees (A.10.c.): Financial status of clients, locality, comparable services
7. Treatment teams (B.3.b.): Client is informed of teams' existence, composition, information shared and purposes of sharing information.
8. Scientific Bases for Treatment Modalities (C.7.a.): Use techniques and procedures grounded in theory and have empirical support. Those techniques and procedures that have been defined as unproven should be subjected to ethical consideration and acknowledged as having a potential risk. Theory effectiveness and efficacious results published in professional journals provide the documentation for scientific and non-scientific use for treatment. (ACA, 2014).
9. Understanding Consultees (D.2.b.): Clear understanding of problem definition, goals for change, predicted consequences of the intervention.
10. Proper Diagnosis (E.5.a.): Assessment techniques to determine client care—the locus of treatment, type of treatment, recommended a follow-up.

Ethics

Questions involving ethical responses and decision-making for the counselor can occur at any time during client care. The authors decided to standardize six questions for many of the clinical cases. Nevertheless, the reader should review the American Counseling Association 2014 Ethical Code (ACA, 2014). Specific focus and attention should be devoted to ethical terms and counselor and supervisor tasks involving consultation, supervision, and administrative tasks. Care should be exercised in the use of DSM-5 labels when the validity of the data is lacking or scant for making an assessment. An ethical approach to this dilemma is to conduct another assessment at a later time and see if the assessment matches.

Standards

The AMHCA standard of practice for supervisors' requirements is knowledge and skill-based. Knowledge standards criteria include (brief) evidence-based clinical theory and interventions, understanding client population and working knowledge of supervision models; understanding roles, functions and responsibilities of supervisors, including liability; communicating expectations and nature of relationships; understanding appropriate professional development activities, supervisory relationships related to issues, and cultural issues; understanding and defining legal and ethical issues (laws, licensure, rules and code of ethics); understanding evaluation processes; and understanding

knowledge of industry recognized financial management processes, record keeping, and transmission of records.

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

Client Rights (HIPAA, FERPA)

Health Insurance Portability and Accountability Act (HIPAA)

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

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

The Privacy Rule was finalized in 2003 and applies to 'covered entities' such as organizations and individuals that transmit patient information electronically, in paper form or orally. The covered entity includes health and mental health plans and written client-signed releases of information. The Privacy Rule includes all records that are held or information disclosed to a covered entity. The interpretation of this rule is that counselors are to provide to the client a written explanation of how the counselor will use, keep and disclose his/her health information. A procedure is to exist so that the client may make amendments or execute changes in the record as well as gain access to his/her records. Also, the counselor is to have an established privacy procedure as to who has access to the client records. Client consent is to be obtained for the release of information about treatment, payment and health care operations purposes as well as transmission of client information to financial institutions. Exceptions are noted in the document whereby information may be released during times of an emergency. Even when clients provide permission to release information, the minimum amount is covered under the "Minimum Necessary" rule. The "Minimum Necessary" rule allows the health provider to use, to request, or to disclose to others only necessary client information to fulfill the intended purpose. Each provider is to consult other privacy federal laws when disclosure is under consideration. The Privacy Rule may be secured at http://www.hhs.gov/ocr/hipaa.

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

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

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

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

Family Educational Rights and Privacy Act (FERPA)

This act, created in 1974, was previously referred to as the Buckley Amendment. The act and specifications affect all public and private parochial educational institutions that receive federal funds. If a school system has a health-based center, it may be subject to HIPAA requirements regarding student health records. FERPA indicates that parents of minor students (under 18 years or in college) have the right to inspect the records and to challenge information contained within the file and to have written authorization obtained before any education records are transferred to any third party (US Department of Education, 2008). Parents or guardians may receive copies of the student records without the permission of the student (Remely & Herlihy, 2010). This does not include case notes if retained as separate from the student file and not made available to anyone else.

RECORD KEEPING: Psychotherapy and Progress Notes

Good record keeping is evidence of quality of care and adherence for state, federal, professional organizations (ethical guidelines and standard of care), and HIPAA guidelines (Zur, 2019). Ethical consideration in writing psychotherapy notes and especially progress notes are covered in Section A (informed consent-A.2.a; types of information needed-A.2.b), Section B (confidentiality and privacy-records and documentation-B.6., B.6.a.-creating and maintaining records and documentation, B.6.b.-confidentilaity of records and documentation, B.6.c.-permission to record, B.6.d.-permission to observe, B.6.e.-Client access, B.6.f.-assistance with records, B.6.g.-disclosure or transfer, B.6.h.-storage and disposal after termination, and B.6.i.-reasonable precautions (ACA, 2014).

Client information is secured from a variety of sources that include the interview, testing, family or therapy participating members, and referral sources. It is important the therapist is knowledgeable about how psychotherapy notes (private notes) differ from progress notes.

Psychotherapy notes are considered to be the therapist's private notes and not a part of the client chart or available to others. Sound judgement is recommended when using psychotherapy notes because there are instances when this information may be required by law such as:

1. court ordered warrant, subpoena by a judicial officer
2. grand jury subpoena
3. a governmental agency summons, investigative demand (Spector, 2014)

The therapist's psychotherapy notes can be in any form and may exclude medication and prescriptions, monitoring, counseling session start and stop times, modalities and frequency of treatment, clinical test results, summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and monitoring notes. It is possible to conceive of the psychotherapy notes as a case conceptualization. Psychotherapy notes are kept from public view and therefore protected by HIPAA releases as long as they are separate from progress notes and the client folder (Spector, 2014).

Progress notes include but are not limited to purposes, goals, techniques, procedures, limitations, potentials risks and benefits of services, counselor's qualifications (credentials, experience), diagnosis, tests, fees, confidentiality rights, supervisory involvements in the treatment, treatment commitment and provisions for refusal rights.

In summary progress notes do include medication prescription, monitoring, modalities (theory and techniques), frequency of treatment, clinical test results, diagnosis, functional status, symptoms, prognosis, and progress monitoring session to session (Spector, 2014). Kettenbach, Schlomer, and Fitzergerald (2016) recommended progress notes specify the frequency, intensity, and duration for symptoms, sources or equipment used in providing treatment, changes in the treatment plan, communication with the client and family consultation that took place during the contractual arrangement.

Client access to their records may be at the discretion of the therapist's judgement concerning reasonable access and client competence and if access would cause harm to the client. The client's

request is to be documented and a rationale included if certain aspects of the record are denied. A release is required and documented if the client requests their record to be disclosed or transferred to a third party.

The counseling relationship involves the therapist's obligation to share client rights in writing and verbally through informed consent procedures. Informed consent allows for client commitment and the right of refusal to any aspect of the relationship and treatment.

Auditing:

Progress notes for insurance purposes are important for counselor providers as well as for clients not supported by an insurance provider. There are numerous ethical reasons for professionals to document and write progress notes that encompass the treatment contract. The documentation for the client's plan should be such that the progress notes are written with behavioral specificity to withstand third-party audits. Progress notes are a legal record of the client's assessment, diagnosis, treatment, monitoring, referrals, testing, and are a part of an ethical contract protected under HIPAA privacy rules. Insurance providers utilize progress notes to determine the client's eligibility for approval for payment for treatment or to extend a treatment plan.

Auditing is to reflect an accurate and precise form for tracking for quality assurance within the mental health counselor-client relationship. Auditing provides for accountability and fidelity in the best client care in the governance and management for agency and therapist records. Service providers (counselors) undertake activities throughout the intake assessment (diagnosis, testing), treatment, and termination in accordance for client rights (ethical and legal) and sound therapeutic practice.

Berk et al. (2003, p. 252) reported four types of clinical audits. These types are:

1. clinical review, a paper review of written clinical notes
2. peer review, a review of practice (professional, departmental or organization
3. client-cohort review, a prescriptive format monitoring practice against a standard and can be content or process
4. selected critical review, a procedural audit rather than individual care. This review is across a department for patterns.

Broad topical areas are used by insurance company reviewers to determine eligibility from progress notes. Topical areas include assessment, diagnostic justification, issues addressed, identified treatment plan and timeline, qualified service providers (what is needed for treatment and if personnel are qualified to treat), and progress update for each session whether or not progress is achieved and what factors are associated for the observations (By Sandy, 2019).

Numerous auditing tools for quality reviews have been developed by insurance companies, clinical and governmental agencies and states. There are many common factors or categories contained within these auditing forms for progress notes and accountability practices.

Computer online examples are provided by Alameda County Behavioral Health Care Services (2014), Beacon Health Care (2015), and Magellan Health (2015). Beacon Health Care has specific auditing standards for different DSM-5 disorders such as ADHD, Major Depression, Bipolar Disorder, and Schizophrenia (2019). Some audit tools or review teams may require supervision as a part of the audit.

Magellan Health (2015) online auditing tools for different purposes include clinical audit, compliance audit, claims audit, and network audit. The Magellan clinical audit includes 61 observations across 10 categories. Five of the categories are general, consumer rights and confidentiality, initial evaluation, individualized treatment plan, and ongoing treatment. A limited number of content observations will be identified for a few of the categories. (See Magellanofpa.com for the complete audit tool.)

a) name, start date, demographic information
b) signed treatment informed consent forms-offer of refusal and documented), client bill of rights, informed consent for medication, releases for communication
c) reason seeking service, DSM-5 diagnosis, history of symptomology, psychiatric history, co-occurring substance induced, current and past suicide/danger risk, assessment of client's strengths, skills, abilities, level of familial support, areas for improvement, allergies, current medication
d) strengths based on treatment, measurable goals, objectives documented, goals/objectives identified with improvement outcome, use of preventive services
e) intensity of support, progress toward measurable goals, clinical assessments and interventions each visit, substance use assessment, comprehensive suicide/risk assessment ongoing, medications are current, compliance or non-compliance, treatment in culturally competent manner, family support, crisis plan documented (Magellan, 2015)

Value Options (November, 17, 2007) included 33 standards in their Provider Treatment Record Audit Tool. The first six of 33 standards include similar topical areas as other audit tools for recording to include:

a) demographic identification/legibility, histories or presenting problem, psychiatric history, medical conditions and issues relevant to race, religion, ethnicity, age, gender level of education, and socio-economic level (demographics)
b) mental status
c) safety evaluation for homicidal, suicidal
d) substance and abuse
e) DSM diagnosis to include mental status functioning, presenting problem
f) psychiatrist medication prescribed, dosages of each and date of first prescription filled treatment plans, progress notes, coordination of care, and child and adolescent.

Specific aspects for progress notes include describing client strengths and limitations in achieving treatment, documentation for relapse prevention , stress management, wellness programs, lifestyle

changes, and referrals to community resources, dates of follow-up appointments or discharge plan (ValuesOptions.com).

American Counseling Association Code of Ethics and Standards of Practice, Effective 2014. http://www.counseling.org/Resources/aca-code-of-ethics pdf

Magellan Healthcare, Inc. 2006-2016 (2015). Preparing for an Audit: Treatment Record Review Tool. Accessed September 20, 2019.

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Values Options (Nov 17, 2007) 2015. Provider Record Audit Tool. Values Options.com

Study Suggestions

1. It is the opinion of the author that those preparing to take the NCMHCE need not memorize all of the symptoms of each mental disorder. Nevertheless, the more you know, the better you will be able to select a correct diagnosis or rule out a disorder.
2. It is suspected that you will not be held accountable for specific medications or the technical names of drugs. Information about medications in this manual may seem excessive to some but is intended to reinforce that aspect of treatment and monitoring. More than likely examinees will be expected to know which disorder is likely to be best treated with the addition of prescribed medications. The role of the counselor is to monitor compliance and make recommendations when the client is not in compliance.
3. Several interview surveys and instruments are listed within each of the disorder categories. They are included as a reminder that some may be utilized for assessment and monitoring client progress. There are many instruments listed throughout the supplement, and many of those instruments will likely not be on the NCHMCE. One approach in preparation for instruments is to focus on those instruments that are widely or frequently used and published in measurement journals.
4. It is standard practice during the initial interview for mental health evaluators to inquire about the physical health of their clients (medical assessment), which often includes asking them to complete intake forms on which basic medical information is requested. The author designed

many case scenarios in which there may not be a specific question in the data-gathering questions that request medical information. In those cases, the test taker should consider the possibility that a medical concern might surface from other questions later in the scenario. If that happens, a referral might be made to Section B to secure medical information that may be helpful in making a diagnosis. For example, a client suffering from a sleep disorder could have a secondary sleep problem based on another mental or medical disorder. The latter possibility would require further medical evaluation. In other cases, the mental health evaluator will not realize until later that additional medical information should be requested because of clues that emerge in the answer sections of some of the case scenarios. In such cases, an additional probe would be necessary to request further medical information and evaluation.

5. Many of the scenarios include a request for psychiatric consultation. A request occurring in a rule in/out question would be either for diagnostic purposes—establishing or confirming a difficult diagnosis—or for initiating psychoactive medications when the client's psychiatric condition is severe enough to warrant immediate intervention. Be aware, however, that ordinarily, a psychiatric consultation for the purpose to start clients on psychoactive medications would not take place until after the provisional diagnosis has been established--during the treatment phase of the NCMHCE.
6. Obtaining a family history is important in the scenario's assessment phase to help make diagnoses for those conditions having a genetic predisposition or biological or environmental markers. These include mood disorders, bipolar disorder, schizophrenia, anxiety disorders, ADHD, eating disorders, tics, alcoholism, and substance use.
7. The scenario's treatment phase is meant to define those treatments, psychotherapies, and alternative treatments demonstrated to be most appropriate and helpful for symptom remission for specific diagnoses. The choice of treatment is also affected by the duration allowed or required to achieve the desired results, availability of trained and experienced therapists, and a supportive treatment setting appropriate for chronic illnesses and personality disorders. Psychodynamic therapies typically require longer treatment duration and may be most appropriate for skilled therapists whose clients have sufficient resources including a supportive environment, motivation, and cognitive capacity.
8. Review the 2014 ACA Code of Ethics Section C.7.a. Scientific Bases for Treatment Modalities regarding obligations to the client.

Unit 2. DSM-5 CLASSIFICATION

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

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

Regarding children, the following disorders are to be found in neurodevelopment disorders.

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

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

Neurodevelopmental Disorders

Intellectual Disabilities

The American Association for Mental Retardation (AAMR), American Psychological Association (APA), and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) offer similar yet subtly different definitions for intellectual disabilities. The DSM-IV-TR (APA, 2000) defined intellectual disabilities according to the essential feature of a subaverage intellectual functioning (IQ < 70) with onset before age 18 accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: use of community resources, self-direction, functional living, functional academic skills, communication, self-care, social/interpersonal skills, work, leisure, health, and safety (p. 41). One criticism made by Greenspan (1999) was that mental retardation is assessed by one factor--that of intelligence quotient (IQ) scores. He suggested the definition should include terms less injurious such as: deficits in social, practical, and academic intelligence; decreased diagnostic reliance on standardized test scores and greater reliance on clinical and consensual judgment; assumption of an underlying biological etiology; ongoing need for supports and protections; and recognition that vulnerability to potential exploitation and manipulation is a universal feature of the disorder (APA, 2013, p. 6).

The panel for the DSM-5 attended to the intelligence factor single assessment indicator and added adaptive behavior. Rather than a single score on an intelligence instrument (< 70), a second measure is to be applied, namely adaptive functioning. The IQ of 70 or less was maintained; however, all other IQ numbers were dropped. The assessment included additional domains to include conceptual, social, and practical. Finally, the name changed from mental retardation to intellectual disability based on the rationale that mental retardation was an injurious and outdated term (King, 2014l).

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

Definition and Interview:

Any assessment should be matched with the characteristics of the person. The characteristics should include the age of the person, mode of communication, and motor and visual-spatial capabilities.

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

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

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

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

Incidence:

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

Screening for medical and neurodevelopment disorders includes gathering information from the history and mental status. The interviewer can be suspicious of a medical or neurological disorder when there are alterations in behavior and personality, mood, and physical signs. Often a medical disorder can exacerbate a mental disorder (Sternberg, 1986). At risk for medical or neurodevelopment disorders that are associated with psychological difficulties include prenatal, perinatal, and neonatal risk factors, individuals with well-established histories of medical illness and neurobehavioral change, the elderly, those with schizophrenia and major mood disorders (Pollak, Levy, & Breitholz, 1999).

Medical:

Pollak, Levy, and Breitholz (1999) proposed a medical checklist for symptoms and signs that may include:

1. the first episode with catatonic, psychotic, and severe mood symptomatology
2. an acute or abrupt onset of symptoms involving a rapid change in mood
3. initial onset of symptoms after age 45
4. symptoms appear after major medical illness while taking medications
5. the absence of recent psychosocial stressors
6. vegetative and cognitive symptoms and cognitive change such as short-term memory
7. rapid change in mental status to include the level of consciousness, alertness and attention, disorientation, confusion, and short-term memory loss, language processing, and organization/planning or problem-solving
8. visual, tactile or olfactory changes
9. alteration in motor functioning to include stuttering, ataxia, gait, and tremor
10. derealization, depersonalization, Déjà Vu, and unexplained epigastric sensation
11. signs of cortical brain dysfunction (aphasia, apraxia, agnosia, and viso-deficits, brain dysfunction (slowed speech, thinking, and movement)
12. multiple medical disorders with mental status change
13. organ failure
14. the sense of physical weakness
15. headaches (pp: 351-52)

Medical signs that may be related to the development of the above symptoms may include endocrinopathies, arterial and vascular disease, neoplasm, infections, nutritional deficiencies, neurodegenerative disease (Alzheimer's disease, Parkinson's disease), other neurological conditions (head injury, seizure, and migraines), and substance-related conditions.

Clues that might suggest an initial mental condition include:

1. a long history of psychosocial difficulties
2. somatic complaints, sensory and motor change
3. object relationship disturbance (help rejecting styles, noncompliance behaviors)

4. lack of concern regarding the symptoms
5. minimizing psychosocial stressors
6. reluctance to consider psychodynamic causes after medical condition is ruled out
7. evidence of secondary gain
8. cognitive complaints (memory deficits)
9. history of substance-related problems and
10. family history of mental disorders (pp. 352-53)

Neurological assessment components that check for symptoms include (examples are abbreviated, see article for additional examples):

1. family history: autoimmune disease, degenerative brain disease, metabolic disease, intellectual disability, neurodevelopmental attention, learning and speech disorder, and mood and temperamental deviations
2. obstetrical history: infections, toxin exposure, toxemia, and malnutrition
3. obstetrical history (prenatal risk factors): low birth rate
4. obstetrical history (perinatal risk factors): jaundice, traumatic brain injury, anoxic or hypoxic brain hemorrhage,
5. developmental history: delayed milestones, mood and temperamental difficulties, cognitive difficulties, motor functioning, handedness, and anomalous physical appearance (skin folds, etc.)
6. high base rate early and middle childhood medical risk factors
7. high base rate adolescent and adult medical risk factors: physical illness, medication use, anoxic/hypoxic insult, electroconvulsive therapy
8. lifestyle-related risk factors
9. medical risk factors across the life span
10. academic/vocational development and functioning

Instrumentation:

There are some norm-referenced instruments for intellectual functioning to determine global estimates of cognitive abilities. Some of these include:

1. Stanford-Binet Intelligence Scale: Fourth Edition (Laurent, Swerdlik, & Rybum, 1992)
2. Wechsler Intelligence Scales (Wechsler, 1974, 1991, 1992, 2003)
3. Test of Nonverbal Intelligence (Brown, Sherbenou, & Johnsen, 1982, 1997)

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

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

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

Attention Deficit Hyperactivity Disorder

Some changes in the definition of attention-deficit/hyperactivity disorder (ADHD) have been included in the DSM-IV (APA, 1994), persist in the DSM-IV-TR (APA, 2000), and in the DSM-5 (APA, 2013). The current approach to understanding this syndrome is to consider two symptom domains: inattentive and hyperactivity/impulsivity. The combined type is classified as a specifier. Attention-deficit/hyperactivity is defined as a persistent pattern of inattention and hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development and interferes with functioning (APA, 2013, p. 59). Criterion A specifies that inattention requires six or more symptoms from a list of nine and persists for six months. Six or more of a similar list exists for hyperactivity and impulsivity for the same six months. A client age 17 or older need only meet five symptoms (APA, 2013). Criterion C requires that the behavior is noted in two or more settings (school, home, work, friends, or other activities). Several inattentive or hyperactive-impulsive symptoms were to be present before age 12 (Criterion B).

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

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

Included as necessary for the diagnosis is an associated impairment in social, academic, or occupational functioning. The symptoms must have lasted for six months before the assessment and have produced maladaptive behaviors, which are inconsistent with group developmental levels.

It has been reported that two-thirds of children diagnosed with ADHD may have a concurrent clinical disorder including oppositional defiant, conduct disorder, learning disorder, and pervasive developmental disorder (Biederman, Newcorn, & Sprich, 1991; Pliszka, 1998). Sinzig, Dopfner, Lehmkuhl, and German Methylphenidate Study Group, 2007), in their study, found that 4.9% of the children showed oppositional defiant disorder/conduct disorder symptoms. The overlap of these disorders with ADHD is well documented. Reeves, Werry, Elking, and Zametkia (1987) suggested that all children under age 12 diagnosed with conduct disorder and oppositional defiant disorder also meet the criteria for ADHD. Several authors have pointed out that children with ADHD are at risk for conduct disorder. A comorbidity rate for ADHD with ODD is 35%, 50% with CD, 15% to 75% with a mood disorder, and 25% with an anxiety disorder (Althoff et al., 2003). It is no surprise those individuals with ADHD, conduct disorder (CD), and oppositional defiant disorder (ODD) have a poorer prognosis when these disorders occur together (Barkley, 1990). Comorbid conditions also may be present, such as intellectual disability, disorders caused by genetic abnormalities, and anxiety or mood disorders provoked by environmental disruptions (e.g., sexual abuse, assault, environmental disruption, and family death).

Biederman et al. (1995) reported that there is a significant link between the parent and the child diagnosed with ADHD.

The DSM-5 refers to differential diagnosis occurring with or sharing comorbid symptoms as oppositional defiant disorder, intermittent explosive disorder, specific learning disorder, intellectual disability, autism spectrum disorder, reactive attachment disorder, anxiety disorders, depressive disorders, bipolar disorder, disruptive mood dysregulation disorder, substance use disorders, personality disorders, and neurocognitive disorders (APA, 2013).

Definition and Interview:

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

Two lists of criterion behaviors are provided for the subtypes (inattention, hyperactivity, and impulsivity) in the DSM-5. A correct diagnosis is dependent on a menu list in which 12 of 18 symptoms must be present for a diagnosis of the combined type for the past 6 months (specifier), and six of nine criteria are to be met for inattention and hyperactivity/impulsivity. Behaviors for inattention include failing to pay close attention to details, difficulty sustaining attention in play activities, a seeming inability to listen, and difficulty organizing tasks. Hyperactivity criteria often include fidgeting with hands or feet, leaving a seat in a classroom, talking incessantly, and running about excessively. Impulsivity criteria behaviors are often blurting out answers, difficulty waiting for his or her turn, and

interrupting others (APA, 2013, p. 60). It may be difficult for the person conducting the assessment to determine what is "often" when assessing reports from others.

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

Parent and teacher interviews are important sources of information for the person conducting the assessment. Rating scales are available to collect this data. In addition to securing parent and teacher information on behavior, rating scales such as the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992, 2004), the Conners Rating Scales, and the Child Behavior Checklist (Achenbach, 1991a, b) are effective scales to assess the problem and for adaptive behaviors. A detailed developmental history is also recommended. This history taking will shed light on the age of onset as well as any parental history of this disorder.

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

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

Many adults who come to counseling for social, occupational or academic issues and who are later diagnosed with adult ADHD may not have been previously treated for this disorder, although having ADHD symptoms has led to employment termination and substance abuse issues (Wadsworth & Harper, 2007). The interview for ADHD for adults necessitates asking the individual to recall behaviors during early and middle school years because the diagnosis requires onset in childhood. Comorbidity can also occur, as the adult may have another disorder at the time of the interview. Borland and Heckman (1976) found a high rate of antisocial personality, anxiety, and depressive disorders in their adult studies when compared with children with ADHD.

Incidence:

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

Barkley (1990) indicated that at least 50% of children with ADHD might develop mood disorders, particularly bipolar spectrum disorders (Pavuluri, Henry, Nadimpalli, O'Connor, & Sweeney, 2006). Hudziak et al. (1998) reported that ADHD has genetic elements. For example, about 70% of children

diagnosed with ADHD have parents either diagnosed with the disorder or who reveal some symptoms of ADHD. Wadsworth and Harper (2007) reported the estimated percentage of adults with ADHD is 4.7% worldwide.

Diagnostic Information:

There has been increasing incidence of behavioral and learning disorders among children and adolescents in the United States. These disorders are most often diagnosed with symptoms of ADHD. Typically, beginning before age 7, symptoms appear more frequently in boys than girls and cause disruption in school and at home. A developmentally inappropriate reduced attention span and age-inappropriate features of hyperactivity and impulsivity characterize the disorder. It must be present for at least six months in duration and interfere with academic or social functioning. Although the cause of such difficulties is frequently genetically based, they have also been associated with child abuse and neglect. Children in institutions are often overactive and have reduced attention spans, but such symptoms disappear when these factors are removed. Predisposing factors to ADHD may include the child's temperament, genetic-familial elements, and the demands of society to adhere to a controlled way of behaving and performing. A low socioeconomic standing does not seem to be a predisposing condition (Kaplan & Sadock, 1998). Jarrett (2016) reported that executive functioning deficits for clients with diagnosed ADHD revealed that inattention followed by hyperactivity/ impulsivity anxieties reflected a gap in self-regulation of emotion and self-organization/problem-solving skills.

Instrumentation:

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

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

1. Wechsler IQ test (WPPSI-R, WISC-III, WAIS-R; Wechsler, 1991)
2. WJ-R or WIAT (Wechsler Individual Achievement Test; Wechsler, 1992)

The behavioral assessment provides important sources of information for the evaluator; however, behavioral reports are known to be frequently inaccurate. Social desirability, halo effects, parent exasperation, and leniency errors affect accuracy. Some rating scales, frequently parent and teacher forms, are available to assess ADHD. Some of these include:

1. Disruptive Behavior Disorders Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992)
2. Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1986)
3. Impairment Rating Scale (Pelham et al., 1996)
4. Conners Rating Scale-Revised (Conners, 1989)

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

When making the diagnosis of ADHD, there should be evidence of six symptoms related to hyperactivity or inattention maladaptive behavior that has been present for at least six months. Comorbid disorders are an oppositional defiant disorder, conduct disorder, learning, mood, and anxiety disorders (Spencer, Biederman, & Wilens, 2004). Also, Tourette's syndrome and tic disorders are found in conjunction with ADHD (Biederman, Harding, Wilens, and Farone, 1995; Spencer et al. 2001; Spencer, Biederman, Harding, Wilens, & Farone, 1995).

Treatment:

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

Children:

ADHD is one of the most efficiently treated childhood disorders. Goldstein (1996) recommended a multimodal, multidisciplinary, and long-term approach to treatment. He recommended parent counseling and training, client education, individual and group counseling, social skills training, psychopharmacological medication, and school intervention. Treatment involves using behavioral and pharmacologic treatments. Some medications have been prescribed; however, the stimulant methylphenidate (Ritalin)--available in both short-acting and extended-release forms--has been the pharmacologic intervention used most frequently in the past with amphetamine-dextroamphetamine (Adderal) and extended-release methylphenidate (Concerta). Also, these stimulant medications are becoming more commonly prescribed (Michelson et al., 2003), with a response rate of 70% for child and adolescent ADHD (Sinzig et al., 2007; Spencer, Biederman, Wilens, & Faraone, 1996, 1998). Improvements in children have been recorded with both ADHD and tics using methylphenidate and clonidine (Johnson & Safranek, 2005).

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

ADHD symptoms occur in 5% of children in the United States. Physician visits by children with this disorder have been up 90% in response to a twofold increase in this diagnosis being made over the past seven years. Although stimulants are used to treat the majority of children with ADHD, some disadvantages have been reported, such as the transitory nature of the effects, which cease when medication is not used, a failure rate of 30% to 40%, and concerns about possible long-term safety (Rappley et al., 1999). Some professionals have been concerned about stimulants and have sought other treatments, including electroencephalogram (EEG) neurofeedback training, a novel treatment approach, which some researchers claim is both effective and more enduring (Kirk, 2004; Lubar, Swartwood, Swartwood, & O'Donnel, 1995).

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

1. conduct an assessment and psychoeducation
2. attention training
3. reinforcement techniques
4. maintenance and implementation of the plan to new situations
5. follow-up (Kronenberger & Meyer, 1996)

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

Treatment (Adults):

Weiss and Weiss (2004) recommended the following activities be a part of the treatment plan for adult ADHD:

1. education about ADHD
2. attention management training
3. behavioral management training
4. social skills training
5. stress management training
6. anger management training
7. problem-solving training

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

In the treatment of ADHD, recent studies have reported success with electroencephalographic (EEG) biofeedback (neurofeedback). These studies have reported improvement in attention and behavioral control and gains on tests of intelligence and academic achievement (Monastra et al.,

2005). A review of this treatment reported that 75% of cases showed this improvement, but continued studies are required.

Faraone (2004) and Spencer et al. (1998) reported in their studies that adults with ADHD were as responsive to the same or similar groups of stimulants as were children and adolescents. Mattes, Boswell, and Oliver (1984) found the response rate for adults to be 25%. Occasionally physicians may prescribe certain medications, including atomoxetine (Strattera), modafinil (Provigil), guanfacine (Intuniv), and bupropion (Wellbutrin), rather than stimulants to treat ADHD but find that patients with significant symptoms do not experience as much improvement. Stimulants such as methylphenidate (Ritalin), including the long-acting form of Ritalin (Concerta) and the combination of dextroamphetamine and racemic amphetamine sulfate (Adderal), lisdexamfetamine (Vyvanse), are the most commonly prescribed medications for adults and children (Michelson et al., 2003).

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

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

Monitoring:

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

1. lengthy pauses in a speech pattern (inattentive)
2. abrupt stops in speaking in the middle of a sentence
3. client forgetting what he or she said
4. wandering into places and forgetting the reason for going to that place
5. clients requesting repeats of what was said to them or requested of them
6. staring into space rather than focusing on a person
7. Interrupting others (impulsivity)
8. wanting things immediately (impulsivity)
9. not thinking about consequences (impulsivity)

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

Efficacious Treatment:

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

Well-established:

Behavioral Parent Training (BPT)

Behavioral Classroom Management (BCM)

Intensive program-based peer interventions (BPI)

In summary, Pelham and Fabiano (2008) reported different guideline recommendations for psychopharmacological intervention (stimulants). The AMA indicated 'may include' pharmacotherapy, AAP 'should' recommend medication, and AACAP treatment 'may consist' of pharmacological intervention.

Motor or Tic Disorder

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

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

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

blowing, making sucking or smacking sounds, and clearing the throat. Obsessions, compulsions, attention difficulties, impulsivity, and personality problems often coincide.

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

Instrument:

1. The Yale Global Tic Severity Scale (YGTSS; Leckman et al., 1989)

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

Treatment:

Treatment of tics may be necessary when they are severe enough to impair the client or cause emotional disturbances. The use of medications is not recommended unless the symptoms are unusually severe and disabling. Behavioral techniques, particularly habit reversal treatment and stimulus control, have been effective in treating transient tics. Cognitive-behavior therapy is the treatment of choice.

Recommendations for treatment would include habit reversal training, stress reduction, and psychoeducation concerning the influence that stress, anxiety, and fatigue affect the severity of symptoms. This education would coincide with education regarding the OCD symptoms.

Researchers have determined that comprehensive behavioral intervention (CBIT) for tic therapy has been helpful for 53% of children involved in this treatment (Piacentini et al., 2010). CBIT is based on habit reversal training that includes two concepts: tic awareness and competing-response training (Piacentini, & Chang, 2006). Tic awareness training teaches the individuals how to monitor themselves for early indications (including the urge) that a tic is about to occur. Competing-response training teaches them how to engage in a voluntary behavior designed to be physically incompatible with the impending tic, thereby disrupting the cycle and decreasing the tic.

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

Tourette's Disorder

Tourette's disorder is a movement disorder usually seen in school-age children and manifested by the presence of tics. Tourette's symptoms are involuntary, sudden, brief, intermittent, repetitive movements or sounds. Tics tend to be clonic (brief), dystonic (prolonged), and sustained. Kenney et al. (2008) provided examples of tics such as the simple motor (eye blinking, head jerking, nose twitching), complex motor (burping, copropraxia, head shaking, hitting, jumping, retching, smelling objects), and simple phonic (blowing, coughing, grunting, screaming, squeaking, sucking, throat clearing). Tics come and go over days, weeks, or months. Tourette's clients may have multiple tic types. This syndrome can be associated with other disorders (Albin & Mink, 2006). For example, a child with Tourette's syndrome may have also been diagnosed with ADHD by age 4 and OCD by age 7.

Treatment:

The goal of treatment is to improve social functioning and self-esteem and to reduce tics (Kenney et al., 2008).

Cognitive-behavioral therapy is the treatment of choice. Behavioral therapies found to be effective for habituation are exposure and response prevention (ERP), habit reversal (HR), and stimulus control (SC). Behavioral treatment targets are reducing the physiological manifestation of anxiety such as heart rate and are based on the belief that tics are intentionally executed responses to relieve tension and associated unpleasant sensory sensations (Verdellen et al., 2008). Symptoms unresponsive to behavioral interventions may require pharmacological and even surgical procedures.

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

Schizophrenia Spectrum and Other Psychotic Disorders

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

Schizophrenia

Definition and Interview:

The DSM-5 renamed the category of schizophrenia spectrum and other psychotic disorders to include schizotypal (personality) disorder, schizophrenia disorder, delusional disorder, brief psychotic disorder, schizophreniform disorder, and schizoaffective disorder. Subtypes have been eliminated from the DSM-5 (APA, 2013). The definition and assessment remain pretty much unchanged from the DSM-IV-TR with the criteria exception consideration for bizarre delusions or hallucinations having been removed. Differentiating between bizarre and nonbizarre delusions is of less importance during the assessment. Catatonia is no longer a subtype. The American Pharmaceutical Association (2001) in a special report emphasized the assessment includes bizarre behavior, negative symptoms, cognition, and mood categories. The first category involves questions about unusual or bizarre behavior (agitation, aggression/hostility, catatonic behavior, combativeness, hyperactivity/repetitive actions), delusions (guilt, loss of mind, persecution), disordered thought and speech (ambivalence, circumstantiality, loose associations, incoherent speech), and hallucinations (auditory, gustatory, olfactory, tactile, visual). The second category for assessment included negative symptoms (alogia, anhedonia, anosognosia, apathy, avolition, blunted or flat affect, emotional withdrawal). The third category is cognition (attention, impaired executive function, and memory deficits), and the fourth category is mood (anxiety, depression).

Schizophrenia is a significant mental illness causing dysfunction in social, academic, and occupational areas with the onset and continuous disturbance duration persisting at least six months (Criterion C) in which there is at least one month of symptoms in Criterion A (APA, 2013, p. 99). Characteristic symptoms of schizophrenia are included within the group of the five listed below and should include one of the first three symptoms (delusions, hallucinations, disorganized speech) during a one-month period (APA, 2013). In the DSM-5, Criterion A for schizophrenia regarding psychosis, the client can no longer meet the criterion with a single bizarre delusion but now requires two or more symptoms from the list below, at least one of which must be delusions, hallucinations, or disorganized thinking (King, 2014p).

1. delusions
2. hallucinations
3. disorganized speech
4. grossly disorganized or catatonic behavior
5. negative symptoms (i.e., affective flattening, alogia, or avolition).

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

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

These symptoms affect social and motor behavior quite adversely because of the resulting incapacitating "distortions of normal functioning" (Keith, 1997, p. 851). Negative symptoms are less obvious and resemble depression, yet they also can impair normal functioning because of avolition (loss of will), limited range of affect, anhedonia (loss of pleasure), or alogia (diminished cognitive capacity and fluency and content of speech). Cognitive impairment is the primary feature of schizophrenia. Cognitive deficits noted during the assessment include executive functioning, attention, memory, and processing speed. The APA (2000) described the following criteria for diagnosing schizophrenia:

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

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

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

Incidence:

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

Andreasen (1999) reported that schizophrenia is one of the most important health problems worldwide, usually occurring in younger adults entering their early 20s. Morbidity is quite high (roughly 60% receive disability benefits within one year of onset), and the rate of suicide is around 10% (Andreasen & Black, 1991; Ho, Andreasen, & Flaum, 1997). Additionally, rates of employment for schizophrenics rarely exceed 20% (Keith, 1997).

Instrumentation:

Assessing cognitive functioning for key features of attention, memory, processing speed and executive functioning are measures of community functioning.

1. Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978)
2. Brief Cognitive Assessment (BCA). The BAC consists of verbal fluency, psychomotor speed and executive functioning, and the Hopkins verbal learning. The administration is 15 minutes and used for dementia (Keefe et al., 2004).
3. Brief Psychiatric Rating Scale (BPRS)
4. Repeatable Battery for the Assessment of Neuropsychological Status (RBANS; Randolph, 1998)

Treatment:

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

Schneider (1999) viewed schizophrenia as a cognitive impairment requiring treatment in an environment that provides adequate structure and sensory input. To be truly effective, caregivers for clients with schizophrenia must communicate clearly and simply. When clients seem to be hallucinating, caregivers should redirect them to concrete tasks. Supportive therapy is helpful, and confrontation and arguments should be avoided (Schneider). A client with schizophrenia, whose positive symptoms are adequately stabilized, can learn more effective coping mechanisms with the use of specific behavioral approaches, one of which has been referred to as the A-B-C: (A) determine antecedents of the behavior, (B) clarify the problematic behavior itself, and (C) reinforce the consequences of the behavior. Turlington et al. (2006) recommended cognitive-behavioral therapy.

Another important element of treatment is enhancing social functioning through affect recognition—addressing the failure of individuals with schizophrenia to recognize emotional cues

necessary for interpersonal relationships. Training in emotion recognition using the microexpression training tool (Ekman, 2003) has been shown to be useful (Russell, Chu, & Phillips, 2006).

Pharmacotherapy is considered the most important element of treatment for both acute psychotic episodes and chronic schizophrenia. Psychiatrists make decisions about which medications to prescribe based on the type and severity of symptoms as well as the most favorable side-effect profile.

The older antipsychotics are typified by such medications as chlorpromazine (Thorazine), which is the earliest of the Phenothiazine category of drugs, dating back to the 1950s, and Haloperidol (Haldol), a more potent antipsychotic drug dating back to the 1970s, that blocks dopamine neurotransmitter activity in the brain and is often accompanied by very uncomfortable motor movement side effects. Chlorpromazine is rarely prescribed now, but Haloperidol is still prescribed for some clients to control symptoms (i.e., hallucinations), particularly when cost is a factor. In most cases, however, psychotic symptoms are being treated with newer and more effective agents that act upon a broader group of neurotransmitters.

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

The newer antipsychotic medications became available for use by American physicians primarily in the early 1990s, although clozapine (Clozaril) was first approved by the FDA in 1989. Olanzapine (Zyprexa) was made available shortly after that and had many of the same characteristics of clozapine. Both of these medications were found to improve cognitive functioning in chronic schizophrenic patients (Delle Chiaie, Salviati, Fiorentini, & Biondi, 2007; Mortimer, Joyce, Balasurbramaniam, Choudhary, & Saleem, 2007). However, the presence of excessive weight gain and Type II diabetes mellitus as potentially serious side effects often precluded their usage. It is of interest that Clozapine remains the most effective of the antipsychotics and for that reason is primarily used to treat chronic schizophrenia and bipolar clients only when all other antipsychotics were tried and found to be ineffective.

Schizophrenic clients who are acutely agitated are treated with rapid-acting antipsychotic medications. These include Haloperidol injections, often prescribed in conjunction with lorazepam (Ativan); ziprasidone (Geodon) intramuscular, olanzapine (Zyprexa Zydis)--a rapidly disintegrating oral antipsychotic; olanzapine (Zyprexa) intramuscular (Centorrino et al., 2007; Centorrino et al., 2008), and aripiprazole (Abilify R) rapid-acting intramuscular injection.

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

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

For clients who request or are frequently non-compliant with oral medications, long-acting antipsychotic drugs are available in injectable form. Haloperidol (Haldol) and fluphenazine (Prolixin) are both older antipsychotics that are still being prescribed by injection every two or four weeks for maintenance therapy, particularly when cost is a factor. They are available as Haldol (Decanoate) and fluphenazine (Prolixin Decanoate). Risperidone (Consta) a newer atypical antipsychotic, was the first of its class for long-acting maintenance therapy when given by injection. It has a 13-28-day duration and is available as Risperdal Constanta. Other newer long-acting injectable antipsychotics are olanzapine (Zyprexa Pamoate)-30-day duration; paliperidone (Invega Sustenna)-28-day duration; Invega Trinz—90-day duration; and aripiprazole (Abilify Maintena or Arista)--28-day duration.

Brief Psychotic Disorder

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

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

Other disorders associated with psychosis include major depressive disorder with psychotic features, the schizophreniform disorder with brief psychotic features, psychotic disorder due to

another medical condition, primary psychotic disorder, brief psychotic disorder, and delusional disorder.

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

Catatonia Associated With Another Mental Disorder (Catatonia Specifier)

Definition:

The APA (2013) reclassified catatonia from a subtype to a separate specifier that can occur with other disorders. The assessment includes twelve characteristic symptoms, three of which need to be met for a diagnosis. Catatonia can be a specifier for depressive, bipolar, and psychotic disorders. According to the APA (2013), the distinguishing features of the 12 catatonic specifiers are psychomotor disturbances that may involve immobility or excessive mobility, peculiar movements, catalepsy, stupor, waxy flexibility, extreme negativism, agitation, stereotypy, mannerism, posturing, mutism, echolalia, or echopraxia. Catatonia specifier diagnostic criteria include the predominance of at least three of the twelve symptoms (APA, 2013, p. 119): Excessive motor activity experienced by individuals with this subtype is purposeless and not provoked by external stimuli. Immobility sometimes referred to as catatonic posturing, may include waxy flexibility, a condition in which one's limbs can be positioned away from the body by another person and continue to remain in that position. Many catatonics alternate between periods of immobility and heightened motor activity (Bootzin & Acocella).

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

Delusional Disorder

Definition and Interview:

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

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

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

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

There are some specifiers for delusional disorder, but the jealous type may be most common. The various types include **erotomanic** (central theme that another person is in love with the individual), **grandiose** (the conviction of having some great but unrecognized talent), **jealous** (the perception that one's spouse is unfaithful, derived from incorrect inferences serving as "evidence"), **persecutory** (perception that one is being conspired against), **somatic** (involves bodily functions or sensations), **mixed** (no one theme predominates), and **unspecified** (type cannot be identified; APA, 2013, p. 91).

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

Incidence:

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

Treatment:

Relatively little is known about the treatment of the delusional disorder. Clients usually deny they have a problem and are difficult to keep in treatment (Opjordsmoen, 1991). Treatment for delusional disorders should include a medical evaluation to rule out medical-related causes and a neurological assessment to rule out central nervous system pathology causing the disorder.

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

Bipolar and Related Disorders

Bipolar and related disorders are separated from the depressive disorders because they are a bridge or link between schizophrenia spectrum and psychotic and depressive disorders (symptoms). Disorders included in bipolar and related disorders are bipolar I, bipolar II, cyclothymic disorder, substance-/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder (APA, 2013; King, 2014e).

Bipolar Disorder

Definition and Assessment:

Bipolar and related disorders and depressive disorders are now separate categories. A recent change for assessment is that there is more of an emphasis on activity and energy in addition to an elevated or expansive mood. Bipolar disorders type I and type II are considered repetitive and chronic disorders, with type I being the most severe and potentially psychotic. Bipolar symptoms are typically cyclic with depression preceding mania, but there are times when the cycle begins with a manic episode followed by depression. The diagnosis of bipolar disorder may not always be precise, particularly when a client seeks a doctor's help for depression and is prescribed an antidepressant medication, but then experiences anxiety, rapid onset of energy, difficulty sleeping, and possibly a clear-cut manic episode. Such a response to antidepressant treatment indicates the presence of bipolar disorder, mixed type. A proper assessment is to investigate for a history of cyclic mood swings and evaluate the activity and energy level of the client's mood, including the presence of depression, heightened and elevated mood symptoms, or mixed states that could be experienced as anxiety.

Bipolar disorder is characterized by the occurrence of one or more manic episode or mixed episodes amid intermittent episodes of depression (APA, 1994; Kates & Craven, 1998). Individuals suffering from bipolar disorder recover completely between episodes and may be symptom-free for

years. However, a few individuals may have frequent mood swings that can occur more than four times in a year (i.e., rapid cycling), with little mood stability between episodes (Kates & Craven). A distinction is made between bipolar I and bipolar II disorders. Bipolar I clients may experience more severe manic and depressed swings, whereas bipolar II clients experience fewer extreme swings with hypomanic rather than manic episodes, respectively (APA; Kates & Craven).

It most often starts with depression, followed by mania. Most individuals suffer both depressive and manic episodes, but 10% to 20% experience only manic ones. Most commonly, manic episodes have a rapid onset but sometimes may slowly evolve over a few weeks. When treated aggressively, a manic episode can be controlled within days with appropriate first-line treatment, most often consisting of mood-stabilizing or antipsychotic medications or both in combination. Untreated, a manic episode can last three months.

Manic episodes may reach psychotic proportions in a client with bipolar I disorder and be misdiagnosed as schizophrenia, whereas depressive episodes may also reach psychotic proportions—both of which may include delusions and hallucinations. About 40% to 50% of bipolar disorder clients may have a second manic episode within two years. Forty-five percent have more than one episode, and 40% have a chronic disorder with a frequency that may even reach 30 episodes over a lifetime. The prognosis for clients with bipolar I disorder is worse than for those with a major depressive disorder. The prognosis for individuals with bipolar II disorder is less severe but also warrants long-term treatment (Kaplan & Sadock, 1998).

Incidence:

The APA (2013) reported a prevalence rate for a 12-month period, as cited in the DSM-IV-TR, to be 0.6%. Hirschfeld et al. (2003) reported a lifetime prevalence of 3% to 6% for bipolar disorder. According to Kates and Craven (1998), 1% to 2% of the population will experience a manic episode during their lifetime, equally probable across the gender line. The first episode occurs in one's early 20s, although there is concern that adolescent cases of depression are often undiagnosed. Bipolar disorder occurs at much higher rates in individuals with a family history (parental) of the disorder. The APA (1994) reported a greater than 90% recurrence of manic episodes in individuals who have experienced a single episode. Sixty percent to 70% of manic episodes tend to occur immediately before or after a depressive episode.

According to SAMHSA (2016a) lifetime co-occurrence of bipolar disorder and substance use disorder ranges from 21.7 percent to 59 percent and 12-month ranges from 4 percent to 25 percent. SAMHSA (2016a) reported that 30% to more than 50% of individuals with bipolar I or bipolar II would develop a substance use disorder.

Instrument (Screening tool):

1. Composite International Diagnostic Interview (CIDI)-Based Screening Scale for Bipolar Spectrum Disorders

Treatment:

Leahy (2007) reported that eight factors are important when considering treatment for bipolar disorder. The factors include: (1) know the diagnostic signs, symptoms, (2) genetic predisposition for bipolar, (3) psychological treatment involves treating episodes for maintenance treatment, (4) pharmacological treatment is essential, (5) psychoeducation is a component of treatment, (6) collaborative association between the therapist and psychiatrist, (7) life events, coping skills, and family environment contribute to the expression of mania and depressive disorders, and (8) integrative cognitive-behavioral models are helpful.

Compliance or adherence is an issue, especially regarding medication. Non-adherence in bipolar disorder range from 20% to 66%. Compliance risk influencing factors are specific to the client diagnosed with bipolar disorder (Berk, Berk, & Castle, 2004, p. 510). Leahy (2007) reported eight influencing factors that are important when considering treatment for bipolar disorder.

Negative influences	**Positive influences**
Younger age	Older age
Early onset	Marriage
History of non-adherence	High level of education
History of grandiosity	Treatment alliance
Mood-incongruent psychotic features	Social support
More hospitalization	Favourable influence by ideas of others
Male gender	Realize threat of illness and benefits of treatment
First year of treatment	
Elevated mood, hypomania, mania, hyperthymia	Recognition of adverse consequences of illness
Personality	
Comorbid drug/alcohol abuse	External locus of control or dependence
Temperament	
Cognitive deficits	
Anxiety regarding long-term safety of treatment	
Denial of severity of illness	
Idea that moods controlled by mediation/need more control	
Idea that taking medication reminded them that they had a chronic illness (stigma)	
Medication does not help depression	
Hassles of medication regimen	
'Missing highs'	
Actual side-effects	

SAMHSA (2016a) reported for bipolar disorder psychosocial therapies include:

1. CBT,
2. Family-focused therapy (FFT)
3. Interpersonal and Social Rhythm Therapy (IPSRT) that includes psychoeducation

Miziou et al. (2015) conducted an exhaustive effectiveness analysis of 78 selected articles from 6,124 research studies regarding CBT, interpersonal and social rhythms therapy, family therapy, mindfulness interventions, and psychoeducation. Their findings included:

1. CBT and ISRT could have some beneficial effect during the acute phase
2. Mindfulness intervention could only decrease anxiety
3. Family intervention benefit mainly the caregivers
4. Psychoeducation was useful for relapse prevention.

Bipolar I Disorder

The diagnosis of bipolar I disorder involves a manic episode, which may be preceded by and followed by a hypomanic or major depressive disorder (APA, 2013, p. 123; King, 2014i). There are ten specifiers and some potential features. There are four different bipolar I diagnoses (a current or most recent episode of manic, current or recent episode of hypomanic, current or most recent episode depressed, and current or most recent episode unspecified) and two bipolar II diagnoses. Bipolar clients experience a decrease in psychosocial functioning and family discord. Criterion A for bipolar I diagnosis accounts for the state of the individual and is summarized by the following (APA, 2013, p. 126):

1. Presence of only one manic episode and no past major depressive episode
2. Currency of a hypomanic episode (less severe than a manic episode and without psychotic features)
3. Currency of a manic episode
4. Currency of a mixed episode
5. Currency of a major depressive episode
6. Currency of an unspecified episode

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

Criterion B addresses the history of previous types of episodes or whether the manic episode is not better accounted for by psychotic-type disorders such as psychotic affective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum (APA, 2013, p. 126). Criterion C involves the degree of intensity of the episode or rules out parameters if Criteria A and B are not better accounted for by other psychotic type disorders.

The DSM-5 separates manic episodes into mania and hypomania. Mania lasts at least a week and hypomania last at least four days and often with less severity (APA, 2013).

Bipolar disorder comorbidity is known to exist with anxiety (Fogarty, Russel, Newman, & Bland, 1994), substance abuse (Kessler et al., 1994), eating disorders (Angst, 1998), paraphilia (Nelson, 2001),

attention-deficit/hyperactivity disorder (Hudson et al., 2003), impulse-control disorders such as gambling (Pallanti, Quercioli, Sood, & Hollander, 2002), conduct disorders (Boyd, 1984), autism, Tourette's syndrome, migraines (Merikangas, Angst, & Isler, 1990; McCracken et al., 2002), diabetes (Regenold et al., 2003), and obesity (Hirschfeld et., 2003; McElroy et al., 2002).

Treatment:

Frank, Swartz, and Boland (2007) reported two large efficacy studies for bipolar I and depression when interpersonal and social rhythm therapy are combined with medication that was reported as effective treatments. These studies compared the three traditional treatments for bipolar illness (family-focused therapy, IPSRT, and cognitive-behavioral therapy). All three treatments emphasize sleep hygiene and sleep-wake cycles.

Nutrient-based therapies, adjunct therapy, in conjunction with pharmacotherapy is an alternative methodology to improve health and residual symptoms. Bipolar disorder clients often present with poor eating and nutritional habits, tend to cook fewer than two meals a day, consume more carbohydrates, sucrose, and sugared beverages, and frequently do not cook food, therefore, eat prepackaged foods. Nutritional therapies involve target treatments (fatty acids, inositol, choline, magnesium, chromium, folate, and tryptophan), mechanisms, and benefits (Sylvia et al., 2013).

Pharmacotherapy remains the treatment of choice for bipolar. However, Sylvia et al. (2013) reported that nutrient-based therapies are helpful because this client tends to demonstrate poor eating and nutritional habits, and increased risk for obesity.

Bipolar II Disorder

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

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

that includes a family history of the possible bipolar disorder before asking a medical consultant (which may include a general physician, physician's assistant, or advanced practice nurse without specialized training in psychiatry to consider prescribing antidepressant medication).

The diagnostic criteria for a bipolar II disorder are a recurring mood episode consisting of one or more major depressive episodes (lasting two weeks) and at least one hypomanic episode (lasting at least four consecutive days). The mood episodes require that five or more symptoms for Criterion A be met for at least two weeks, and one of the two symptoms must be either a depressed mood or loss of interest (APA, 2013, p. 133). The mood is to be most of the time, nearly every day and can be derived from a subjective report.

Treatment:

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

Fountoulakis et al. (2005) conducted a critical review of bipolar treatments that was updated three years later with recommendations that separate treatments be provided for manic, hypomanic, mixed, and bipolar depression diagnoses. This work was later supported by Fountoulakis, Grunze, Panaqiotidis, and Kaprinis (2008) and Fountoulakis et al. (2007). Recent findings and rigorous studies are being conducted to support sleep therapy for depression treatment (Carney, 2013; Carney & Edinger, 2013). Sleep psychology is of interest for the American Psychological Association's research and study of sleep disorders. Sleep therapy is referred to as cognitive behavioral therapy for insomnia or CBT-I. To date, CBT-I has a 40% to 50% cure rate and seems to have staying power. CBT-I is a collection of steps that include stimulus control (limiting stimulation before bedtime); sleep hygiene (controlling the environment and behaviors before sleep); sleep restriction (controlling time in bed); and sleep (diary, sound advice). The client addresses these steps with a standard questionnaire to be completed with "agree" or "disagree." Frank, Swartz, and Kupfer (2007) reported two large efficacy studies for bipolar I and depression when interpersonal and social rhythm therapy combined with medication were introduced as treatment. These studies compared the three well-known treatments for bipolar illness (family-focused therapy, IPSRT, and cognitive-behavioral therapy). All three therapies emphasize sleep hygiene or sleep-wake cycles.

Pharmacotherapy:

When treating bipolar disorders, psychopharmacological approaches are essential. Manic episodes are treated with antipsychotics mood-stabilizing medications, whereas mixed bipolar symptoms are treated with mood stabilizers that are most often specific anti-convulsant medications.

Pharmacotherapy is considered to be the most effective treatment to control and stabilize bipolar symptoms (Markowitz & Klerman, 1991). The first medication approved by the FDA for the treatment of bipolar disorder was lithium (Fountoulakis et al., 2008; Goodwin & Viea, 2005), which is still widely

prescribed primarily as a maintenance medication to prevent recurring bipolar symptoms and bipolar depression and has been demonstrated to reduce the risk of suicide. Lithium has not proven effective to treat acute manic episodes or to control agitated behavior, and it has side effect risks such as a mild tremor, hypothyroidism or goiter, and potentially fatal toxicity from overdose or renal failure.

Several anticonvulsive drugs, particularly valproate, carbamazepine, and oxcarbazepine, have been commonly prescribed for mood stabilizing purposes. Carbamazepine, which was a popular treatment option for bipolar in the late 1980s and early 1990s, effectively treats manic episodes and rapid-cycling bipolar disorder but is less effective in preventing relapse than lithium or valproate. Carbamazepine is not currently prescribed as often as valproate, which is particularly effective in treating manic episodes. Lamotrigine, a less frequently prescribed anticonvulsant mood stabilizer, is somewhat effective in treating bipolar depression and has some benefit in preventing further depressive episodes but is of little benefit in controlling mania or rapid cycling disorder. Depending on the severity of the case, anticonvulsants may be used in combination with lithium or on their own. Antipsychotic medications are effective for short-term treatment of bipolar manic episodes and appear to be superior to lithium and anticonvulsants for this purpose. Manic clients suffering from psychotic symptoms and acute agitation may respond more quickly to selected antipsychotic and anticonvulsants, particularly olanzapine and valproate (Centorrino et al., 2005; Centrorrino et al., 2008). Atypical antipsychotics that have been used to treat bipolar disorders include Clozaril, aripiprazole, olanzapine, risperidone, ziprasidone, asenapine, and lurasidone and quetiapine, the combination of fluoxetine and olanzapine, and the anticonvulsant lamotrigine have all been prescribed and found helpful, with lurasidone becoming increasingly predominant for the most severe bipolar depression. Fountoulakis, Grunze, Molar, Grunze, and Broich (2007) cited research findings that indicated antidepressants should be avoided in bipolar clients because antidepressants might trigger manic episodes, rapid cycling, anxiety attacks, or agitation.

Manic clients suffering from psychotic symptoms and acute agitation may respond more quickly to selected antipsychotics and anticonvulsants, particularly olanzapine and/or valproate (Centorrino et al., 2005; Centorrino, 2008).

Monitoring:

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

intervention. Other significant side effects of bipolar agents include weight gain (olanzapine, quetiapine, valproate), thyroid toxicity (lithium), hair loss (valproate), muscle tremors (lithium), liver function abnormalities (valproate and carbamazepine), abnormal muscle movements and rigidity (some antipsychotic medications), and thrombocytopenia (Carbamazepine).

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

Psychotherapy supports the use of family-focused therapy (Rea et al., 2003) and family psychoeducational programs (Simoneau, Miklowitz, Richards, Saleem, & George, 1999).

Effective therapies include brief cognitive (Cochran, 1984), cognitive-behavioral (Basco et al., 2003), psychoeducational, and interpersonal social rhythm therapies (APA, 2002; Frank, Swartz, & Kupfer, 2000, 2007). These interventions are important because they can assist in increasing medication adherence, reduce relapse rates, shorten recovery time from the depression, and improve the overall functioning of the client (Keck, 2006). Mood charting is also recommended to recognize subtle mood changes and symptoms, trigger recognition, detect warning signs for acute episodes, and monitor treatment protocol overall (APA, 2002).

Cyclothymic Disorder

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

Depressive Disorders

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

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

sometimes thoughts of death. Depressive disorders may also include symptoms of anxiety, obsessions, irritability, physical symptoms, and insomnia. Such changes nearly always result in impaired interpersonal, social, and occupational functioning. Individuals with elevated mood (mania) tend to experience expansiveness, heightened sense of esteem, grandiosity, diminished sleep, pressured speech, and excessive energy. Individuals suffering from recurrent mood swings (previously called manic-depressive illness) will receive a diagnosis of bipolar disorder. Bipolar disorders can occur at any time in life but usually begin during the 20s and tend to be recurring, with episodes lasting an average of several months.

It is now known that depressive symptoms are caused by abnormalities in at least three neurotransmitters—serotonin, norepinephrine, and dopamine. The most frequently prescribed antidepressants are the SSRIs (selective serotonin reuptake inhibitors) or SNRIs (serotonin & norepinephrine reuptake inhibitors), which focus on raising low serotonin or low serotonin and norepinephrine levels in the brain in depressed persons. It is recommended that antidepressants be taken for six to twelve months for a first-time depression, but individuals who have a recurring depression should continue medications indefinitely to prevent relapse. Although antidepressant medications are the most common treatment for depressed individuals, psychotherapy has also been found to be effective, either alone or in combination with antidepressant medications. Electroconvulsive therapy (ECT) has also been used with moderately good results for treating depressed individuals. It has sometimes revealed dramatically effective results for depressed hospitalized patients unresponsive to other therapies and who are considered suicide risks. Another treatment that is administered only in specific centers is transcranial magnetic stimulation (TMS), a noninvasive method to treat depression causing depolarization or hyperpolarization in brain neurons. A depressed individual with undiagnosed bipolar disorder must be properly assessed before medication is prescribed because a manic episode may be induced if an antidepressant medication is given without a concomitant mood stabilizer (Kaplan & Sadock, 1998).

Major Depressive Disorder

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

Depression, the most prevalent mood disorder, is a vast topic that has been researched and studied exhaustively in the fields of both psychology and medicine. Depression underlies many mental and physical disorders and disabilities and may lead to suicide (Keller, 1994). Clients diagnosed with depression show symptoms that include, along with depressed mood, an inability to carry out normal activities, frequent absenteeism from work, and social and cognitive dysfunction (Kessler et al., 2003). In the workplace, depression accounts for approximately 11% of all absenteeism and half of all days lost due to a mental disorder (Goff & Young, 1996). According to a study by Goff and Young, people with major depression have more difficulty with day-to-day functioning than do those with

chronic physical conditions, such as hypertension, diabetes, and arthritis. These researchers have also reported that 40% of those who frequently seek medical care suffer from depression. A study of 13 years researching first on-set for depression in a sample of 3481 adult household residents including 92 first lifetime onset of major depression reported that female participants showed higher risk of onset of a depression disorder, longer duration of episodes, and a nonsignificant tendency for higher risk of recurrence (Eaton et al., 2008).

Definition and Interview:

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

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

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

1. significant weight loss (5% of body weight in one month)
2. insomnia or hypersomnia nearly every day
3. psychomotor agitation or retardation (observable by others) nearly every day
4. fatigue every day
5. feeling of worthlessness or excessive, inappropriate guilt nearly every day
6. diminished ability to concentrate
7. recurrent thoughts of death or suicide
8. depressed mood most of the day as indicated by subjective reports or observation by others
9. loss of interest or pleasure (pp. 160-161)

The interviewer should also inquire about the duration of symptoms and observe presenting features of the individual (e.g., tearfulness, complaints of pain, and obsessive rumination). The diagnostician should also consider the degree of severity of the episode or disorder, with or without psychotic features, recurrence, remissions, and other features such as catatonia (marked psychomotor disturbance), melancholia (loss of interest or pleasure in all or nearly all activities), atypicality, postpartum onset, cycling, and seasonal patterns (Blehar & Lewy, 1990).

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

Incidence:

Depression rates for clients of diversity living in different countries are scarce. A prevalence rate for Mexicans is considered to be 4.9% (Burnam, Hough, Karno, Escobar, & Telles, 1987). Mexican-Americans born in Mexico have prevalence rates that are lower (3.3%) compared with Mexicans Americans born in the United States. Slone et al. (2006), in a study of depression in four cities in Mexico, found that the lifetime prevalence rate in Oaxaca, Guadalajara, Hermosillo, and Merida was 12.8% and was lower than was the prevalence rate for the United States (17.1%). A factor contributing to the lower rate is the intact family structures that appear to offer resistance to depression symptoms (Vega, Kolody, Aguilar-Gaxiola, Alderette, & Ralph, 1998). Diminished ability to think, sleep disturbances and weight and appetite symptoms were the most prevalent symptoms for those with lifetime experiences with depression (Slone et al., 2006).

Instruments:

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

1. Assessment of Depression Inventory (Mogge & LePage, 2004)
2. Beck Depression II (Beck et al., 1996a, b)
3. Carroll Depression Scales-Revised (Carroll, 1998; Carroll, Feinberg, Smouse, Rawson, & Greden, 1981)
4. Center for Epidemiological Studies-Depression Scale (Radloff, 1977)
5. Depression Questionnaire (Bertolotti, Zotti, Michielin, Vidotto, & Sanavio, 1990)
6. Diagnostic Inventory for Depression (Zimmerman, Sheeran, & Young, 2004)
7. Hamilton Depression Inventory (Reynolds & Kobak, 1995)
8. Hopelessness Depression Symptom Questionnaire (Metalsky & Joiner, 1997)
9. Inventory Depressive Symptomatology (Rush, Gullion, Basco, Jarrett, & Trivedi, 1996; Rush, Carmody, & Reimitz, 2000; Rush et al., 2006)
10. MMPI-2 Depression Screener (Burnam, Wells, Leake, & Landsverk, 1988): The current Scale 2 (D) consists of 57 items.
11. MOS-Item Depression Screener (Burnam et al., 1988)
12. Patient Health Questionnaire-9 (Kroenke, Spitzer, & Williams, 2001, 2003)
13. Revised Hamilton Rating Scale for Depression-Self Report (Warren, 1994)
14. Zung Depression Self-Rating Depression Scales (Zung, 1965)

15. Structured Interview Guide for the Hamilton Depression Rating Scale (Williams, Link, Rosenthal, Amira, & Terman, 1988)
16. Mood Disorder Questionnaire (MDQ; Hirschfeld, 2002; Hirschfeld et al., 2003)

Treatment:

How should depression be treated? Wexler and Cicchetti (1992) noted from a compilation of outcome studies that psychotherapy is as effective as pharmacotherapy and psychotherapy combined. They proposed initially using psychotherapy to avoid medication noncompliance, prescription costs, and potential side effects. These findings should be interpreted with caution about individuals suffering from more severe depression, symptoms which, in general, require pharmacotherapy to control (Matheny, Brack, McCarthy, & Penick, 1996; Wexler & Cicchetti, 1992). When medications are prescribed for severe depression Bender (1999) reported the importance of maintaining medication because there can be both positive and negative side effects. In the current managed care environment, the use of medication is emphasized, and a significant percentage of depressed patients who are prescribed the newer and safer antidepressant medications will respond with generally good results.

Weissman et al. (2000) reported that CBT produced more rapid changes in depression than other psychotherapy strategies. Interpersonal psychological therapy is indicated to be an effective therapy for depression when interpersonal issues are a component of the symptoms.

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

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

These regulation skills include the ability to: (a) be consciously aware of emotions, (b) identify and (c) correctly label feelings, (d) identify what has caused and maintains one's present emotions, (e) actively modify emotions in an adaptive manner, (f) accept, (g) tolerate undesired feelings when they cannot be changed, (h) approach and confront situations likely to trigger negative emotions if this is necessary to attain personally relevant goals, and (i) provide compassionate self-support when working to cope with challenging emotions (Thompson, p. 249).

Treatment (Children and Adolescents):

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

Children treatment:

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

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

Adolescent treatment:

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

Probably efficacious: CBT, IPT (Self-control therapies and coping with depression), adolescent group plus parent component, CBT individual, and CBT individual plus parent/family component.

Persistent Depressive Disorder (PDD)

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

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

Definition and Interview:

PDD refers to a prevalent form of sub-threshold depressive pathology characterized by features such as morosity, introversion, low energy, low drive, low self-esteem, anhedonia, eating and sleeping disturbances, a pessimistic outlook, and/or an inability to have fun (Akiskal, 1983; Bootzin & Acocella,

1988; Brunello et al., 1999). Although comorbidity with panic, social anxiety, phobia, and alcohol use disorders has been described, the most significant association is with major depressive episodes. Family history is replete with affective disorders, including bipolar disorders. Genetically predisposed individuals may suffer childhood-onset mood swings, both spontaneously and upon psychological challenge in as many as 30% of sufferers (Brunello et al., 1999).

According to the APA (2013), the essential difference between major depressive disorder and PDD is that major depressive disorder is more discrete and severe, whereas PDD is characterized by a chronically depressed mood with diminished self-esteem that occurs for most of the day, for more days than not, for at least two years. The absence of suicidal thoughts seems to distinguish a persistent depressive disorder from a major depressive disorder, whereas symptom-free episodes are occurring longer than two months would rule out the diagnosis of the dysthymic disorder.

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

1. poor appetite
2. insomnia or hypersomnia
3. low energy
4. low self-esteem
5. poor concentration
6. feelings of hopelessness (p. 168)

Assessment:

Leskela et al. (2006) reported that two-thirds of individuals with major depression recover within 1 to 2 years. However, some experience long-term symptoms for more extended periods. Comorbid disorders are linked with longer durations of depression symptoms such as anxiety and personality disorders (Leskela et al., 2006). Walker and Druss (2015) reported predictors for PDD include two or more chronic medical conditions, female gender, never having been married, activity limitations, low social support, and less contact with the family. Anxiety disorder and substance use disorder are comorbid with the persistent depressive disorder (APA, 2013).

Incidence:

Approximately 3% to 6% of the adult population suffers from the depressive disorders prevailing at least two years during their lifetime (Kessler et al., 2005; Murphy & Byrne, 2012). The lifetime prevalence of the dysthymic disorder (reclassified category and symptoms) is about 6%, and it is two to three times more likely to occur in women than men. In children, gender prevalence rates seem to be equal (APA, 2000, pp. 378-379). The APA (2013) reported a prevalence rate of 0.5% for PDD and 1.5% for the major depressive disorder.

Instrumentation:

1. Beck Depression Inventory-II
2. Hamilton Rating Scale for Depression rates the severity of depression (Hamilton, 1960)

Treatment:

Kriston et al. (2014) recommended combined treatment of medication and cognitive behavioral analysis system of psychotherapy (CBASP) and CBASP and interpersonal psychological therapy for the persistent depressive disorder. Severe symptoms of depressive disorder treatment recommended is electroconvulsive therapy followed by cognitive behavioral analysis system of psychotherapy (Kohler et al., 2014). The authors researched 28 drugs, five psychotherapies, and five combined psychotherapy and medication from data samples consisting of 2,657 and 2,719 patients. Interpersonal psychotherapy and medication outperformed medication alone. Efficacious medications found to be effective include fluoxetine, paroxetine, sertraline, moclobemide, imipramine, ritanserin amisulpride, and acetyl-l-carnitine were more significant than placebo regarding the persistent depressive disorder. Interpersonal psychotherapy combined with medication is recommended for acute PDD, and cognitive behavioral analysis system of psychotherapy (CBASP) was a weak or moderate strength as helpful.

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

Antidepressants from different classes, modulated by one or more of the following neurotransmitters: serotonin, dopamine, or noradrenaline, have been shown to have effective antidepressive activity in an average of 65% of cases (Brunello et al., 1999). The antidepressant medications include several groups. The tricyclics, which act on the two neurotransmitters serotonin and norepinephrine, include (amitriptyline (Elavil), doxepin (Sinequan), imipramine (Tofranil), desipramine (Norpramin), clomipramine (Anafranil), and nortriptyline (Aventyl, Pamelor) and have been effectively used to treat depression for many years. Because of their somewhat adverse side effects and potential lethality, if taken in overdose, they are rarely prescribed any longer. MAO

inhibitors (MAOIs) Emsam (selegiline), Marplan (isocarboxazid), Nardil (phenelzine), and Parnate (tranylcypromine), which act by inhibiting the activity of monoamine oxidase, may cause potentially dangerous side effects under certain conditions. The biological effect of MAOIs is to prevent the breakdown of monoamine neurotransmitters (serotonin, melatonin, epinephrine, norepinephrine, and dopamine), which provide the antidepressant effect. But it can also cause a risk for individuals who consume foods containing tyramine (found in cheese) or foods containing tryptophan, or specific red wines, and who could suffer a hypertensive crisis caused by excessive amounts of norepinephrine suddenly flooding circulation. However, the recently introduced Selegiline transdermal system introduces an MAO inhibitor into the system via the skin so that this potential crisis is averted, promising no significant side effects. MAOIs are still being prescribed and are often effective when other antidepressants have not worked, but they cannot be prescribed if an individual is also taking SSRI or antidepressants, amphetamines, chlorpheniramine, cocaine, cyclobenzaprine, dextromethorphan, phencyclidine (PCP), pheniramine, and over-the-counter food supplements such as St. John's Wort, because the combination might cause a potentially fatal hypertensive crisis.

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

The SSRIs (selective serotonin reuptake inhibitors) had become more widely prescribed since 1987 when fluoxetine (Prozac) was approved by the FDA and became a widely successful anti-depressant. After that time, other SSRIs entered the market, including sertraline (Zoloft), paroxetine (Paxil), Fluvoxamine (Luvox), citalopram (Celexa) and escitalopram (Lexapro). The most recent is vilazodone (Viibryd). Selective serotonin reuptake inhibitors act only by increasing levels of the neurotransmitter serotonin. Other antidepressants that work somewhat differently from the SSRIs, MAOIs and tricyclic include nefazodone (Serzone, which is no longer available), bupropion (Wellbutrin), mirtazapine (Remeron), trazodone (Deseryl), escitalopram (Lexapro), sertraline (Zoloft), paroxetine (Paxil), Fluvoxamine (Luvox), and citalopram (Celexa). Selective serotonin reuptake inhibitors act only on the neurotransmitter serotonin. Other antidepressants that work somewhat differently from the SSRIs, MAOIs, and tricyclics include nefazodone (Serzone), bupropion (Wellbutrin), mirtazapine (Remeron), trazodone (Deseryl), Venlafaxine (Effexor) and duloxetine (Cymbalta). The latter two are serotonin and norepinephrine reuptake inhibitors (SNRIs), which are more effective when compared with the SSRI antidepressants in some clients and also appear to help control pain (primarily duloxetine). The availability of effective antidepressant medications is a promising development because of social and characterologic disturbances, so pervasive in dysthymic symptoms, often recede with continued pharmacotherapy.

Extended Bereavement Exclusion:

The DSM-5 considers the possibility that when symptoms of depression occur after a significant loss, these symptoms could be more than bereavement. The guideline for differentiating might be that a) grief may subside over weeks, b) grief tends to come in waves, and c) cultural factors should be considered (APA, 2013, p. 126; King, 2014l). A significant loss may be bereavement, financial ruin, and injuries from a natural disaster, severe medical illness, or disability.

Normal grieving is not considered a disorder and passes through different phases such as anger, numbness, insomnia, crying, appetite loss, sighing, and sense of unreality, guilt, denial, disbelief, and thoughts of the dead (Brown & Stoudemire, 1998; Stoudemire, 1988). If a grieving person becomes "fixed" in any of these phases after a significant loss and symptoms become exaggerated, the bereaved individual may appear to have a mental disorder and may, in fact, develop symptoms consistent with the major depressive disorder. According to Hensley and Clayton (2008), about 24% of bereaved individuals meet criteria for major depression at two months, 15% at one year, and about 7% at two years. Although grieving is considered normal, it does depend upon the characteristics of the griever and the nature of the loss (Schwartzberg & Halgin, 1991). Persistent complex bereavement disorder was included in the chapter for further study.

Treatment:

The treatment for individuals who are suffering from bereavement is supportive counseling. Treatment is usually brief, and the procedure is to work through the developmental process of the loss. Many individuals have also benefited from supportive group therapy when the focus of the group is seeking resolution from impacted grief. Specifically, client-centered therapy provides nurturing and empathetic understanding, Gestalt therapy focuses on feelings, cognitive therapies emphasize client awareness of destructive thought patterns, and behavior therapies focus on specific behaviors. Allumbaugh and Hoyt (1999), in conducting a meta-analysis of the effectiveness of grief therapies, found inconclusive evidence of grief reduction effectiveness.

Persistent Complex Bereavement Disorder and Bereavement versus Major Depressive Disorder

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

Pathological bereavement may result when the loss is sudden, caused by horrific circumstance and is associated with guilt, and if there was an intensely ambivalent or dependent relationship to the person who died. Because pathological bereavement is often associated with traumatic death, there may also be symptoms consistent with posttraumatic stress disorder. Also, there are usually additional symptoms, including (a) guilt about actions taken or not taken by the survivor at the time of the death; (b) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; (c) morbid preoccupation with worthlessness; (d) marked

psychomotor retardation; (e) prolonged and marked functional impairment; and (f) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person. The diagnosis of major depression may be given to someone severely bereaved whose symptoms meet the criteria for that diagnosis and have persisted for two months or more after the loss. Comorbid diagnoses should also be considered since the most common comorbid disorders with persistent complex bereavement disorders are depressive disorder, PTSD, and substance use disorders. The treatment of major depression which may replace bereavement or even become a comorbid diagnosis warrants the use of antidepressant medications.

Anxiety Disorders

Some disorders are contained within the classification of anxiety disorders. According to the American Psychological Association (APA, 2013), these are separation anxiety, selective mutism, specific phobia, social anxiety disorder, panic disorder, agoraphobia, generalized anxiety disorder, substance/medication-induced anxiety disorder, anxiety disorder due to another medical condition, other specified anxiety disorder and unspecified anxiety disorder. Anxiety disorders no longer include OCD, PTSD, and acute stress disorders. Panic attacks with and without agoraphobia are unlinked and are separate disorders, panic attack and agoraphobia (King, 2014j).

Fear and anxiety are predominant emotions and autonomic responses. Assessment of anxiety disorder tends to differentiate according to the age of onset, the different types of objects or fears, autonomic reactions, thoughts, danger expressed, and escape from the situations.

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

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

Definition and Interview:

Individuals experiencing anxiety have one or more of the following presenting symptoms: emotional (fear and dread), cognitive (worry), physical/physiological (palpitations, tightness in the chest, shortness of breath, physical tension) or behavioral (fight/flight). Knowing the relationship of the main presenting symptom to the disorder provides a clue to the type of anxiety disorder from which the client suffers. However, Fong and Silien (1999) and Brown, O'Leary, and Barlow (1993)

suggested that individuals with different anxiety disorders may share similar symptoms. One such symptom is anxious apprehension.

Anxious apprehension is defined as "a future-oriented mental state in which the individual becomes anxiously concerned and cognitively prepared for upcoming negative events" (Brown et al., 1993, p. 13). A panic attack has both physiological and behavioral components (i.e., an unknown precipitating event triggers a predictable physiological response, along with automatic withdrawal and avoidance). All of the different anxiety disorders share avoidance as a common symptom. For example, as a defense against experiencing panic, the anxious client avoids certain situations: leaving home (agoraphobia), group situations (social phobia), traumatic reminders (posttraumatic stress disorder/PTSD), and dirt or disorderliness (obsessive-compulsive disorder).

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

Incidence:

Many of the anxieties are rooted in childhood and females are approximately a 2:1 ratio compared to males (APA, 2013). Frances and Ross (1996) indicated that anxiety disorders are the second most common type of all mental disorders and are frequently misdiagnosed or unobserved. The National Comorbidity Survey data reveals that 24.9% of the population experiences symptoms typical of an anxiety disorder at some time during their lifetime (Kessler et al., 1994).

Assessing Anxiety Disorders:

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

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

Step 2: Ask if there were any precipitating events or antecedents to the panic attack. First, Frances, and Pincus (1995) and APA (1994) differentiated according to whether the panic attack was uncued (unexpected) such as occurs with panic disorder, cued (situationally bound) as happens within social phobia, or non-specific situationally predisposed anxiety.

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

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

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

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

Step 7: Once medical conditions and substances are ruled out, the task is to identify whether attacks are random, predictable, or episodic. Panic disorder is characterized by unpredictable episodic panic attacks. Persistent "worry" and non-specific anxiety are consistent with generalized anxiety disorder. Repetitive, compulsive rituals are associated with obsessive-compulsive disorder. Mixed anxiety symptoms, intrusions, and nightmares follow post-traumatic stress and acute stress disorders. The presence of more than one anxiety disorder together or combined with a personality disorder such as obsessive-compulsive personality disorder or borderline personality disorder complicates the diagnostic process.

While assessing anxiety for children, it is important to secure information on ways the anxiety might be interfering with daily activities. To obtain this information, it is important to validate this information eliciting feedback from a parent or school personnel. Lyneham et al. (2013) cited literature that frequent client answers to interference for children include: (a) peer relationship problems, (b) school absenteeism (c) decreased concentration, (d) poorer school performance, (e) quality of interactions between members of the family, and (f) restricts or limits the type of activities the family participates in.

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

Instrumentation:

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

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

Instrumentation (Children and Parent):

Lyneham et al. (2013) identified widely-used instruments for parent and child data gathering. Although not ranked, they include:

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

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

Erford and Lutz (2015) surveyed and evaluated 14 anxiety measures to determine the usefulness and best choices for future outcome research and clinical practice. The five self-report inventories frequently used for outcome research and clinical practice include:

1. Revised Children's Manifest Anxiety Scale, Second edition (RCMAS-2; Reynolds & Richmond, 2008) The RCMAS contains 49 items, 6 to 19-years of age, Scales: physiological anxiety, worry, social anxiety, and defensiveness subscales.
2. Child Behavior Checklist (CBL; Achenbach & Rescoria, 2001) The CBL represents ages 4 to 18, parent form (CBCL), youth self-report (YSR) and teacher report form (TRF; Achenbach, 1991c). CBCL scales include internalizing and externalizing and eight subscales. Internalizing subscales (withdrawn, somatic, complaints, anxious/depressed).
3. State-Trait Anxiety Inventory for Children (STATIC-C; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1973). The STATIC-C includes ages 9-12 years, 20 items per scale, Scales: S (anxiety proneness) and T (anxiety). Also, STAIC-P, parent form.
4. Fear Survey Schedule for Children-Second edition (FSSC-II; Gullone & King, 1992; Burnham & Gullone, 1997). The FSSC-II includes ages 7 to 18 years, 75 items, Scales: Total fear and five subscales (fear of unknown, fear of failure/criticism, animal fears, fear of death and danger, and school/medical fears).
5. Anxiety Disorders Interview Schedule for DSM-IV Child Version (ADIS-C; Silverman & Albano, 1996). The DSM-IV includes ages 6-16 years, interview to assess anxiety, mood, and externalizing symptoms.

Monitoring Outcome:

The Child Anxiety Impact Scale-Parent is considered a useful tool to measure recovery from common anxiety disorders, social phobia, and generalized anxiety except for other specific phobias. The Spence Child Anxiety Scale (SCAS-C/P-SA) identified recovery for separation anxiety disorder (Evans, Thirlwall, Cooper, & Creswell, 2017; Langley, Bergman, McCracken, & Piacentinni, 2004).

Treatment (Children and Adolescents):

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

Well-established: None

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

Probably efficacious: SET-C for SOP met probably efficacious

Compton et al. (2010) conducted a randomized placebo-controlled trial comparing four treatment groups that included (separation anxiety disorder (SAD), sertraline (SRT), and their combination (COMB) against pill placebo (PBO), generalized anxiety (GAD), and social phobia (SP). The outcome of

this six-year study involving 488 children and adolescents has yet to publish results. Timing and duration of treatment are issues for counselors and clients. Gryczkowski et al. (2013) reported shorter treatment duration for exposure therapies when compared to efficacy trial.

Erford et al. (2015) conducted a meta-analysis of 80 anxiety treatment studies conducted with youth at termination. The study did not include PTSD or OCD. The analysis was to determine if a statistical difference existed between the therapeutic approaches used to treat anxiety in school-aged youth. Is one individual approach superior to a group or family-based approach or if CBT was superior to psychodynamic or EMDR? The statistical analysis at termination or later did not support any one approach instead all approaches had a positive reduction in anxiety symptoms

Separation Anxiety Disorder (SAD)

Definition and Assessment:

John Bowlby's early work on attachment focused on relationships and environment that he believed shaped early development. This belief was centered on his observations about how animals seek protection when frightened (survival pattern). He translated this idea to humans and further conjectured that this concept could be applied to how individuals, particularly children, seek protection and closeness with a protective person. From these observations, he developed two principles; the quality of early interactions with caretakers (mainly parental figures) that shape the quality of and the foundation for later personality development (Sroufe & Siegel, 2011).

Mary Ainsworth conducted field experiments and focused on attunement (sensitive responsiveness to an infant's cues, cries) critical to determine the type and quality of interactions between the caregiver and infant. When caregivers willingly and effectively respond to an infant's cry, this leads to less crying. When there is less crying, the infant begins to trust that the caregiver is reliable and displays confidence in the caregiver (securely attached). Jane Ainsworth developed the 'strange situation' procedure which created separation anxiety between the infant and caregiver. The observer evaluated how the infant reacted to the reunion and determined that there were different attachments. The patterns she found were measured behaviorally according to a child's emotional response to separation. During this procedure, the child was brought into a room to play for 20 minutes and then observed while caregivers and strangers first entered and then left the room. The child's responses, including changes in anxiety related to separation and reunion, were observed and found to be comprised of the following attachment patterns: secure, anxious, avoidant, ambivalent/ resistant, and disorganized.

The reunion is what determined the patterns, which were classified as securely attached, anxiously attached, avoidantly attached, anxiously resistant, and disorganized. The significance may not be a dysfunction but is likely to be a liability and if not corrected could lead to psychological dysfunctions. The securely attached child seeks or is active in initiating renewed engagement. The anxiously attached infant actively avoids the caregiver upon reunion or failure to be comforted by the caregiver. The avoidantly attached experiences routine rebuff when the infant needs tender care. During the

field experiments, these avoidantly-attached children were held as much but not when they needed it, and the anxiously/resistant attached child failed to be comforted (passive or angry) upon reunion.

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

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

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

Incidence:

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

Treatment:

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

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

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

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

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

There are some techniques that are incorporated into these family programs, such as reframing, exposure, coping strategies, exception technique, habit reversal, restructuring, relaxation, and deep breathing for anxiety reduction.

Social Anxiety Disorder (Social Phobia)

Definition, Interview, and Assessment:

A phobic disorder is diagnosed by a persistent fear of objects or situations to which exposure to the phobic stimulus elicits an immediate panic response. A social anxiety disorder or phobia is a fear of public scrutiny in one or more places and evaluation resulting in humiliation or embarrassment and impairment in functioning. Crome and Baillie (2014) reviewed four epidemiological surveys that identified the most fears and the severity of those fears through the use of face-to-face interviews. The DSM-5 specifier for social anxiety is performance only such as public speaking. Using item theory, the findings suggested that lower ranking fears included public speaking, participating in meetings and classes, and being the center of attention. Moderate severity rankings involved talking to people in authority, being assertive, talking to unfamiliar people, and attending public parties. Severe rankings included entering a room when others are present, working in small groups, writing, eating or drinking in public, and using bathrooms. Typical characteristics of social phobia include fearfulness, shyness, anxiousness, self-consciousness, submissiveness, anger, and experience of being shamed (Hofmann & Barlow, 2002; Hofmann, Heinrich, & Muscovitch, 2004). Otto and Gould (1996) illustrated

three maladaptive conditions associated with cognitive functioning. These are: 1) underestimating individual ability to cope in social situations; 2) exaggerating the perceived consequences of performing inadequately in social situations, and 3) rehearsing self-defeating and global failure attributions about themselves and their future social behavior. These thought patterns and fear of negative evaluations by others cause avoidance behaviors. Individuals with social anxiety disorder experience intense fears of negative evaluation and being subjected to embarrassment. Child anxiety symptoms include few friends, few extracurricular activities, underachieving, having more instances of school refusal or in-attendance, selective mutism, and comorbidity with anxiety, depressive, somatic symptom, and substance use disorders (Essau, Conradt, & Petermann, 1999).

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

Incidence:

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

Instrumentation:

Instrumentation can be helpful in sorting out associated features of a disorder and in determining a differential diagnosis between all of the anxiety disorders. The instruments selected to assist in the assessment (subjective-cognitive) data-gathering should be chosen for their diagnostic specificity. The presenting order of the instruments does not indicate preference (instruments 1-5 are widely used).

1. Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovex, 1990)
2. Penn State Worry Questionnaire—Adults (PSWQ-A; Hopko 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 & Clark, 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)

Assessment:

When making a diagnosis of social phobia, the evaluator should ask about specific situations that trigger symptoms. The differential diagnosis should also be assessed to include avoidant personality since the boundary between social phobia and avoidant personality is not always clearly distinct. Individuals with avoidant personalities have lifestyles pervaded by the avoidance of interpersonal relationships and social encounters, while individuals with social phobias tend to have symptoms under more specific conditions. Although they may have phobic symptoms in generalized conditions (fears in all domains), it is more likely that symptoms are associated with specific conditions. These may include entering rooms or locations under public scrutiny, answering questions where everyone can hear, speaking in a class or group settings, formal speech making to a large group, and being in a setting where one is afraid of being noticed. The diagnosis of social phobia might also have specific sub-types, one of which is a social phobia, performance anxiety. These subtypes are credited to Heimberg (Heimberg, Holt, Schneier, Spitzer, & Liebowitz, 1993), although subtypes are not listed in the DSM-5. The duration of the disturbance is at least six months (APA, 2013).

Adults and children are suffering from social anxiety disorder, express fears of speaking, reading and eating in public, or going to parties, of talking to authority figures and of informal social interactions. Performance fears are specific to certain situations in which the client has concerns of negative evaluations (FNE) or fears of positive evaluations (FPE). Kocijan and Harris (2016) reported clients might also have a fear of favorable evaluation in social and public situations. Reported physical symptoms include choking, flushes or chills, palpitations, fainting, shaking, fear of dying, and headaches (Beidel, Turner, & Morris, 1999). The interviewer should consider genetic transmission as family studies reveal that first-degree relatives of clients with social anxiety disorder manifest higher rates of social phobia than healthy controls (Fyer et al., 1993). Hoffmann (2007) identified factors that serve to maintain social anxiety. These factors include unrealistic social standards, shift attention toward their anxiety, view themselves negatively as a social object, overestimate the negative

consequences of a social encounter, believe that they have little control over their emotional response and view their social skills as inadequate to cope with the social situation.

Treatment:

The treatment of choice for social phobias is cognitive-behavioral therapy and the only empirically supported treatment listed (APA Div. 12 SCP, 2013; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2007; Hofman & Otto, 2008). Fang, Sawyer, Aderka, and Hofmann (2013) reported that weekly group sessions of cognitive-behavioral therapy produced a significant decrease in specific symptoms for social anxiety and body dysmorphic clients. Specific changes were noted through the use of attention retraining in modifying attentional biases. Other interventions helpful include in vivo exposures (maladaptive beliefs about feared consequences of social mishaps) and the dot-probe detection task. Hope, Herbert, and White (1995) conducted a study using group therapy to treat social phobia and results indicated client improvement. Craske et al. (2014) reported that CBT is the empirically supported treatment for social phobia; however, some clients remain symptomatic. Their efficacy study regarding ACT and CBT for social phobia resulted in the ACT specifically targeted anxiety symptoms (avoidance, negative evaluation). Key features of CBT and ACT are that CBT emphasized symptom reduction while ACT focused on psychological flexibility. The outcome indicated that CBT and ACT performed equally. Their randomized clinical study was comparing ACT with a waitlist. Psychopharmacology has also been effective and SSRI antidepressants, particularly Paroxetine, which has received approval from the FDA to treat social phobia. Social skills training as a treatment intervention, when compared with social effectiveness therapy (SET) was efficacious. SET provided additional benefit specifically for social distress and social behavior (Beidel et al., 2014).

If symptom fear of negative evaluations (FNE) and fear positive evaluations (FPE) are present, group cognitive behavioral therapy (GCBT) may be a treatment recommendation. This recommendation is dependent upon the degree of anxiety intensity the client is experiencing at the time. If the intensity is severe individual CBT is the initial step followed by a group experience.

Shahar (2014) reported that emotion-focused therapy (EFT) was effective in treating maladaptive shame as a symptom of social anxiety disorder.

Techniques/Interventions:

1. reframing
2. exposure
3. coping strategies
4. exception technique
5. Habit reversal
6. sculpturing (depending on age)

Panic Disorder

Definition and Interview:

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

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

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

Symptoms specifically related to panic disorder include heart palpitations, shortness of breath, dizziness, chest tightness, and fear of dying. The DSM-5 lists 13 symptoms, at least four of which must be present (APA, 2013). Specific panic attacks usually last 10 to 15 minutes, leave the sufferers feeling spent and drained of energy, and are generally not triggered by specific external events. However, Otto and Gould (1996) indicated that individuals with panic disorder may or may not recall their initial panic attacks as having first occurred after a significant stressful event or events. Clients engage in safety behaviors to escape or avoid a feared outcome may sit down, hold onto an object or person for support, and use overt avoidance behaviors (Craske & Simon, 2013).

Incidence:

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

community samples is 3.5%, mental health settings 10%, and 10% to 30% in medical settings (APA, 2000, p. 436).

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

Diagnostic Consideration:

Panic disorder is a psychiatric condition manifested by panic attacks precipitated by any known triggering events and often, but not always, associated with agoraphobia. Lifetime prevalence rate is 3.5% (APA, 2000, p. 436). The typical age of onset is between late adolescence and the mid-30s. This disorder is chronic and progressive, although sometimes waxing and waning. Agoraphobia may develop at any point, but the onset is usually within the first year (30% to 50% of the time). In some cases, agoraphobia may become chronic, regardless of the presence or absence of panic attacks. If agoraphobia is present and contains two or more agoraphobic situations, a separate diagnosis of agoraphobia should be given (APA, 2013, p. 209).

Fava, Porcelli, Faranelli, Mangelli, and Grandi et al. (2010) pointed out a panic disorder may be associated with a medical issue such as hyperthyroidism, hyperparathyroidism, pheochromocytoma, vestibular dysfunction, seizure disorders, and cardiopulmonary condition.

Concurrent Diagnosis (comorbidity):

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

Differential diagnosis is necessary to clarify panic disorder from other specified anxiety or anxiety disorder due to another medical disorder. One determining factor in panic disorder and agoraphobia is a time element. If the individual suffers recurrent unexpected panic attacks, at least one of the attacks must be followed by one month or both of persistent concern about having additional attacks, worry about the implications of the attack or consequences and a significant change in behavior as a result of the attacks. If the individual has a panic attack immediately after the cued exposure (e.g., being the center of attention in a group of people), more than likely a social phobia classification is warranted. It is recommended that the interviewer is aware of comorbidity, and there is at least a 5% chance that an alcohol involvement exists with a diagnosis of panic disorder and agoraphobia (Kushner, Sher, & Beitman, 1990).

Treatment:

Beamish et al. (1996) conducted outcome studies for the treatment of panic disorders and found psychopharmacological and cognitive-behavioral interventions as more effective than other forms of treatment. McCarter (1996) has reported on the effectiveness of pharmacotherapy and cognitive-behavioral treatment and found success rates of 80% for cognitive behavior therapy and 70% for pharmacotherapy. Sturpe and Weissman (2002) reported that medication (SSRIs, tricyclic antidepressants, benzodiazepines) and cognitive behavioral therapy are effective treatments for panic disorders and agoraphobia. Addis et al. (2006) conducted an effectiveness study between two groups. The first group was a treatment as usual (TAU) and the second was panic control therapy (PCT) over a duration of 12 to 15 weeks. The PCT treatment consisted of a manual-guided approach while the TAU treatment was the counselor's deemed approach to panic disorder. Effectiveness information was supportive of PCT treatment.

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

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

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

1. Cognitive therapy, including cognitive restructuring and focused cognitive therapy;
2. Combined cognitive-behavioral treatment including panic inoculation, panic information, cognitive restructuring, breathing retraining, biofeedback, and relaxation training.
3. Craske and Simons (2013) recommended a treatment approach for panic disorder includes:
    a. psychoeducation to correct common myths, cognitive misappraisals, and overt avoidance behaviors
    b. self-monitoring for ongoing changes in panic, anxiety, and avoidance improving in self-awareness and increased accuracy in self-observation
    c. developing a panic attack record to include cues, maximal distress symptoms, thoughts, and behavior
    d. developing a daily mood chart and situations avoided

e. breathing retraining for reduction in hypocapnia and levels of carbon dioxide, dizziness, shortness of breath
f. progressive muscle relaxation
g. cognitive restructuring for types of errors
h. in vivo-repeating and real-life exposure for the removal of safety signals
i. interoceptive exposure-deliberately induce feared physical sensations and correct misappraisal about sensations
j. relapse prevention

Agoraphobia

Panic disorder with and without agoraphobia has been separated or unlinked to be separate disorders, panic disorder, and agoraphobia disorder, although the symptoms for each remain the same. If a client meets full criteria for both disorders, both are recorded (APA, 2013).

Interview, Definition, and Assessment:

Agoraphobia is defined as anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event the individual has an unexpected or situationally predisposed panic attack or panic-like symptoms (Frances & Ross, 1996, p. 163). Individuals with this disorder usually are fearful of being outside of the home alone, in a crowd, confined, or encountering the public. The DSM-5 defined agoraphobia as an intense fear of a real or anticipated exposure to situations in which two of five situations are noted. Criterion A specifies the five situations to be using public transportation, being in open spaces, in enclosed situations, standing in a line/crowd, and being outside of the home alone (APA, 2013, p. 217). The individual avoids these situations because of fear that it will be difficult to escape and experience the panic-like symptoms and resultant harm. Frequently the client will request another person to accompany them in a social context. The fear is out of proportion to any actual danger (Criterion E) and the agoraphobia specifiers last six months.

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

Incidence:

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

Treatment:

A structured and focused treatment plan is recommended. Frances and Ross (1996) suggested an integrative approach, which includes psychoeducation for agoraphobia and panic disorders, medication to alleviate the panic attacks and cognitive-behavioral therapy (CBT) strategies for coping skills. Craske (1999) also suggested components to CBT to include: (1) education; (2) cognitive restructuring; (3) breathing retraining (designed to treat or manage anxiety and panic); and (4) exposure to internal and external cues that trigger panic and agoraphobia. Agoraphobia treatment often includes exposure techniques designed to address the avoiding behaviors for feared situations. When alcohol is involved in the diagnosis, Lehman, Brown, and Barlow (1998) found cognitive-behavioral treatment to be effective along with panic control treatment (PCT; Craske & Barlow, 1993).

White and Barlow (2002) recommended CBT treatment when panic attacks are not a component of agoraphobia. Behavioral interventions to reduce symptoms of agoraphobia include relaxation, assertiveness training, and thought stop, restructuring of negative thoughts, and training in positive self-statements. The client during treatment can be taught how to keep log notes to reinforce progress.

Generalized Anxiety Disorder (GAD)

Interview, Definition, and Assessment:

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

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

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

Incidence:

The 12-month prevalence for GAD is 0.9% among adolescents and 0.2.9% among adults (APA, 2013). Data from the National Comorbidity Survey reveals that 5.1% of the population will experience a generalized anxiety disorder during their lifetimes (Kessler et al., 1994). Kessler et al., (2005) raised the increase to 5.7%. Otto and Gould (1996) estimated a 3% prevalence rate, while APA (2000) reported lifetime prevalence rate to be 5%. The disorder is twice as common in women as in men. Keable (1989) indicated that studies have revealed that clients who have been diagnosed with a generalized anxiety disorder have tended to be older than 24, separated, widowed, divorced, unemployed, homemakers, and associated with other mental disorders.

Instrumentation:

The interviewer may use clinical interviews, self-report scales, behavioral observations, and physiological recordings to assist in the assessment. Some examples of instruments used by the assessment expert may be:

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

Treatment:

According to Frances and Ross (1996), very little research has been conducted on generalized anxiety disorder, and there does not appear to be an agreed-upon definition of the disorder. As a result, little is known about effective treatments. Of the anxiety disorders, GAD is the least effectively treated (Brown, Barlow, & Liebowitz, 1994). Frances and Ross indicated that medications in the past had not produced effective outcomes, although benzodiazepines seem to have the widest clinical use in spite of the potential risk for dependency. Fortunately, there are some nonbenzodiazepine medications which have anxiolytic effects and are sometimes effective, including SSRIs, buspirone, and the SNRI-venlafaxine (Ellison, 1996; Ellison & Ross, 1997).

Psychotherapies which have been most helpful include cognitive-behavioral therapy (Evans et al., 2008), which focuses on the target symptoms of worry and avoidance (internal and external anxiety cues and somatic symptoms). Psychodynamic psychotherapy has also been found to have a role for individuals whose GAD symptoms are caused by unconscious conflicts. Mavissakalian and Prien (1996) found success rates varying from 37% to 42% when medication treatment and anxiety management programs were combined. Overholser and Nasser (2000) indicated that GAD could be treated effectively by cognitive-behavioral therapies and that treatment plans should include "relaxation

training, calming self-statements, and exposure to the feared situations" (APA, 2013, p. 150). Evidence-based psychological treatment for older adults has been reported for the use of relaxation training, cognitive-behavioral therapy (CBT) and supportive therapy (Ayers, Sorrell, Thorp, & Wetherell, 2007). Recently, Evans et al. (2008) reported that GAD clients improved with a mindfulness-based approach with CBT utilizing meditation. Other authors have expressed skepticism about meditation being useful for this disorder (Krisanaprakornkit, Krisanaprakornkit, Jrusabaorajirbjutm Piyavhatkul, & Laopaiboon, 2006).

Hoge et al. (2017) conducted a study to determine the effect mindfulness-based stress reduction (MBSR) has for evidence of biological marker changes. The study procedures included randomized control trial to a group of MBSR (n=43) members and a stress management education (SME) group (n=29). The MBSR was an 8-week program composed of breath awareness, a body-scan, and gentle Hatha yoga to cultivate awareness of internal present-moment experiences in an accepting and non-judgmental stance. The SME group emphasis was a didactic attention control intervention in lectures for overall health and wellness (diet, exercise, sleep, and time management). Results revealed more substantial reductions in stress markers (symptoms) for the MBSR group members when compared to the controls (SME).

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

Obsessive-Compulsive and Related Disorders

Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive and related disorders include obsessive-compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder, hair-pulling disorder (trichotillomania), and excoriation disorder (skin picking). OCD was previously within the DSM-IV-TR category of anxiety, body dysmorphic disorder was formerly within the somatoform category, and trichotillomania was previously within the other impulse control disorders. McCarty, Guzick, Swan, and McNamara (2017) reported four types of OCD symptoms. The four types include contamination, symmetry, harm, and taboo content.

Interview, Definition, and Assessment:

Obsessive-compulsive disorder (OCD) is comprised of both obsessions and compulsions. Obsessions are recurrent and intrusive thoughts, feelings, ideas, or sensations. Compulsions are conscious, standardized recurring patterns of behavior, such as counting, checking, or avoiding (APA, 2013). Obsessions take time and interfere with people's normal routine, occupation, and social activities. Researchers concluded that OCD is associated with impaired social functioning, more

mediocre quality of life (Tenney, Schotte, Denys, van Megen, & Westenberg, 2003), increased use of health services and heightened attempts at suicide (Hollander et al., 1996).

Obsessive-compulsive disorder frequently occurs with substance use disorder and has a greater level of impairment in psychosocial functioning. Clients with both obsessive-compulsive disorder and substance use disorder have a higher occurrence of suicide. It is suspected that OCD clients use the substance as a means of coping and thus complicate treatment (SAMHSA, 2016b). Rasmussen and Tsuang (1986) reported that OCD clients might have associated risks of social phobia, panic disorder, and other phobias.

Clinical studies reported that OCD clients are four times more likely to be unemployed than other persons (Koran, Thienemann, & Davenport, 1996).

OCD is recognized as an excessive and disruptive disorder characterized by recurrent obsessions and persistent intrusive and inappropriate thoughts, impulses, or images associated with repetitive, compulsive behaviors. When obsessions are assessed to be excessive or unreasonable, and the client is unable to perceive them as irrational and may considered them as an overvalued idea (OVI). Client lack of insight regarding OVI's is likely to result in resistance to treatment (Borda, Neziroglu, Taboas, McKay, & Frenkiel, 2017).

The diagnostic criteria and definition include the presence of obsessions, compulsions or both. Clients with obsessions attempt to suppress and neutralize their anxiety through compulsive behaviors. Compulsions are repetitive, driven behaviors or mental acts (APA, 2013, p. 235, King, 2014n). According to Frances and Ross (1996), approximately 90% of the individuals with this disorder have both obsessions and compulsions, while a smaller percentage may have only one of the two. Obsessions are the presence of recurrent or persistent thoughts that the individual tends to ignore or suppress. Compulsions are repetitive behaviors and mental acts meant to prevent or reduce the anxiety.

Cognitive models emphasize six domains of dysfunctional beliefs or thoughts. These include: (1) over-importance of thoughts, (2) need to control these thoughts, (3) perfectionism, (4) intolerance of uncertainty, (5) inflated personal responsibility, and (6) overestimation of threat (Alonso et al., 2013; OCCWG-Obsessive Compulsive Cognitions Working Group, 2005). Criterion A requires one of two symptoms for each compulsion and obsession. Criterion B indicates that the compulsions or obsessions occupy more than one hour per day and cause distress or impairment (APA, 2013). Anxiety is prominent in that it is a result of behavioral activation, a building of tension. Client behavioral avoidance is the clue to this restlessness. Criterion A.1. Specifies that thoughts, urges, or images are intrusive and unwanted. Criterion A.4. specifies that the client recognizes that his/her thoughts and urges are a product of his/her mind and in Criterion B the client recognizes that these thoughts and urges are unreasonable and excessive (APA, 2013). The assessor is to specify if the OCD assessment is with good or fair insight, with poor insight, or with absent insight/delusional beliefs.

Comorbidity is important to assess because the diagnosis of OCD is not appropriate if the recurrent intrusive thoughts or impulses are in the context of another mental disorder (i.e., PTSD). Clients who lack awareness of the severity of their obsessions and compulsions are assigned a

diagnosis of OCD with poor insight. During 1996, the World Health Organization classified OCD as the fourth most common psychiatric disorder and the 10th leading cause of disability. SAMHSA (2016b) reported the relationship between OCD and other mental disorders include depression, GAD, social phobia, specific phobia, panic disorder, and PTSD. Assessing for OCD should include symptoms of incompleteness or overlap as a link between obsessive-compulsive disorder and obsessive-compulsive personality disorder. The symptoms of checking, ordering, hoarding, and counting are noted for both disorders (Ecker, Kupfer, & Gönner, 2014).

Tapanc, Yildirm, and Boysan (2018) reported neurological soft signs are important determinates and indicators associated with impairment in sensory, motor performance and cerebral dysfunction. These soft signs are complicated with altered sensory integration, motor coordination, and sequencing of complex motor behaviors. Assessment for OCD should involve probing for the client's ability to identify and describe feelings, difficulties in differentiating between bodily sensations and feelings, and for cognitive concrete thinking (Alexithymia). Symptom severity, frequency, and duration involve associations regarding consciousness, memory, identity, and perceptions of the environment. The degree of dissociative absorption and imaginative involvement will contribute to the severity.

Also, include family accommodation (FA) questions because the literature is replete with documentation that family members carry out specific duties for the OCD family member. The family intentions are to provide reassurance, avoidance of anxiety-provoking situations that trigger the symptoms, functional impairment, and amount of time spent on compulsions to reduce the client's distress and participating in the actual rituals (Peris et al., 2008; Gomes, Cordioli, & Heldt, 2017). Accommodations by family members have been documented to occur in 60% to 97% of families for individuals with OCD (Stewart et al., 2008). The Family Accommodation Scale for Obsessive-Compulsive Disorder (FAS) assesses the severity of consequences and distress experienced (Wu et al., 2016).

Incidence:

The APA (2013) reported a 12-month prevalence rate of 1.2%. The DSM-IV-TR (2000) reported a lifetime prevalence rate for OCD of 2.5% with a one-year rate of 0.5% to 2.1%. A 2.0 to 2.5% lifetime prevalence rate of OCD has been reported in two epidemiological studies by Karno, Golding, Sorenson, and Burnam (1989) and Weissman (1994). Meltzer, Gill, and Petticrew (1995) reported the six-month prevalence rates to be 1.5% to 2.1% in Great Britain. Comorbid psychiatric disorders (OCD plus a second disorder) run as high as 50% for clinical disorders and 40% for personality disorders (Mavissakalian & Prien, 1996). The onset of the obsessive-compulsive disorder appears to occur before 18 years of age (Insel, Donnelly, Lalakea, Alterman, & Murphy, 1983), although the onset of OCD in children has been found to be within an age range of 9 to 12.8 (Riddle et al., 1990). In summary, SAMHSA (2016b) reported the lifetime rate of OCD in the United States range from 1.6 percent to 2.3 percent.

Instrumentation:

Instrumentation can be helpful in the assessment of OCD because of the high rate of comorbidity with anxiety disorders, mood disorders, learning disorders, somatic symptom disorders, psychoses,

eating disorders, and substance disorders (Albano, March, & Piacentini, 1999). Careful selection of instruments for soft signs will be helpful. Soft signs include impulses, washing, checking, rumination, precision, absorption and imaginative involvement, amnesia, depersonalization/derealization, difficulty describing feelings, difficulty identifying emotions, externally-oriented thinking, sensory integration, motor coordination, sequencing for complex motor acts (Tapanc et al., 2018).

1. The Yale-Brown Obsessive Compulsive Scale II (Goodman et al., 1989; Steketee, Frost, & Bogart, 1996) is the most frequently utilized instrument to measure for OCD symptoms (Lopez-Pina et al., 2015).
2. The DSM-5 Level 2-Repetitive Thoughts and Level 1 Cross-Cutting Symptom Measure are recommended for data gathering, monitoring, and treatment planning for children ages 6 to 17 (King, 2014n). When co-existing diagnoses have been defined, it becomes possible to plan or triage for appropriate treatments. Several semi-structured interview schedules are available to assist in differential diagnosis.
3. PSU Inventory-Revised (Pi-R; Sanavio, 1988a, b)
4. Toronto Alexithymia Scale (TAS; Bagby, Parker, & Taylor, 1994)
5. Dissociative Experience Scale (DEC; Carlson & Putnam, 1993)
6. Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Version (Silverman & Albano, 1996)
7. Child OCD Impact Scale (Piacentini & Jaffer, 1996)
8. Children's Yale-Brown Obsessive-Compulsive Scales (Goodman et al., 1989)--a semi-structured interview schedule
9. Comprehensive Psychopathologic Rating Scale OCD (Thoren, Asberg, Cronholm, Jornestedt, & Traskman, 1980)
10. Leyton Obsessional Child Version (Berg, Rapoport, & Flament, 1986)
11. Leyton Obsessional Inventory (Cooper, 1970)
12. Maudsley Obsessional-Compulsive Inventory (Hodgson & Rachman, 1977)
13. Thought Fusion Instrument (TFI; Wells et al., 2001)
14. Obsessive-Compulsive Beliefs Questionnaire (OCBQ; Wells, & Carter, 1999)
15. Obsessive Compulsive Scale of the Symptom Checklist 90, Revised (Woody, Steketee, & Chambless, 1995)

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

Treatment:

CBT-based theory models involving exposure to the obsessive-compulsive procedure include habituation model, inhibitory model, cognitive model, and acceptance and commitment therapy (ACT) model. The goal of exposure ritual (response) and prevention (ERP) for clients is to learn to interact with the feared stimuli (ACT) in a new and more functional way. ERP is exposure to the anxiety stimuli and prevention is the compulsive responses that reduce the anxiety. Fisher and Wells (2005) and van der Heiden, Rossen, Dekker, Damstra, and Deen (2016) reported that ERP treatment revealed that 75% of clients after treatment were significantly improved, 60% achieved recovery, and 25% were asymptomatic.

Karno and Golding (1991) found that clients reported they had OCD symptoms at least seven years before seeking the treatment. After seeking help, they are likely to receive medication, nonmedical approaches such as psychotherapy or CBT, or combined treatments. Kobak, Greist, Jefferson, Katzelnick, and Henk (1998) and Greist and Jefferson (2007) pointed out that psychodynamic therapy had been the treatment of choice until other therapies such as exposure response prevention (ERP) became available and was supported by research effectiveness studies. Hill and Beamish (2007), in their literature search of effectiveness studies, indicated that behavioral treatment is the most effective. The interventions were systematic desensitization, modeling, muscle relaxation, exposure, and response prevention (McLeod, 1997). Combined treatments of exposure and response prevention (Basco, Glickman, Weatherford, & Ryser, 2000) and ritual prevention (Allen, 2006; Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Riggs & Foa, 1993) have been found to be most effective.

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

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

Fisher and Wells (2008), in a case study of four clients, provided support for metacognitive therapy as an effective treatment. This treatment differs from the traditional cognitive behavioral approach in that metacognitive focus is to acquire the knowledge or beliefs about thinking and strategies that are used to regulate and control the thinking processes. The specific aim is to determine the maintenance of the disorder. The approach is to recognize themes of thought-action fusion (TAF) regarding obsessions and compulsions. This approach does not attempt to modify uncertainties, perfectionism, and client responsibilities.

Harris and Wiebe (1992) recommended a less intense form of exposure therapy for children, as well as relaxation and breathing training. Marks (1981) indicated that for adults combining exposure

therapy with response prevention is a treatment of choice. Karasu (1989) found support for supportive psychotherapy.

Acceptance and commitment therapy (ACT) has demonstrated promise in treating OCD. ACT's objective is to increase flexibility regarding the belief system held by many OCD clients. Six core processes are the treatment goals that include: acceptance, defusion, self as context, present moment awareness, values, and committed action (Hayes, Strosahl, & Wilson, 2011; Hayes, Pistorello, & Levin, 2012).

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

A treatment based on family accommodation (FA) and cognitive-behavioral group therapy (CBGT) reported a significant reduction in OCD symptoms after a three-year follow-up (Gomes, Codioli, & Heldt, 2017). CBT and FA treatment involved 12-sessions with family members participating in two sessions. Outcome data supported previous research that family involvement in OCD treatment produces a reduction in symptom severity.

Treatment Efficacious:

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

Well-established (WE): None

Probably efficacious: Individual exposure-based CBT

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

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

Hollander, Alterman, and Dell'Osso (2006) suggested that approximately 40% of OCD clients are resistant to pharmacologic and behavioral treatment. For patients with treatment-resistant OCD, some direct physical interventions in the brain have been studied. These include transcranial magnetic stimulation (TMS; alternating magnetic fields--coil applied to the head), deep brain stimulation (DBS; a

surgical implantation of a 'brain pacemaker' which sends electrical impulses to specific parts of the brain) and electroconvulsive therapy (ECT). None of these techniques are recommended at this time (Hollander, Alterman, & Dell'Osso, 2006). However, while ECT is not a first line treatment. Several case reports revealed that modified bifrontal ECT could be effective for severe OCD when other therapies including pharmacotherapy, behavioral therapy, and cognitive therapy have failed (Liu et al., 2014).

A computer-assisted assessment and treatment program has been recently developed to treat OCD and consists of three types of specific technology include virtual reality, hand-held computers, and software programs (Lack & Storch, 2008). Greist et al. (2002) conducted a study of 218 OCD clients using the BT STEPS and results revealed a significant improvement in symptoms for OCD clients. The authors concluded that BT STEPS treatment is superior to no treatment and it was found to be as effective as a client-counselor face-to-face treatment.

In summary, SAMHSA (2016b) reported that the first-line psychosocial treatment for OCD is cognitive-behavioral therapy (CBT) especially CBT with ERP. Pharmacotherapy medications approved include clomipramine, fluoxetine, fluvoxamine, paroxetine, and sertraline.

Relapse Prevention:

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

Body Dysmorphic Disorder

Body dysmorphic disorder is classified as a disorder within the obsessive-compulsive and related disorders in the DSM-5 (Knoblock, 2013). In earlier versions of the DSM, it was classified as a somatoform disorder and even a psychotic disorder. Body dysmorphic disorder is a preoccupation (often a secret) with one or more perceived defects or flaws (imagined defect in appearance) and often-repetitive behaviors to avoid the appearance (APA, 2013). The client may demonstrate repetitive behaviors of an imagined defect in appearance. The imaged object is frequently the facial features and body parts such as the proportion of limbs and impairment in psychosocial functioning and quality of life. The client has reduced or absent insight (Toh et al., 2017). The average age of onset is 15 and typically lasts 18 years. Others do not notice the flaws or concerned defects, but often the client compares oneself to others. The concern can be that one's body is too small or too large. Phillips, McElroy, Keck, Pope and Hudson (1993, 2006) reported in 30 cases of imagined ugliness that men (17) and women (13) reported defects with an average of four preoccupations such as hair, nose, and skin. There is a preoccupation with delusional or nondelusional defects, and the behavior of an individual with this disorder is characterized by mirroring, checking, camouflaging or attempting to hide the flaw, avoiding social gatherings, and even making suicide attempts. The severity of these symptoms decreases effective psychosocial functioning and quality of life (Phillips, Menard, Fay, & Pagano, 2005). Frequently an individual with this disorder will also suffer from another disorder such as a major depressive disorder or a psychotic disorder.

Assessment and Instrumentation:

Added to the DSM-5 symptom list is client awareness to performing repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or a mental act of comparing.

1. The Liebowitz Social Anxiety Scale (ISAS) and the Body Dysmorphic Disorder Symptom Scale (BDD-SS) are useful instruments to measure the severity of symptoms (Liebowtiz, 1987; Wilhelm, Phillips, & Steketee, 2013).
2. The Brown Assessment of Beliefs Scale (Eisen et al., 1998; Knoblock, 2013) is a useful measure regarding appearance because it is a brief 7-item scale assessing for beliefs in the past week for insight and provides a cut score for nondelusional beliefs.
3. The Peters Delusions Inventory (PDI) measures the propensity for delusional thinking (Peters, Day, & Gareity, 2004). Thinking styles measured by the PDI include persecution, suspiciousness, paranoid ideation, religiosity, grandiosity, paranormal beliefs, thought disturbances, negative self, catastrophic ideation, thought broadcast, ideation of reference and influence, and depersonalization. It would be important to assess for depression when the client expresses beliefs of ugliness.
4. The Hamilton Rating Scale for Depression can be useful to determine if there is an accompanying mood disorder (Hamilton, 1960).

Treatment:

Cognitive models of therapy emphasize dysfunctional cognitive processes that include negative appraisals of body image, self-focused attention, and post-event rumination. Treatment goals are specific cognitive aspects to include mirror checking, social avoidance, and comparing appearance with others. Many of these symptoms overlap with social anxiety disorder and obsessive-compulsive disorder. Fang, Sawyer, Aderka, and Hofmann (2013) pointed out that positive psychological treatment of social anxiety disorder improves body dysmorphic concerns. Attentional bias modification intervention improves social anxiety disorder and anxiety symptom severity and also BDD related cognitions and symptoms. The dot-probe detection task is an intervention to manipulate attentional biases for checking and comparing beliefs about appearance (Posner, Snyder, & Davidson, 1980).

Possible treatment outline may involve:

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

Hoarding Disorder

Hoarding is a new disorder in the DSM-5 although previously was a symptom in OCD. Characteristics include the urge to save and acquire inanimate and animate objects (McGuire,

Kaercher, Park, & Storch, 2013; Ferreira et al., 2017). The estimated prevalence rate is 2% to 6% in the general population (APA, 2013).

Assessment:

Criteria A-F includes (a) persistent difficulty discarding possessions regardless of value, (b) difficulty is due to perceived need to have items and distress associated with parting, (c) difficulty parting with objects results in accumulation of possessions and complicates use of living space, (d) impairment in social, occupational or other areas of functioning, (e) hoarding is not attributable to a medical condition, and (f) condition is not better explained by another mental condition (APA, 2013, p. 247).

Assessing for hoarding disorder should begin with childhood behaviors inclined to hoard (Frost, Ruby, & Shuer, 2012; Grisham, Frost, Steketee, Kim, & Hood, 2006). Numerous beliefs and experiences exist about hoarding (Gordon, Salkovskis, & Oldfield, 2013). Two factors are reported in numerous research articles, that of experiential avoidance and dysregulation of emotions. Experiential avoidance is a tendency to avoid attending to unwanted internal experiences (de la Cruz et al., 2013).

Kress et al. (2016) reported that animate hoarding involves collecting a large number of animals and a more significant severity of dysfunction with poorer insight (APA, 2013). The client is likely to report an emotional attachment as the reason for the hoarding of animals. Hoarding animals takes on special conditions that include: a) hoarding a large number of animals; 2) failure to provide minimum conditions for nutrition, sanitation, and veterinary care; and 3) failure to act on animals deteriorating conditions or negate effect hoarding has on the individual's physical and mental health (Patronek, 1999). Comorbid conditions exist for depressive disorders and attention-deficit /hyperactivity disorder (APA, 2013). Some medical conditions are also known to exist with those with a hoarding disorder. These medical conditions include diabetes, sleep apnea, arthritic complications, hematological conditions and some cardiovascular problems (Ayers, Iqbal, & Strickland, 2014).

Instruments:

1. Saving-Inventory-Revised (SI-R; Frost et al., 2004)
2. Hoarding Rating Scale-Interview (HRS-I; Tolin et al., 2010)

Treatment:

The gold-standard treatment is cognitive-behavioral therapy (CBT) and group (GCBT; Steketee et al., 2010). Treatment emphases include problematic beliefs and behaviors, avoidance of emotional distress, and information-processing deficits. CBT symptom focus comprises (a) skills training for problem-solving, decision-making, and organization; (b) imagined or direct exposure to stimuli, and (c) cognitive restructuring. Treatment for children involves a family-based approach involving psychoeducation, rewarding positive discarding, and setting deadlines for discarding (Ale et al., 2014).

Excoriation (Skin-Picking) Disorder

Excoriation is defined as a recurrent picking at one's skin typically the arms, face, and hands and often more than one area of the body. Picking is with fingers, tweezers, pins, other objects and rubbing, squeezing, lancing and biting (APA, 2013). Client distress may be an embarrassment (hiding picked areas, clothing), negative affect, feeling a loss of control, and shame. Skin picking can occur at any age although for adolescents frequently skin picking begins around the time of puberty. Three subtypes of skin picking include automatic, focused, and mixed. Experiential avoidance is a focused type in which the client avoids experiencing aversive affective states because it helps to regulate a client's negative emotions (Jagger & Sterner, 2016). The automatic subtype does not attempt to regulate emotion rather are unaware of the action which occurs during sedentary times (boredom, watching television, riding in a car, etc.). During the process of the interview, the client may express a low-esteem, dissatisfaction with appearance, depression, anxiety, and issues involving occupational, or academic performance.

Prevalence:

APA (2013) reports a lifetime prevalence of 1.4% for adults and three-quarters of the amount are females.

Assessment:

Assessing involves an interview that includes observation indicators, control issues, and avoidance components. The interviewer should be alert to physical and psychological signs when assessing the severity of skin picking. Physical symptoms may involve lesions (visible), scars, wearing long pants, long-sleeved shirts, hats, gloves, and open wounds. The client might sit on hands, refuse to shake hands, and conceal sores. Psychological signs may include low self-esteem, dissatisfaction, depressed state, impaired social function, feelings of shame, avoiding sports, and anxious behaviors (Hayes, Storch, & Berlanga, 2009; Neziroglu, Rabinowitz, Breytman, & Jacofsky, 2008).

Differential Diagnosis:

Psychotic disorder, other obsessive-compulsive disorder, neurodevelopmental disorders, somatic symptom and related disorders (APA, 2013, p. 256).

Instruments:

1. Skin Picking Scale (SPS; Keuthen et al., 2001) is a six-item self-report measuring the severity of skin picking. SPS categories include frequency of urges, the intensity of skin picking urges, time spent picking, interference due to skin picking distress, and avoidance. The SPS-R included two additional items to assess for control factors and physical damage to the skin.
2. Milwaukee Inventory for Dimensions of Adult Skin Picking (MIDAS; Walter, Flessner, Conelea, & Woods, 2009). The MIDAS is a 12-item self-report to measure for automatic and focused skin picking.

Treatment:

There is a lack of efficacious treatment modalities for excoriation disorder. The treatment provided should consider co-occurring disorders.

1. Acceptance and Commitment Therapy (ACT) targets experiential avoidance processes to increase the client's psychological flexibility using six processes: (a) confronting the system, (b) control is the problem, (c) acceptance as an alternative agenda, (d) self as context, (e) cognitive defusion and mindfulness, and (f), a willingness and commitment to carry out valued actions (Hayes et al., 2012; Hayes, Levine, Plumb-Vilardaga, Villatte, & Pistorello, 2013).
2. Acceptance-Enhanced Behavior Therapy (AEBT) and Cognitive Behavioral therapy have also received support in reducing excoriation symptoms (Jagger & Sterner, 2016).

Techniques/Interventions:

Habit reversal training (HRT) is a technique to decrease the frequency of repetitive behaviors that includes five interventions; awareness training, relaxation, training, competing for response training, social support, and generalization training (Azrin & Nunn, 1973).

ACT, AEBT, and CBT utilize psychoeducation, cognitive restructuring, and relapse prevention (Gelinas & Gagnon, 2013).

Trauma and Stressor-Related Disorders

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

Adjustment Disorder

Adjustment disorder is one of the most frequent disorders (Bachem & Maercker, 2016). The DSM-5 adjustment disorder has been reclassified and placed in the category of trauma and stress-related disorders. Adjustment disorder is a maladaptive reaction to an identifiable psychosocial stressor, and a preoccupation with the stressor or its consequences, and characterized failure or avoidance to adapt and impairment in personal, family, social, occupational or other important areas in life. This definition is a component of the ICD-11 conceptualization. The client's reaction is different from a normal response but does not meet criteria for psychopathology. Stressors in the form of life events for adjustment disorder may include a serious illness, conflict with neighbors, and job-related strife (Skruibi et al., 2016). Adjustment disorder is a low threshold disturbance between normal behavior and the major psychiatric disorders. The clinical picture is usually vague although more than normal reactions. The maladjustment or disturbance of mood should be within three months of the experience of the stressor and should not exceed six months in duration. The pattern may be a

significant stressor (school, work, conflict with friends/loved one or family) followed by a mood disturbance or behavioral distress (Strain & Diefenbacher, 2008).

An adjustment disorder comprises 5% of the client population in outpatient clinics and up to 50% in hospitals or psychiatric consultations (APA, 2013). Field data reported that 10% of psychiatric diagnoses are adjustment disorders. A national study in Germany revealed that 9% prevalence of adjustment disorder met full clinical significance for impairment (Skruibis et al., 2016). This diagnosis is defined as a constellation of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors, causing moderate symptoms or moderate impairment in social or occupational functioning occurring within three months of the stressful event and lasting no longer than six months (APA, 1994). Symptoms include depressed mood, anxious mood, disturbed conduct, or a mixture of several of these features.

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

Suicidal behaviors associated with adjustment disorder are common, varying between 25% and 60% depending on age (Casey, Jabbar, O'Leary, & Doherty 2015; Pelkonen, Marttunen, Henriksson, & Lonnqvist, 2005). Suicidal behaviors and adjustment disorder comparisons are made with depressive episodes but occur earlier in life with adjustment disorder.

Adjustment disorder poses a challenge when diagnosing because of the difficulty separating adjustment disorder from a depressive episode and a personality disorder. Separating the complexity of conditions such as transient situational personality disorder, adult situational reaction, and gross stress reaction requires clinical symptoms that are yet unclear involving temperament. Doherty, Jabbar, Kelly, and Casey (2014) suggested that adjustment disorder is associated with a high level of personality disorder and personality disorder has a stronger association with depressive episode than adjustment disorder.

The symptoms of adjustment disorder, which must be different from bereavement, should appear within three months of a stressor's onset and are disproportionate to the nature of the stressor and cause more significant impairment in social or occupational functioning than would be expected. There is usually resolution within six months, although symptoms last longer if produced by a chronic stressor or one with long-lasting consequences (Kaplan & Sadock, 1998). The severity of the stressor is not always predictive of the severity of the disorder and is influenced by factors such as culture, degree, quantity, duration, reversibility, environment, and personal context. Criterion B emphasizes that the severity is out of proportion to the stressor according to external and cultural factors (APA, 2013). Furthermore, not everyone who is exposed to a stressful event develops symptoms because of the following factors: the nature of the stressors, coping skills, unique conscious and unconscious meanings, individual vulnerabilities, individual ego strength, social supports, unresolved emotional stressors, losses, and disappointments from the past (Kaplan & Sadock, 1998).

Specifiers for adjustment disorder include:

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

Specifiers include acute and chronic distinctions of adjustment disorder. Acute indicates the persistence of symptoms for less than six months. Chronic indicates the persistence of symptoms longer than six months. Because adjustment disorder, by definition, cannot last longer than six months, chronicity describes the condition of a chronic stressor with "enduring consequences" (APA, 2013). The DSM-5 does not list the severity ratings of acute and chronic.

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

Child Factors:

1. child temperament
2. psychological deficits and difficulties
3. subclinical levels of conduct disorder
4. academic and intellectual performance

Parent and Family Factors:

1. prenatal and perinatal complications
2. psychopathology and criminal behavior in the family
3. parent-child punishment
4. monitoring of the child
5. quality of the family relationships

6. marital discord
7. family size (the larger, the higher risk)
8. sibling with antisocial behavior
9. socioeconomic disadvantage

School-Related Factors:

Internalizing and externalizing behaviors in the form of maladjustment are a characteristic of childhood adjustment disorder (e. g., classroom social-behavioral maladjustment, little emphasis on academic work, infrequent praise). Behaviors may exacerbate anxiety, depression, aggression, and misconduct. Internalizing factors include withdrawn (shy, be alone, sulks, underactive, sad), somatic complaints (e.g., dizzy, tired, headaches, nausea), and anxious/depressed (lonely, cries, nervous, fearful, guilty, self-conscious, worries). Externalizing factors may be delinquent behaviors and aggressive behaviors. Abry et al. (2017) in a study of classroom adversity did not report these symptoms as events or long-term maladjustment rather they may be symptomatic of an event in the life of the child (e.g., loss of a loved one, bullying, loss of friendship) suggesting an assessment.

Incidence:

The APA (2013) reported that adjustment disorders are relatively common. In fact, it is estimated that in the mental health outpatient setting prevalence rates are between 10% and 30%. Individuals coming from disadvantaged lifestyles are thought to be at an increased risk of developing adjustment disorders, primarily because of increased likelihood of having and developing stressors (Swartz, van Schagen, Lancer, & van den Bout, 2013). The prevalence rate is 12% in a hospital setting (APA, 2000). According to Kazdin (1998), one of the most frequent findings is that men and boys show three to four times higher prevalence rates than do women and girls.

Instruments:

1. Diagnostic Disorder New Module (ADNM-20) lists 19 items grouped into six-module of preoccupations, failure to adapt, avoidance, depression, anxiety, and impulsivity) and one question for impairment (Lorenz, 2015).
2. The Diagnostic Interview Adjustment Disorder (DIAD; Cornelius et al., 2014)

Diagnostic Considerations:

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

The Adjustment Disorder New Module (ADNM-20; Einsle et al., 2010; Lorenz, 2015) listed seven types of acute events and nine types of chronic stressors. Acute stressors include the death of a loved one, moving, criminal act, accident, retirement, and termination of leisure activities. Chronic stressors

include financial difficulties, family conflict, and conflict with neighbors, too much/too little work, illness/care of a loved one, unemployment, and pressure to meet deadlines (Glaesmer, Romppel, Brahler, Hinz, & Maercker, 2015).

Adjustment disorder with depressed mood should also be differentiated from other depressive disorders. A client with the major depressive disorder would have more significant symptoms, including thoughts about death or suicide, loss of pleasure, guilt feelings, hopelessness and helplessness, weight loss and psychomotor disturbances, sleep and appetite disturbance, loss of energy, loss of concentration and cognitive functioning, and significant interpersonal withdrawal. Individuals with uncomplicated bereavement, which is not considered a disorder, typically improve over several months.

Treatment (Adults):

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

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

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

Sundquist et al. (2015) conducted a randomized control study with primary care patients with depression, anxiety, stress and adjustment disorders using mindfulness group therapy and found similar outcome findings as reported by individualized-based therapy or CBT. The authors at the conclusion of their research reported in eight of 15 studies a significant reduction in symptoms using mindfulness-based therapy.

Bachem and Maercker (2016) recommended a self-help manual consisting of four chapters that included some CBT techniques. Techniques included in each chapter for sensing of self, activation, coping, relaxation, and practicing relaxation.

Skruibis et al. (2016) introduced an Internet-based modular program, BADI, for adjustment disorder. The BADI includes treatment consisting of relaxation exercises, time-management, mindfulness, and strengthening relationships. The models are based on maladaptive behavioral

reactions to stressors that are between 'normal' behavior and psychiatric illness. The reactions include intrusive preoccupations with stressors, avoidance, and failure to adapt to life events, and an inability to adapt. Life events may include severe illness, conflict with neighbors/family, and job-related conflicts.

Treatment (children and adolescents):

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

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

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

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

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

Techniques/Interventions:

1. bibliotherapy (helpful for preoccupation and posttraumatic symptoms)
2. stress inoculation training
3. solution-focused therapy
4. self-help (stress response, expression of emotions, personal risk, coping strategies, the link between thoughts and emotions)
5. coping skills training (negative thoughts: stopping technique, anti-rumination training, written exposure exercises, the purpose of fear, dealing with anxieties)
6. activation training (life review, realistic aims, activation social network, hobbies, training in sensual enjoyment, the effect of sport)

7. relaxation training (balanced activities and relaxation, physical, mental, and emotional correlates of relaxation, practice relaxation regarding sleep hygiene, imaginary (timeout), progressive relaxation, autogenic training, meditation, and yoga (Bachem & Maercker, 2016)

Acute Stress Disorder

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

The four types of exposures are:

1. directly experiencing
2. witnessing, in person, the event as it occurs to others
3. learning about the event to a close family member or close friend
4. experiencing repeated or extreme exposure to aversive details of the traumatic event (APA, 2013, p. 280).

The 5 Criterion categories include 14 symptoms spread through intrusion symptoms, negative mood, dissociative symptoms, avoidance symptoms, and arousal symptoms. Acute stress disorder (ASD), like PTSD, can occur after individual experiences, witnesses, learns about or experiences extreme aversive details that involve a threat or actual death, serious injury, or another kind of physical violation to the individual or others, and responds to this event with intense feelings of fear, helplessness or horror. A summary of prospective studies of acute disorder included 6 motor vehicle accidents where 78% developed PTSD and 39% were previously diagnosed with ASD, 6 brain injury where 83% developed PTSD and 40% were diagnosed with ASD, 6 assaults where 83% developed PTSD symptoms and 57% were previously diagnosed with ASD, 6 motor vehicle accidents where 72% developed PTSD where 59% were previously diagnosed with ASD, 6 motor vehicle accidents where 30% developed PTSD symptoms and 34% were previously diagnosed with ASD, 6 motor vehicle accidents where 34% developed PTSD and 10% were already diagnosed with ASD, 8 typhoons, where 30% had PTSD symptoms and 37% were previously diagnosed with ASD, 6 cancer, where 53% had PTSD symptoms and 61% were previously diagnosed with ASD, 24 motor vehicle accidents where 82% had PTSD symptoms, and 29% were previously diagnosed with ASD, and 24 brain injury where 80% had PTSD symptoms, and 72 % had previously been diagnosed with ASD (Bryant, 2006, p. 238).

The diagnosis of ASD was established when it became clear that trauma survivors often quickly exhibited signs of PTSD-like symptoms after major traumatic events. It was also found that more than 50% of those who had the symptoms of ASD would eventually develop a posttraumatic stress disorder. While ASD is a relatively new diagnosis, this condition was once referred to as "shell shock" in World War I and, even before that, symptoms now characterized as acute stress disorder were

observed in soldiers as far back as the U. S. Civil War in 1865. It is now known that severely traumatized individuals, both combatants and civilians, may also suffer from ASD.

The acute stress symptoms that played a role in the onset and maintenance of the acute stress disorder and symptoms maintained in PTSD are maladaptive strategies for managing intrusive trauma-related memories. Meiser-Stedman et al. (2014) reported that intrusive memories are maintained due to cognitive avoidance (suppression/abstraction), rumination, and perseveration thinking (worry, rumination).

Incidence:

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

Instruments:

1. Acute Stress Disorder Scale (ASDS; Bryant et al., 2000) is a 19-item self-report screener to identify ASD and predict subsequent PTSD.
2. Acute Stress Disorder Interview (ASDI; Bryant et al., 1998)
3. Clinician-administered PTSD Scale
4. Beck Depression II
5. Impact of Event Scale (IES; Maercker & Schutzwohl, 1998), Three subscales of posttraumatic stress reaction-intrusion, avoidance, and hyperarousal

Treatment:

Not all acute stress disorders require treatment because most remit in the following months. (Bryant, 2006; Roberts, Kitchiner, Kenardy & Bisson, 2009)

1. Cognitive Behavioral therapy (CBT). Bryant et al. (2003a) reported a four-year follow up of 80 survivors of a motor vehicle or non-sexual assault. Fifty patients received the CBT treatment while 39 received supportive counseling. Patients in the CBT group after four years reported less intense PTSD symptoms, less frequent and fewer avoidance symptoms than those receiving supportive therapy.
2. CBT with prolonged exposure, psychoeducation, progressive relaxation, and anxiety management was effective compared to a wait list and supportive therapy (Freyth, Elsesser, Lohrmann, & Sartory, 2010).
3. Eye Movement Desensitization Reprocessing (EMDR) may have results (Buydens et al., 2014). There are three EMDR protocols. The Standard EMDR Protocol includes a three-pronged approach involving past events, present triggers, and future-related concerns. EMDR protocol is a focus on the traumatic event. Recent Traumatic Episode Protocol (R-TEP) adds strategies for containment and safety with 8 phases. EMDR-PRECI is a single–session protocol for the latest event referred to as a critical incident.

4. Cognitive Processing Therapy (CPT) applied to significant trauma in the first month of physical and sexual assault, war or combat-related trauma, motor vehicle accidents, and natural disasters (APA, 2000) in a 9-hour, 6-week program reported gains that were maintained for six months (Nixon, 2012).
5. Supportive therapy (Nixon, 2012)

Posttraumatic Stress Disorder (PTSD)

Definition and Interview:

The definition of PTSD has expanded to include the hearing of trauma, direct experience, learning that it happened to someone else, repeated exposure to details of trauma and also includes new symptom clusters, and separate criteria for children age 6 or younger (APA, 2013). Posttraumatic stress disorder (PTSD) is defined by events that involve actual or threatened death or serious injury, or threat to the physical integrity of oneself and others, plus a response at the time that involved intense fear, helplessness or horror (APA, 2000, p. 463). The main symptoms are distressing intrusive thoughts, feelings, and images lived again and again from a traumatic event and responded with intense fear, helplessness, or horror (Criteria A). The response includes Criterion B symptoms of re-experiencing the event; avoidant and numbing behaviors (Criterion C), hyperarousal (Criterion D), and lasted for at least one month (Criterion E). The client experiences severe impairment and distress (Boal et al., 2017)

The traumatic event is re-experienced in one of the several ways such as recurring recollections of the event, distressing dreams, sense of reliving the event, psychological distress at experiencing symbolized aspects of the trauma, and physiological reactivity to the expressed aspects of the event (Frances & Ross, 1996). Another major symptom of PTSD is a persistent hyperarousal as manifested by sleep disturbances, anger, impaired concentration, hypervigilance, and the startle response. Most client assessed with PTSD did not initially have ASD (Roberts et al., 2009).

The posttraumatic symptoms that played a role in the onset and maintenance of the PTSD symptoms included maladaptive strategies for managing intrusive trauma-related memories. Cognitive avoidance (suppression/abstraction) and perseveration thinking (worry, rumination) maintained the symptoms (Meiser-Stedman et al., 2014).

This condition is different from anxiety disorders, although has some similar symptoms with acute stress disorder because symptoms are caused by a prolonged physiological and psychological response to an extreme stressor.

Assessment:

Assessment consists of the type of exposure such as direct, watching it occur to others, learning that it happened to someone else, repeated exposures to details of trauma, but does not apply to media exposure unless it is work related as exemplified by first responders. Symptom clusters for Criterion B are intrusions, avoidance, alterations in cognition and mood, and increased arousal and reactivity.

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

Varela and Vernberg (2003) recommended the interviewer assess for objective and subjective elements of the trauma. Objective elements include: (a) intentional injury, (b) exposure to the grotesque, (c) violent, (d) sudden loss of loved ones, (e) learning of exposure to a noxious agent and (f) being the cause of death or severe harm to another. Subjective elements include interpretations of the events. Examples of subjective elements may include: (a) perceived threat or harm, (b) negative internal experiences (intense fear, panic, anger, and feelings of dissociation or unreality; p. 4).

Prominent symptoms include:

1. loss of interest in daily activities
2. sadness, an emptiness of feeling down
3. hopelessness
4. tiredness and lack of energy
5. low self-esteem, self-criticism or feeling incapable
6. trouble concentrating and making decisions
7. irritability or excessive anger
8. decreased activity, effectiveness, and productivity
9. avoidance of social activities
10. feelings of guilt and worries over past
11. poor appetite or overeating
12. sleep problems

Ford, Russo, and Mallon (2007) reported that clients with PTSD use substances to cope with intrusive memories, hyperactivity, sleep disturbance, irritability, and physical reactively. Intrusions are memories, dreams, flashbacks, and physiological or psychological reactions from trauma reminders. Avoidance is to avoid situations that elicit the memories or external reminders (requirement of one). Alterations in cognition and mood are to forget details of the trauma, have negative beliefs or distorted thoughts about the cause of the trauma, and negative emotional state. Increased arousal and reactivity are characteristics such as irritability, recklessness, hypervigilance, sleep problems, increased startle response, and decreased concentration (APA, 2013; Kroner-Borowik, 2013).

Assessment of posttraumatic stress disorder or acute stress disorder first depends on exposure to any psychological event outside the range of normal experiences (i.e., disaster, assaults, war, etc.; Emmelkamp, 1994) and the client's subjective description of symptoms (King, 2013k; Resnick, 1997). If the client does not spontaneously report having survived a traumatic event during the initial interview, the interviewer should ask about past traumatic events and associated features, such as anxiety, depression, and substance abuse, which may be prominent in the history of the individual. To avoid triggering undesirable traumatic emotions the examiner can ask the client to discuss only as much as he or she is comfortable (APA, 2013). Breslau, Kessler, and Peterson (1998) recommended using a structured interview during the assessment. The interviewer should also attempt to clarify whether the client's symptoms are consistent with criteria for acute stress disorder as described in the DSM-5, i.e., symptoms of dissociation (e.g., numbing, depersonalization, reduced awareness, derealization, and amnesia). Other symptoms which may be present in either ASD or PTSD include re-experiencing (e. g., intrusive thoughts or actions, dreams, sense of reliving the trauma, and distress on exposure to reminders of the trauma), avoidance (e.g., not talking or thinking about the trauma, avoiding places or people that are reminders of the trauma, active avoidance of distress) and arousal (e.g., sleep disturbance, irritability, concentration deficits, hypervigilance, exaggerated startle response, and autonomic arousal; Bryant et al., 1998).

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

Incidence:

The APA (2013) cited a 12-month prevalence rate of 3.5%. The APA (2000) cited a lifetime prevalence of posttraumatic stress disorder (PTSD) in approximately 8% of the adult population while the DSM-5 cites 8.7% at age 75. The lifetime prevalence for men is 5% to 6% and 10% to 14% for women (Breslau, 2002). In medical facilities, the percentages are even higher (12% general medical population, 20% VA mobile care clients; Hankin, Spiro, Miller, & Kazis, 1999).

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

Symptoms of PTSD are more severe and prolonged in individuals who have suffered catastrophic traumas. Among World War II POWs, 40 years after combat duty and prison confinement, the prevalence of PTSD was found to be around 50% (Goldstein, van Kammen, Shelly, Miller, & van Kammen, 1987; Kluznik, Speed, Van Valkenburg, & MaGraw, 1986). Selected groups of combatants from military action have also demonstrated higher rates of PTSD. Solomon (1987) reported that 56% of 3,553 Israeli soldiers who had had acute combat stress reaction during the 1982 Lebanon War showed symptoms of PTSD two years later, while only 18% of the noncombat soldiers had PTSD. Of interest is the incidence of comorbid disorders associated with PTSD. At least 50% of Vietnam combatants were found to have PTSD, plus one of the following: panic disorders, generalized anxiety

disorder, OCD, major depression, substance use disorder, and personality disorder (Kulka et al., 1990). Otto and Gould (1996) cited the following prevalence statistics for PTSD: 1% for the general population, 15% of individuals with mental disorders, 13% for Vietnam veterans, 27% for crime victims, and 57% for rape victims.

Instrumentation:

Instrument frequency of use studies are reported for the years 2016, 2011, and 2007. It is recommended to be aware of self-reports screeners and longer-versions of instruments appearing in the exhaustive studies.

Bardhoshi et al. (2016) conducted a study to identify the frequency of different PTSD instrument use for screening and outcome research. Their findings involved 15 instruments considered outcome measures. The following six were most frequently used:

1. Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990) 33%
2. Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997) 28%
3. Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995) 25%
4. PTSD Checklist (Weathers et al., 1993) 10%
5. Mississippi Scale for Combat-Related PTSD (M-PTSD; Keane, Caddel, & Taylor 1988) 8%
6. Structured Interview for PTSD (SI-PTSD; Davidson et al., 1991) 8%

Meiser-Stedman et al. (2014) in preparing a child and adolescent treatment protocol for PTSD singled out the thought Control Questionnaire (TCQ; Wells & Davis, 1994) to assess for strategies that maintain PTSD symptoms. The TCQ contains five strategies that include distraction, social control, punishment (self-blame, criticism), reappraisal (to review aspects of the intrusion), and worry (negative concerns).

De Vecchio, Elway, Smith, Bottonari, and Eisen (2011) in an exhaustive literature search to identify self-report PTSD assessment instruments reviewed three electronic data banks, MEDLINE, PsycINFO, and the Published International Literature for traumatic stress. The search identified 41 instruments that assessed for the 17 DSM-IV sub symptoms and met the seven inclusion criteria. From this list, they reported that the two gold standards for PTSD include:

1. Clinician-Administered PTSD Scale (Blake et al., 1995) and
2. Structured Clinical Interview for DSM-IV, PTSD module (First et al., 1996).

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

1. The Revised Civilian Mississippi Scale for PTSD (Keane et al., 1988; Norris & Perilla, 1996) Self-reported symptoms of posttraumatic stress in veteran populations.
2. Civilian Version of the Mississippi PTSD Scale (Norris & Perilla, 1996)

3. MMPI-PTSD (Keane, 1998; Keane, Malloy, & Fairbank, 1984)
4. Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979)
5. Diagnostic Interview Schedule for DSM-IV (Robins, Cottler, Bucholz, & Compton, 1995)
6. Composite International Diagnostic Interview (CIDI; World Health Organization, 1997)
7. Short Screening Scale for DSM-IV Posttraumatic Stress Disorder (Breslau, Peterson, Kessler, & Schultz, 1999)
8. Short Screen Scale for DSM-IV PTSD (Breslau et al., 1999)
9. Harvard Trauma Questionnaire (Mollica et al., 1995)
10. PTSD Interview (Watson, Juba, Manifold, Kucala, & Anderson, 1991)

Treatment:

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

The following treatments are noted to be effective:

1. Prolonged Exposure Therapy (PET) is the standard gold treatment for PTSD (Bryant et al., 2008; Cooper et al., 2017; DeRubeis & Crites-Christoph, 1998; Markinson & Young, 2012; Foa et al., 2005; Foa et al., 2009; Schnurr et al., 2007; Shaley, 2009)
2. Behavior therapy (exposure-based
3. EMDR (adaptive information processing processes information related to traumatic and distressing experiences; Bisson & Andrews, 2007; Bradley et al., 2005; Lee, 2008; Makinson & Young, 2012; McLean & Foa, 2003)
4. Mindfulness-based cognitive therapy (MBCT)
5. Cognitive Processing Therapy (CPT)

Several therapeutic approaches that have been found useful to help resolve the symptoms of traumatic stress include:

1. critical incident stress debriefing (CISD; Mitchell, 1988)
2. psychotherapy, (c) group therapy
3. pharmacotherapy
4. cognitive-behavioral therapy
5. art therapy
6. hypnotherapy
7. abreactive therapy
8. flooding
9. neurolinguistic programming
10. eye movement desensitization reprocessing (EMDR)

11. trauma incident reduction therapy (TIR)

Many posttraumatic treatment modalities are based on variations of hypnosis (Brende, 1985) and 'reliving' techniques first used a century ago such as hypnotic abreactive treatment (Breuer & Freud, 1893) and abreaction (Jung, 1954). Drug-induced abreaction was also used (Perry & Jacobs, 1982), as well as other nonchemical 'adaptive regressions' (Fromm, 1977), integrative regressions (Brende & McCann, 1984), meditation (Carrington & Ephron, 1978), and biofeedback and meditation (Glueck & Stroebel, 1975). Desensitization techniques alone or in combination with relieving techniques also have been used with success. These include eye movement desensitization and restructuring (EMDR; Shapiro, 1995, 1996) and trauma incident reduction (French & Harris, 1999).

Behavioral treatment for PTSD has been cited as an effective mode of psychotherapy. Behaviorists believe that PTSD is created by an aversion resulting from operant or classical conditioning (Emmelkamp, 1994). Behavior therapy consists of some form of exposure exercise (flooding, in vivo, or imaginative) to habituate to the experience and stress management (Felmingham et al., 2007). Behaviorists would argue that clients with PTSD caused by war trauma have benefited from flooding as a specific technique (Boudewyns et al., 1990; Cooper & Clum, 1989; Fairbank & Keane, 1982). Bradley et al. (2005) reported that a randomized trial study for patients exposed to psychotherapy with cognitive and eye movement and reprocessing desensitization improved and maintained that improvement.

Rape trauma victims with PTSD have benefited from stress management (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick & Schnicke, 1992; Resick, Jordon, Girelli, Hunter, Marhoefer-Dvorak, 1988; Veronen & Kilpatrick, 1983). Specifically, Foa et al. (1991) and Resick, Schnicke, and Markway (1988) found stress inoculation training (SRT) to be superior in the short-term versus supportive counseling and exposure. However, to sustain symptom reduction beyond 3.5 months, exposure therapy was found to be the most effective treatment for rape victims experiencing PTSD. Additionally, compelling evidence shows that brief psychotherapy can be effective (Foa, Hearst-Ikeda, & Perry, 1995; Smith, Glass, & Miller, 1980).

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

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

Treatment (Evidence-based Child and Adolescent):

Evidence-based treatment for children and adolescents exposed to trauma was evaluated by Silverman et al. (2008) for efficacy. The evaluation covered the years 1992 to 2006. The authors analyzed 23 peer-reviewed randomized controlled studies regarding sexual abuse (11 studies), physical abuse (3), community violence (1), major hurricane (1), marital violence (1), and vehicle accident (1). Seven of the studies were classified as Type 2 and 16 Type 1.

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

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

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

Traumatic Brain Injury (TBI):

Increasing numbers of athletes and military personnel are experiencing a traumatic brain injury. Treatment for TBI is in the initial phase of research and practice. Treatments for traumatic brain injury noted in the literature cite behavioral therapy, narrative therapy, and CRATER therapy. CRATER therapy has six components (catastrophic reactions [C], regularization [R], alliance [A], triangulate [T], externalize [E], and resilience [R] (Zerner, 2014).

Dissociative Disorder

Dissociative disorders include dissociative identity disorder (DID), dissociative amnesia, depersonalization/derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder. Derealization is included in what was formerly depersonalization disorder, a detachment from one's mind, self, or body. Dissociative fugue is a specifier of dissociative amnesia (King, 2014f).

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

Dissociative Identity Disorder (DID)

Dissociative identity disorder (DID) is a disruption of identity characterized by two or more distinct personality states (APA, 2013, p. 292). In dissociative identity disorder (DID), previously called multiple personality disorder, different representations of the self take on the existence of separate personalities. The APA (2000, 2013) characterizes a dissociative disorder as a disruption in the usually integrated functions of consciousness, memory, identity, or perception of one's environment.

Assessment:

The assessment is made when two or more distinct personality states or an experience of possession and recurrent episodes of amnesia are present. The disruption is a discontinuity in the sense of self with alteration in affect, behavior, consciousness, memory, perception, cognition, and sensory-motor functioning (APA 2013, p. 292). The age of onset of a person developing dissociative disorder may vary, but it is most commonly observed during adolescence or early adult life for individuals if they have been abused as children. Foote, Smolin, Kaplan, Legatt, and Lipschitz (2006) reported that 71% of clients with DID had experienced childhood physical abuse and 74% sexual abuse.

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

Dissociative identity disorder (DID) is defined as the "presence of two or more distinct personalities or identity states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and the self" (APA, 2013, p. 292). There are additional essential features combined with the definition as mentioned earlier to consider the DID diagnosis.

1. Criterion A states that there is a "disruption in identity regarding a sense of self and a sense of agency. At least two of the personalities recurrently take control of the person's behavior. The disruption is evidenced by alterations in affect, behavior, consciousness, memory, perception, cognition, and sensory-motor functioning" (APA, 2013, p. 292). Criterion A has been modified and now may be observed or reported, and everyday gaps in memory may be a symptom.
2. Criterion B states there are recurrent episodes of amnesia (gaps in memory of everyday activities, personal information, and traumatic events) that are inconsistent with everyday memory. Recurrent memory gaps in everyday events, important personal information and trauma events that are independent of common forgetfulness are assessed (King, 2014g).
3. Criterion D states that the disturbance is not attributable to cultural or religious practice (APA, 2013).
4. Criterion E states that the symptoms of DID are not attributable to the direct effects of a substance or general medical condition (APA, 2013; Chu, 1998).

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

Incidence:

The APA (2013) reported a prevalence rate from a small U.S. community was 1.5% and 2% as a lifetime prevalence rate. The overall prevalence of these disorders is probably unknown; however, at some time approximately all adults have experienced depersonalization, as well as one-third of those exposed to life-threatening dangers and 40% of hospitalized clients with mental disorders (APA, 2000, p. 531). It is not easy to find useful prevalence statistics regarding dissociative identity disorder; however, it is interesting to note that the reported numbers of DID clients have risen dramatically over the past five decades. Braun (1984) found a ten-fold increase in DID cases reported in the literature compared to 1944, at which time there were only 76 documented cases. There seem to be some reasons for the increase in reported DID cases, including the increased incidence of child abuse occurring in the U.S. society and improved diagnostic sensitivity to the symptoms of the disorder. Nonetheless, such symptoms are not easy to recognize. Putnam, Guroff, Silberman, Barbara, and Post (1986) have found that it takes an average of 6.8 years after first entry into the mental health system before the typical DID client is accurately diagnosed.

Instrumentation:

1. The Dissociative Experience Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993) is a 28-item self-report scale that requires 7 to 20 minutes for administration and scoring. It is a screening instrument wherein an approximate score of 30 or more is considered positive.
2. The Dissociative Disorders Interview Schedule (DDIS; Ross, 1989; Ross, Heber, Norton, & Anderson, 1989). The DDIS is a 236-question structured interview that is 90% sensitive and takes 75 to 90 minutes to administer.
3. Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1993a, b).

Treatment:

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

The treatment of DID is individual psychotherapy. The therapeutic process should include helping the client reduce reliance on dissociation by acquiring new, flexible, and adaptive coping resources (Ross, 1997). This procedure will involve some training in cognitive behavioral techniques although cognitive behavioral treatment alone is inadequate. The psychological treatment is usually followed by medication (antidepressants and anxiolytic medication) and expressive therapies (Brand et al., 2009).

The initial goal of treating a client with DID is to identify and gain control over or rapport with one or more of the 'persecutor' personalities to prevent 'them' from sabotaging the therapy. It is equally

important to identify and gain cooperation with the 'protector' personality to protect the 'victim' personality and counteract the persecutor(s). It is helpful to know that one or more of the personalities are typical of a different sex than the client as well as different ages (Ross, 1989). The treatment most utilized has been psychodynamic psychotherapy. In some cases, the judicious use of hypnosis can also be helpful. The goal of therapy, ideally, is 'integration' of all personality fragments, which is not achieved. A secondary but more obtainable goal allows the therapist to bring about a greater level of cooperation within the inner "family" of conflicting personalities which Kluft (1995) has referred to as 'resolution'--functioning 'well' despite remaining multiple. He referred to integration as the "ongoing process of undoing all aspects of dissociative dividedness that begins long before there is any reduction in the number of distinctness of the personalities. This process persists via fusion of some personalities and even disappearance of others no longer essential. This process continues at a deeper level even after the personalities have blended into one" (pp. 1616-1617). Follow-up data indicated that clients who achieve and sustain 'integration' do far better and relapse into dysfunctional dividedness far less frequently than those who opt for 'resolution' (Kluft, 1995).

Jacobson, Fox, Bell, Zeligman, and Graham (2015) researched survivors of DID and reported their perspectives regarding effective techniques and approaches for treatment. The survivors identified 17 effective techniques and approaches they benefited from that include pacing the sessions (secure structure), connection to a recovery program and support group, grounding processes, coping skills, trauma work, identifying and assigning alter roles, reviewing sessions, hypnotherapy, setting clear boundaries, four effective relationship-building techniques (sparingly using self-disclosed insight, collaboration, client-centered approach, and model) are a few of the 17.

Bowers et al. (1971) offered the general guidelines for the therapist role embarking on therapy although the approach to treatment has changed. Some guidelines common to treatment include empathy and cooperation between alternates, be gentle and supportive, remember the severity of trauma, stay within the limits of counselor competence, treat the person in his/her social context and intervene systematically when necessary.

Braun (1986) recommended 13 guidelines in treatment, (although not included in the important step of controlling persecutory or destructive personalities) that include:

1. developing trust
2. making and sharing the diagnosis
3. communicating with each personality state
4. contracting (this would include setting boundaries and 'rules' for the therapeutic relationship)
5. gathering history (the history of abuse, welfare, drug abuse)
6. working with each personality state's problems
7. undertaking special procedures
8. developing inter-personality communication
9. achieving resolution/integration
10. developing new behaviors and coping skills

11. networking and using social support systems
12. solidifying gains
13. following up

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

1. establish the diagnosis
2. develop awareness of multiplicity
3. develop knowledge of history and the purpose of alters
4. work through dissociative defenses
5. integrate and fuse
6. post integration
7. termination

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

Dissociative Amnesia (DA)

Dissociative amnesia (DA) is a disturbance characterized by one or more episodes during which times individuals are unable to recall important personal information that is not explained by ordinary forgetfulness. An individual with DA can be expected to report gaps, retrospectively, in his or her personal history, frequently associated with one or more traumatic or stressful events (APA, 2000, 2013, p. 520). The prevalence rate is reported to be 1.8% over a 12-month period (APA, 2013).

Dissociative Fugue (DF)

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

Depersonalization/Derealization Disorder (DD)

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

Somatic Symptom and Related Disorders

Somatic symptom and related disorders include somatic symptom disorder, illness anxiety disorder, conversion disorder, factitious psychological disorder, other specified somatic symptoms and related disorders, and unspecified somatic symptom and related disorder (APA, 2013). Somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder were removed from this category to avoid overlap. Somatic symptom disorder replaces somatoform disorder, undifferentiated somatoform disorder, and pain disorder, but only if the person also has maladaptive thoughts, feelings, and behaviors that define the condition (Carter, 2008; King, 2014f; Jacobsen, Einzig, Gray, & Gudjon, 2016).

Somatic Symptom Disorder

Definition and Assessment:

Somatic symptom disorder is a chronic relapsing condition, which is difficult to treat. The disorder commonly begins during late adolescence, although it may start up during the 30s. These clients tend to repress childhood memories and do not volunteer the fact they may have suffered from child abuse. They find emotional expression difficult, if not impossible and tend to somatize painful memories and emotions. Individuals with this disorder often have complicated medical histories rather than emotional complaints and report vague and inconsistent medical symptoms that are often associated with psychological problems such as anxiety, substance abuse, and personality disorders. Symptoms of somatic symptom disorder include gastrointestinal complaints such as vomiting, nausea, bloating, and diarrhea, pain in at least four different places on the body, one sexual symptom, and one pseudo-neurological symptom such as fainting or blindness. Such symptoms cannot be related to a diagnosable medical disorder, do not have to occur at the same time, cannot be feigned out of an effort to gain attention, and they cannot be deliberately induced. Typically, somatic symptom disorder complaints are often triggered by or become worse with, stress or fear of having a serious disease (Smith, 1995).

These clients' physical symptoms, which are somatization of emotional states such as anxiety and depression, will last from 6 to 12 months with periods of distress coinciding with the development of

new symptoms or worsening of pre-existing symptoms. To be diagnosed with somatic symptom disorder the client is to be symptomatic for at least six months (King, 2013j).

An accurate mental health assessment relies a great deal on the physician's findings and medical report. Thus, it is imperative for the mental health professional to request the client's medical record and have a collaborative relationship with his or her doctor. Because clients with somatization disorder have physical symptoms that represent emotional states, the mental health assessment must take this into account, and the interviewer's questions should be directed in ways that can determine the connection. Carter (2008) suggested the assessment protocol should include an evaluation for malingering. Clients with physical symptoms and somatization disorder may also have been victims of childhood trauma, and sexual abuse (Brende, Dill, Dill, & Sibcy, 1998; van der Kolk, 1994; Walker & Stenchever, 1993) and the interviewer's questions can pursue this information.

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

1. disproportionate and persistent thoughts about the seriousness of the symptoms
2. persistently high level of anxiety about health
3. excessive time and energy devoted to symptoms or health (APA, 2013, p. 311).

When the mental health professional sees the client during subsequent interviews or therapy sessions, symptoms may vary and change with time, depending on the client's level of emotional distress. When the client presents a new physical symptom, he or she is communicating an emotional need, saying, "I hurt" or "I am in distress." Rarely do new symptoms represent the onset of a new illness. However, if a real disease is present, the client's manner is qualitatively different, and that may be evident to the examiner (Smith, 1995).

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

Incidence:

The APA (2013) reported no known prevalence rate at this time; however, it may be around 5% to 7%. Prevalence is predicted to be between undifferentiated somatoform disorder (19%) and somatization disorder (< 1%; Carter, 2013). Somatic symptom disorder is relatively rare in the general population according to the ECA Study (Swartz, Landerman, George, Blazer, & Escobar, 1991). It is estimated that .13% of the general population or one in every 1,000 people suffer from this disorder, although some sections of the country seem to be higher (Blazer, Kessler, McGonagle, & Swatz, 1994; Kessler, Somnega, Bromet, Hughes, & Nelson, 1995; Swartz, Blazer, George, & Landerman, 1986). More current data reports as many as 2% of women suffer from this disorder (APA, 2000, p. 487). Clients with this disorder tend to congregate in primary care and hospital settings because they perceive themselves to be very ill. Thus, estimates of the prevalence of somatization disorder among clients seen in primary care settings range from .2% to 4% (Kessler, Cleary, & Burke, 1985).

Instrumentation:

The Prime-MD is a validated instrument (Spitzer et al., 1995; Spitzer et al., 1994) that has been used by primary care physicians to quickly diagnose major psychiatric disorders that are often overlooked. This instrument, which can also be used by mental health professionals, measures several categories of physical and emotional symptoms in clients--mood, anxiety, alcohol use, eating behavior, and somatic symptom disorders.

A History and Severity of Traumatic Events and the Twelve Theme Assessment of Post-Traumatic Symptoms (HSTE-12) is a validated instrument (Brende, Gfroerer, & Arthur, 1997) that assesses the prevalence of traumatic histories and the severity of posttraumatic symptoms. This self-report questionnaire includes 43 possible stressful or traumatic events, including 12 violent stressors and 24 questions pertaining to 12 symptom categories: (a) powerlessness, (b) loss of meaning and concentration, (c) shame and distrust, (d) memory problems, (e) anger, (f) fear, (g) guilt, (h) unresolved grief, (i) suicidal thinking, (j) bitterness and revenge, (k) purposelessness, and (l) difficulties with interpersonal relationships.

Treatment:

The treatment of individuals with somatic symptom and related disorders is a challenge to health care providers. Physicians are most commonly involved with these clients but often make referrals to mental health professionals when the physical complaints are recognized as having strong emotional overtones.

Somatizing clients tend to be "doctor shoppers," high users of medical care, and tend to avoid seeking psychiatric treatment on their own (Ford, 1995). At least 10% of all medical services are, in fact, provided to individuals with no apparent evidence of a physical illness or disease stated (Ford, 1984). The diagnosis of somatic symptom disorder had not been clear until the 1960s when diagnostic consistency was obtained after a series of research studies (Guze & Perley, 1963; Perley & Guze, 1962). A previous name, Briquet's syndrome, had been used for this disorder before the DSM-III was published in 1980 (Smith, 1995).

Most clients with this disorder have many medical complaints and treatment tends to be medical with primary care physicians being primarily responsible. Because of their multitude of medical complaints, physicians may soon become frustrated with these clients because of failed medical treatments. Ideally, clients with this disorder should remain with one physician rather than change frequently, as they often do. There are frequent comorbid conditions, such as anxiety, which accompanies many medical illnesses (Smith, 1995); depression, which often accompanies cardiovascular disease (Musselman, Evans, & Nemeroff, 1998); body dysmorphic, undifferentiated somatization; hypochondriasis; mono-hypochondriasis (Looper, & Kirmayer, 2002; McKay & Bouman, 2008) and emotional distress often associated with respiratory illness, migraines, hypoglycemia, hyperthyroidism and cardiac arrhythmias (Sadock & Sadock, 2000).

Mental health professionals have a significant role in the treatment of individuals with somatic symptom disorder and should continue collaborative relationships with the referring physicians. Counselors can utilize a variety of therapeutic modalities to help clients with issues like distorted body image, somatization of anxiety, somatization of traumatic memories and loss, and repressed emotion and techniques for emotional expression. Cognitive-behavior therapy (CBT) has been recommended for the treatment of hypochondriasis, body dysmorphic disorder, and undifferentiated somatoform disorder. Looper and Kirmayer (2002) and McKay and Bouman (2008) include CBT as a treatment for the medically unexplained chronic fatigue syndrome and group treatment for somatization disorder. Each of these disorders has a theme of worry or conviction of a serious medical illness (hypochondriasis), physical defect (body dysmorphic), unexplained bodily complaints (somatization), and unexplained symptoms.

Group treatment may be most beneficial for somatization disorder clients, with an emphasis on improving the clients' socialization and coping skills (Corbin, Hanson, Hopp, & Whitley, 1988; Ford, 1984, 1986). Smith described a 7-step approach in leading such a group that includes:

Session 1: Set goals and procedural rules for the group

Session 2: Address techniques that patients use for coping with their physical problems

Session 3: Discuss how to be assertive with physicians

Session 4: Discuss how patients can take more control and increase the positive aspects of their own lives

Session 5: Address structured problem solving

Session 6: Focus on personal risk taking

Session 7: Help patients identify any positive changes they had made during part of the group and encourage them to continue making positive changes after the group ends.

Moreno et al. (2013) reported when 168 somatizations diagnosed clients were compared using three treatments; treatment as usual (TAU), individual CBT, and group CBT that post-treatment screening results revealed that greater individual changes were achieved in the individual CBT patients. Looper and Kirmayer (2002) conducted a review of treatments and interventions for

hypochondriasis, body dysmorphic disorder, conversion disorder, and somatization disorder. These interventions are composed of theories, attention training, distraction, hypnosis, social and environmental manipulation, and awareness of physiological disturbance.

Conversion Disorder (functional neurological symptom disorder)

This disorder may have one or more symptoms: motor, sensory, episodes, unresponsiveness, the absence of speech volume, articulation, and diplopia (APA, 2013).

This diagnosis assesses for unexplained motor or sensory functions and is to be devoid of a neurological disease, and clear evidence is required. See APA (2013), page 318, for diagnostic criteria. The functional neurological symptom disorder symptom specifiers include weakness, abnormal movement, swallowing, speech, seizures, sensory loss, and special sensory, and mixed symptoms. The assessor is to specify if the acute episode is persistent and with psychological stressors or without psychological stressors (APA, 2013). A neurological examination is emphasized and the recognition for the importance of relevant psychological factors present at the time of diagnosis.

Treatment:

Treatment findings are scant, although hypnosis and stress management counseling have been used with hospitalized clients (Oakley, 2001).

Factitious Disorders

Factitious disorder provides criteria specific for imposed on self and imposed on another (proxy). Factitious disorder is characterized by an intentional production of physical or psychological signs or symptoms. Somatic symptoms are prominent in this condition. Some confusion exists in the literature as to an agreed-upon name for this disorder. Several alternate terms have been used, such as Munchausen syndrome, hospital addiction, polysurgical addiction, factitious illness, hospital hoboes, peregrinating patients, and factitious disorder by proxy (Parnell & Day, 1998).

Definition and Interview:

A factitious disorder is a falsification of medical or psychological signs and symptoms in oneself or others that are associated with the identified person (APA, 2013, p. 325). Physical symptoms may be a fabrication, self-infliction, or an exaggeration of a pre-existing physical condition. An interviewer conducting an assessment must consider malingering as a differential diagnosis and be alert to unique motivational factors. Motivational interviewing is recommended for patients suspected of psychotic and drug use disorders (Martino, Carroll, Charla, & Rounsaville, 2006) and as an adjunct to exposure therapy for anxiety disorders (Slagle & Gray, 2007). The malingerer presents symptoms deceitfully to obtain secondary gains such as avoiding work, obtaining drugs, getting lighter criminal sentences, trying to get out of going to school, or simply to attract attention or sympathy. The

factitious disorder client feigns symptoms to receive care and habitually enters one hospital after another. When pressed for details, he or she will become very vague, although possessing considerable knowledge of medical practices, terms, routines and diagnostic tests to manipulate admission to a hospital (Comer, 1996). When confronted with or hoping to avoid the truth about exaggerated or faked symptoms, the client will self-discharge and often enter another hospital the same day. He or she will angrily discontinue care from a physician or therapist who begins to question in a confrontational manner about distortions or exaggerations and seek a different therapist or physician. A careful review of this individual's previous medical record and history of physical or psychological care likely would reveal a variety of diagnoses.

Munchausen syndrome is the previous name which the DSM-5 now calls factitious disorder imposed on self. Munchausen by proxy is causing harm or injury to others in their care such as children or the elderly. This disorder has also been referred to as factitious disorder with physical symptoms (Comer, 1996a, b; Taylor & Hyler, 1993) and is characterized by the fabrication or deliberate self-infliction of harm to the self. It can also take the form of infliction of injury on others (previously called Munchausen syndrome by proxy) as exemplified by parents who fabricate or induce physical illnesses in their children. The DSM-5 labels this as factitious disorder imposed on another. Early investigation of a possible factitious disorder can prevent client self-harm as well as iatrogenic complications arising from unnecessary tests and treatments.

Factitious disorder is not easy to diagnose but should be considered when the client repetitively seeks the care of doctors for suspicious reasons. If the diagnosis cannot be substantiated (there is often a history of deception), and there appears to be a hidden agenda or secondary gain, it is recommended that a team of professionals be involved. Parnell and Day (1998) provided 18 guideline features and three categories: child-victim, mother-perpetrator, and family.

Incidence:

The APA (2013) reported the prevalence rate is unknown other than in hospital settings (1%). Frances and Ross (1996) considered this disorder one of the most under-diagnosed. Parnell and Day (1998) reported some studies about specific populations sampled in research or practice, such as 1% asthmatic patients (Gooding & Kruth, 1991), .27% apnea patients (Light & Sheridan, 1990), 1% of hospitalized patients seen by psychiatric consultants (APA, 2000), and 5% allergy clients (Warner & Hathaway, 1984).

Assessment:

An accurate assessment of factitious disorder relies a great deal on the physician's findings and medical report. Thus, it is imperative that the mental health professional request the client's medical record and have a collaborative relationship with his or her doctor to ascertain the truth about the client's medical condition. Carter (2008) indicated that assessment procedures should include an observation for malingering or screening using an instrument. An assessment that provides for instruments to validate suspected malingering might consist of the Minnesota Multiphasic Personality Inventory-2, Structured Interview of Reported Symptoms, Specialized Tests of Poor or Intentional Failure on Neuropsychological Assessments, Tests of Memory Malingering (TOMM), Word Memory Test,

Computerized Assessment Response Bias, Portland Digit Recognition Test, and Victoria Symptom Validity Test. Because individuals with the factitious disorder have physical symptoms that represent self-destructive or injurious behaviors that hide emotional pain, the mental health assessment must take this into account. The interviewer's questions should be directed gently, yet confrontively, in ways that can determine the truth. Because reports have indicated a high rate of suicide in clients with factitious disorder, it is important to assess the presence of depression (Popli, Masand, & Dewan, 1992).

Specific criteria for factitious disorder imposed on self or another include:

> Criterion A: imposed on self: falsifications of physical or psychological signs or symptoms or induction of injury or disease in another, associated with the identified client.
>
> Criterion B: the client presents another person to others as ill, impaired or injured
>
> Criterion C: the deceptive behavior is evident in the absence of obvious external reward
>
> Criterion D: behavior is not better explained by another mental disorder (APA, 2013, pp. 324-325).

The mental health professional must differentiate between factitious disorders and malinger, as previously described. The malingerer intentionally makes false or grossly exaggerated physical or psychological symptoms to obtain secondary gain, while the client with the factitious disorder may be deliberately self-injurious but with a different intent to obtain attention through self-injurious behavior or express a negative emotional response such as anger in a physically self-injurious way.

The most common psychodynamic explanation for a factitious disorder is the presence of unresolved conflicts from childhood. Physical symptoms become an indirect means to obtain medical attention as a substitute for love and affection because desired parent-child relationships were either unavailable or repeatedly broken. However, these clients frequently fail to resolve their conflicts because they tend to provoke caregivers and experience rejection, repeating a pattern experienced as children. One study reported a 9% rate of factitious disorders among those admitted to a hospital. It is important for the physician or counselor to secure information from available friends, relatives, or other sources to verify the facts of the physical or psychological illness. Psychiatric consultation is requested in about 50% of cases when these patients are treated in a hospital setting. It is important that the professional or consultant carry out evaluations in ways that avoid accusatory questioning, which would only provoke more serious symptoms (Kaplan & Sadock, 1998).

Instrumentation:

The Prime-MD is a validated instrument developed by Spitzer et al. (1995) that has been used by primary care physicians to diagnose major psychiatric disorders often overlooked by doctors. This instrument, which also can be used by mental health professionals, measures several categories of physical and emotional symptoms in patients such as mood, anxiety, alcohol use, eating behavior, and somatoform disorders. Although it is more useful in clients with somatization disorders, it could also be of some use in diagnosing factitious disorders.

A History and Severity of Traumatic Events and the Twelve Theme Assessment of Post-Traumatic Symptoms (HSTE-12) is a validated instrument (Brende et al., 1997) which has been used to assess the

prevalence of traumatic histories and the severity of post-traumatic symptoms. The HSTE-12 is a self-report questionnaire, which includes 43 possible stressful or traumatic events, including 12 violent stressors and 24 questions about 12 symptom categories. Although it is more useful in clients with posttraumatic syndromes or somatic symptom disorder, it also may be of some use in the client with a factitious disorder.

Treatment:

The level of denial, manipulation, and deception is to be taken into consideration when developing a treatment program for these clients, who often have personality disorders in conjunction with Munchausen by proxy. A treatment framework is recommended that includes avoiding unnecessary hospitalization. While no specific treatment is known to be consistently beneficial, it is recommended that the therapist is empathic and gently confrontative while reducing or avoiding dependency. Individual therapy is recommended if the client is old enough and has a capacity for insight. The presence of a co-therapist may help to deal with denial and other resistance more effectively while family therapy can be used to help individuals with supportive families regain some degree of autonomy (Eisendrath, 1995).

Feeding and Eating Disorders

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

Abraham and Llewellyn-Jones (1997) postulated that individuals with eating disorders attempt to control their "love" for food either "rigorously or intermittently" (p. 64). Increased attention has been given to eating disorders in the professional literature, particularly over the last three decades. According to the APA (1994), eating disorders are, in general, characterized by "severe disturbances in eating behavior" (p. 539). The most common eating disorders are anorexia nervosa and bulimia nervosa and are associated with significant morbidity and mortality. There is "an enormous personal and systemic cost" (Shekter-Wolfson, Woodside, & Lackstrom, 1997, p. 2) due to prolonged hospitalizations and comparable mortality to diabetes mellitus or schizophrenia over a similar duration of time. Psychological disturbances associated with eating disorders include irritability, confusion, depressed mood, insomnia, and obsessive-compulsive behavior. Physical disturbances, particularly in anorexia nervosa, include emaciation, brachycardia (heart rate less than 60 beats per minute, slow heartbeat), low blood pressure, bloating, constipation, swelling of hands and feet, dry scaly skin, appearance of fine facial and body hair, loss of head hair, feeling cold, and mild anemia (Abraham & Llewellyn-Jones).

Definition and Interview:

It is recommended that the interviewer learns when and why the client developed eating disturbances and whether it has been associated with health problems, vomiting, diarrhea, menstrual irregularities, and other metabolic disorders (Shekter-Wolfson et al., 1997). An essential part of the interview is obtaining the client's weight history, which is vital for the diagnosis and also gives the clinician an indication of the extent of the client's preoccupation with size and shape. The clinician should be supportive of the client but also firm and forthright when asking for a history and details of disturbances. Also, the interview should include the following: the history of emotional disturbances, past medical history, and family history both past and present (King, 1989; Shekter-Wolfson). Shallcross (2013) indicated that gender is important because males and females use different language to describe an eating disorder and body image with words such as "toned or ripped" for males regarding desire. Women tend to describe the same with weight or dress size.

The assessment should include questions to determine influences regarding snacking; what prompts individuals to eat. Snacking may be according to the client's motivation and goals or environmental contextual cues that influence snacking such as sight or the smell of food (Pavey & Churchill, 2017). Treatment approaches for snacking will consider the influences for interventions. Temporal self-regulation theory posits motivational and momentary influences, and situational and environmental influences (Hall & Fong, 2007). Snacking is often unplanned, and predictors of snacking include seeing others eat, negative affect, nearness to food, and snack availability (Elliston, Ferguson, & Schuz, 2017).

Anorexia Nervosa Disorder

Definition:

The core concepts for anorexia nervosa are unchanged in the DSM-5. The requirement for amenorrhea has been eliminated and is not to be applied to males, pre or post-menstrual women or some using oral contraceptives. Anorexia nervosa is characterized by the self-imposition of dietary restriction caused by a distorted self-image and an intense drive for thinness (Shekter-Wolfson et al., 1997). The essential features of anorexia nervosa as reported by the APA (2000, 2013) are unchanged and are the following: refusal to maintain a minimally normal body weight, intense fear of gaining weight, and a significant disturbance in the perception of the shape or size of their body. The criteria have been expanded to include persistent behavior that interferes with weight gain in addition to an overly expressed fear of gaining weight. Severity is based on BMI.

Assessment:

Palmer, Oppenheimer, Dignon, Chaloner, and Howells (1990) recommended that history of sexual abuse should be taken in the early phase of the interview and assessment.

Criterion A refers to a restriction of energy intake regarding the requirements. Thus, the individual is prone to a significantly low body weight based on age, sex, developmental trajectory, and physical health. Significant low body weight is defined as weight that is less than minimally normal for children

and adolescents, less than that minimally expected. Criterion B is an intense fear of gaining weight or of becoming fat and Criterion C refers to a disturbance in how one's body weight or shape is self-evaluated and experienced (APA, 2013, p. 338-339).

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

a. primary symptoms (duration/severity, associated cognitive features, associated behavioral features
b. co-occurring features (depressive mood symptoms, anxiety symptoms)
c. common psychological and development themes (low self-esteem, interpersonal dependency, perfectionism)
d. common psychosocial, environmental, and family features (family history and dynamics, school and academic pressures, psychosocial history)
e. help-seeking characteristics (multiple help-seeking attempts, initial presenting concerns, past counseling, and past adjunct supports (p. 282).

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

a. screening: Eating behaviors--"What is your general eating pattern?"
b. compensatory behaviors--"Have you ever done anything to compensate for what you have eaten, such as self-induced vomiting or taking laxatives?"
c. body esteem--"How do you feel about your shape and weight?"
d. diagnostic fear of weight gain--"Have you ever been afraid of gaining weight?"
e. overvaluation of shape/weight--"Does your shape/weight influence how you feel about yourself?"
f. body image disturbance--"Do you still feel that your body or part of your body is too large?"
g. the seriousness of low body weight--"Has anyone told you that it could be dangerous to be as thin as you are?"
h. binge eating--"Have you ever had a binge eating episode?"
i. dietary restriction--"Have you ever tried to follow any dietary rules such as rules about how much you can eat, what types of foods you can eat, or what you can eat?" (p. 264)

The diagnosis is to specify one of two commonly identified subtypes of anorexia nervosa: restricting and binge-eating/purging within the last three months. The restricting subtype presents with weight loss that is accomplished through dieting, fasting, or excessive exercise. The individual who has regularly engaged in binge eating or purging (or both) during the current episode typifies the binge-eating/purging subtype. Purging is usually self-induced by purposeful vomiting or by misusing laxative agents (p. 339). Several noteworthy conditions may mimic anorexia nervosa. For instance, weight loss associated with depression (generally there is no drive for thinness in this case) and

psychotic illnesses in which the person may develop bizarre delusions about food (Shekter-Wolfson et al., 1997). Binge eating/purging type clients engage in recurrent episodes of binge eating or purging behavior.

Incidence:

The prevalence for a 12-month period for anorexia for young females is 0.4% (APA, 2013). The incidence of eating disorders is most appropriately separated by gender. Most research has shown prevalence rates of anorexia nervosa to be around .5% for women between 15 and 40 years old. While there are cases of anorexia nervosa in men, the prevalence appears to be 1/20 of that for women (Garfinkel et al., 1995; King, 1989; Lucas, Beard, O'Fallon, & Kurland, 1991; Shekter-Wolfson et al., 1997). Bulimia prevalence rates are reported by the APA (2000) to be slightly higher (1% to 3%) in young females, with male occurrences of 1/10th that for women.

Instrumentation:

1. Bulimia Test-Revised (BUILT-R; Thelen, Farmer, Wonderlich, & Smith, 1991)
2. Body Esteem Scale (BES; Franzoi & Shields, 1984)
3. Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairbum, 1987; Mazzeo, 1999)
4. Eating Disorder Belief Questionnaire (EDBQ; Cooper, Cohen-Tovee, Todd, Wells, & Tovee, 1997)
5. Eating Disorder Thoughts Questionnaire (EDTQ; Cooper, Todd, Woolrich, Sommerville, & Wells, 2006)
6. Body Image Avoidance Questionnaire (BIAQ; Rosen, Srebnik, Saltzberg, & Wendt, 1991)
7. Body Checking Questionnaire (BCQ; Reas et al., 2002)
8. Satisfaction with Body Parts Scale (SBPS; Berscheid, Walster, & Bohrnstedt, 1973)
9. Eating Disorder Examination Interview (EDE-Q; Fairburn & Beglin, 1994)
10. Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Rieger, Touyz, & Beaumont, 2002)
11. Emetophobia Questionnaire (EmetQ-13; Boschen, Veale, Ellison, & Redell, 2013)

Treatment:

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

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

Anorexia nervosa can be a potentially life-threatening disease requiring immediate medical attention. An extensive list of mainly female celebrities including actresses, athletes, musicians, fashion models, ballerinas, and authors have died from anorexia. Because of that fact, there are numerous eating disorders treatment centers across this country that include inpatient, residential, partial

hospitalization, recreation, psychotherapy, and behavior interventions to treat this and other eating disorders.

Wilson et al. (2007) cited research reports on family therapy by Fairburn (2005) and Vitousek and Gray (2005) and concluded that family therapy had been researched most thoroughly and results are encouraging, particularly for young persons (The NICE Guidelines, 2004). The Maudsley model has been studied more than any other family model. The overall goal for these psychotherapies is for symptom reduction and elimination and in reducing the risk of relapse (Lowe et al., 2001; Steinhausen, 2002). Psychoeducation is recommended because of lack of knowledge and misconceptions about eating disorders (Bowers & Andersen, 1995).

Typically, anorexia nervosa clients maintain body weight 15% below expected weight, and for adolescents, this can hurt normal development. They tend to have a distorted self-image and attempt to maintain weight loss by restricted calorie intake, exercise, vomiting, and purging (Gowers, 2005). Emaciation is the prominent concern for family and health providers, although there are also other physical features that need attending. Considering a variety of treatment strategies that have been employed for eating disorders, the treatment of choice is cognitive-behavioral therapy (Harrington, Whittaker, Shoebridge & Campbell, 1998; NICE, 2004), which includes exposure and prevention (ER), monitoring food intake, meal planning, problem solving and cognitive restructuring (Cooper, Todd, Turner, & Wells, 2007).

Therapy should focus on improving mood disturbances, poor self-esteem, and feelings of ineffectiveness (control), which comprise a significant component of psychological concerns for eating disorder clients. A discrepancy exists regarding effectiveness regarding CBT for body image. CBT results do reflect improvement in the symptoms of binge eating/purging (Walsh et al., 1997).

CBT is moderately effective at the symptomatic level for adults. A recent treatment strategy is mirror exposure or mirror confrontation. Clients will systematically observe themselves in a full-length mirror and react to the distress as a phobic stimulus (Tuschen-Caffier, Voegele, & Hilbert, 2003). This strategy is based on Linehan's Mindful treatment. This approach emphasizes emotional processing of distressing thoughts and feelings about body shape and weight. Improvement has been detected in body checking and avoidance, weight, dieting, depression, and self-esteem (Delinsky & Wilson, 2006).

Although most outpatient treatments for anorexia have not been successful, Bowers and Anderson (1995) indicated that outpatient treatment may be appropriate for a few individuals, mainly those who have been ill for less than a year and have lost less than 25% of their ideal body weight, do not binge or purge, and have a well and supportive family. Cooper et al. (2007) believed that treatment approaches could be modified or elaborated to consider the extreme weight and shape concerns that play a crucial role in dieting, binge eating and purging, fasting, and excessive exercising. For serious or protracted cases hospitalization is the treatment of choice because of the potential lethality of the disorder, not necessarily for pharmacotherapy but to manage the weight loss and establish dietary counseling, individual, and group counseling. Hospitalization is also recommended for suicidal risk and after failing to improve from psychotherapy. Although selected antidepressant therapy has sometimes been used, there is no empirical evidence that antidepressants are consistently effective for this disorder (Wilson et al., 2007).

Psychotherapy in the form of systematic desensitization and operant conditioning procedures, which include reinforcers as well as individual psychoanalytically based psychotherapy (Eckert & Mitchell, 1989), has been found effective in treating anorexia nervosa. However, many clinicians prefer cognitive-behavioral approaches to address eating behaviors and interpersonal strategies in order to explore other issues related to the disorder. Family therapy has been used to examine interactions among family members as contributing to the disorder (Kaplan & Sadock, 1998).

Bulimia Nervosa Disorder

Definition and Assessment:

The DSM-5 (APA, 2013, p. 345) described the essential features as binge eating, inappropriate compensatory methods to prevent weight gain, and self-evaluation that is unduly influenced by body shape and weight.

Criterion C changed the minimum frequency of binge eating average from twice a week to once weekly for three months. Severity is based on the number of purge behaviors per week (mild, 1-3, moderate, 4-7, severe, 8-13, and extreme, 14 or more). Binge eating has been removed from the Appendix in the DSM-IV-TR and is considered a disorder in the DSM-5. Body shape, weight, and the capacity, or lack of it, influences the bulimic's self-evaluation regarding the ability to maintain self-control. Ironically, the loss of self-control is a significant part of both bingeing and purging. Criterion A requires that both A.1. and A.2. behaviors are met. A.1.stipulates that the eating occurs during a discrete period (any two-hour period in which an amount of food is eaten that is larger than what most people would eat in that same period). The A2. requirement is that the client experiences a sense of a lack of control over the eating during the episode (APA, 2013, p. 345). Criterion B refers to the compensatory behaviors such as self-induced vomiting, misuse of laxatives, diuretics, or other medications and fasting or excessive exercise.

The clinician should consider the context of the binge for purging and restricting. The purging type refers to self-induced vomiting or misuse of laxatives, diuretics, or enemas. The restricting type involves the use of other compensating behaviors, such as fasting or excessive exercise.

Leraas et al. (2018) researched indicators in the assessment of bulimia nervosa. They reported using multiple research that there are two pathways that exist for different clients reporting. The two models include high levels of overall dietary restraint and negative affect characterized by negative affect, emotional reactivity, and impulsive behaviors and predispose clients to binge eating. If these characteristics are observed the interviewer should target emotion regulation (Accurso et al., 2016). The client may binge eat to escape from or regulate the aversive affective states. Various models (affect regulation, escape theory, ICAT, dual-pathway) believe the maintenance and causal roots are to be found in affect regulation and negative affectivity.

Incidence:

The prevalence rate for young females for a twelve-month period is 1% to 1.5%.

Instrumentation:

The Positive and Negative Affect Schedule (PANAS; Watson et al., 1988)

The PANAS is an 11-item measuring negative affect and 13-items positive affect. Negative affect include afraid, lonely, irritable, ashamed, angry, disgusted, nervous, dissatisfied with self, jittery, sad, and angry. Positive affect includes happy, alert, proud, cheerful, enthusiastic, confident, concentrating, energetic, calm, strong, determined, attentive, and relaxed.

Treatment:

The treatments of choice for adults with bulimia nervosa include CBT (Hay, Bacaltchuk, Stefano, & Kashyap, 2009; NICE, 2004), nutritional counseling (diet therapy), psychotherapy, parental counseling, and pharmacotherapy (Halmi & Garfinkel, 1995). Treatment of choice for adults is manual-based cognitive-behavioral therapy (NICE, 2004). Cognitive-behavioral treatment (CBT) is currently considered to be the most effective treatment for eating disorders, especially for bulimia nervosa (National Institute for Clinical Excellence; NICE, 2004). Also, interpersonal psychological therapy (IPT) is reported to be effective for bulimia nervosa and binge eating (Weissman et al., 2000).

The aim of therapy and psychoeducation for individuals with eating disorders may include the following (Abraham & Llewellyn-Jones, 1997; Tuschen-Caffier, Pook, & Frank 2001):

1. persuade the client to achieve a weight that lies within the normal range
2. help the client to gain insight into eating behavior and why the behavior is persisting
3. educate the client about nutrition and normal eating and dispel myths about food and eating
4. help the client to overcome any problems in her life which may be aggravating the eating behavior or preventing her recovery
5. help the client alter or modify her lifestyle, if appropriate (p. 67)

Three primary psychological treatments have been shown to be the most effective: cognitive behavioral therapy, supportive therapy, and behavioral techniques. Of these, cognitive-behavioral therapy has demonstrated superior results to the other two treatments (Abraham & Llewellyn-Jones, 1997). The specific aim of cognitive behavioral therapy is to:

1. explore the client's thoughts and beliefs, which maintain binge-eating and dangerous methods of weight control.
2. establish healthy eating habits.
3. establish regular eating behavior in which the client eats three meals a day, with one or two snacks if desired.
4. help the client learn about food, eating, shape, and weight and to eliminate myths about food and eating.
5. help the client increase self-esteem and decrease the importance of physical appearance in self-evaluation (sic) (Abraham & Llewellyn-Jones, 1997, p. 74).

According to Abraham and Llewellyn-Jones (1997), most authorities support a multidisciplinary, multidimensional treatment approach due to the belief that these illnesses start with any variety of psychological problems that include family, biological, or intrapsychic issues. The first step of treatment is to help normalize eating and then to address other issues associated with the eating disorder. Normalization begins with a dietary consultation to formulate a plan for healthy eating. The second step is psychoeducation, which is providing the client with accurate information about the illness.

Accurso et al. (2018) investigated predictors and moderators for treatment outcome for two enhanced CBT programs. Fairburn (2008) developed and compared an enhanced CBT (CBT-E) treatment to an integrated CBT (ICAT-E). Wonderlich et al. (2014) using integrative cognitive affective therapy (ICAT-E) emphasized targeting triggers for client emotion dysregulation. Accurso's randomized comparison of CBT-E and ICAT-BN randomized controlled study reported predictors included dietary restraining, weight and shape concern, and depression and moderators included affective lability and stimulus seeking. CBT-E treatment techniques include psychoeducation, self-monitoring, behavioral exposure, and problem-solving. The ICAT-BN focus is modifying and tolerating momentary affect.

Finally, psychotherapy and the use of medication should be determined. One of the SSRI antidepressant medications, Fluoxetine, has been demonstrated to be helpful in bulimic patients in high doses, i.e., 60 mg daily (Fluoxetine BNC Study Group, 1992), but the combination of medication and psychotherapy in the treatment of eating disorders appears to be better than medication alone. When comparing psychotherapies, cognitive-behavioral therapy (CBT) and interpersonal therapies (IPT) show the most significant effectiveness, with no clinical efficacy differences between the two. CBT has an advantage, however, since it has been proven to be more cost-effective. Trials have shown that CBT brings positive results within 20 weeks, while IPT needs one year (Fairburn, Jones, & Peveler, 1991; Stolorow, Brandchaft, & Atwood, 1987).

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

Treatment: (children and adolescents)

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

Binge Eating Disorder (BED)

Definition:

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

Assessment:

Criterion A stipulates for recurrent episodes of binge eating during any two-hour period and includes a sense of a lack of control in eating. Assessing for binge eating consists of eating episodes associated with three (or more) of the following: (a) eating much more rapidly than usual, (b) eating until uncomfortably full, (c) eating large amounts of foods when not feeling physically hungry, (d) eating alone because of being embarrassed by how much one is eating, and (e) feeling disgusted with oneself, depressed, or very guilty after overeating (APA, 2013, p. 350). Also, Criterion C specifies that the binge eating does not include compensatory behavior. Binge eating predictors include body mass index (BMI), impulsivity, negative emotions and irrational food beliefs.

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

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

Perfectionism may be a trait or factor worthy of assessment for binge eating. The perfectionism model of binge eating (PMOBE) targeted perfection traits as factors for increased eating. The findings indicated uncertainty if perfectionism is an antecedent or consequence or both for increased eating. Factors to consider for perfectionism include the tendency to demand perfection of oneself, unrealistic high personal expectations, to perceive others as demanding perfection, doubts about

performance, and negative reactions to perceived failures (Smith et al., 2017). Also, Nikcevic, Marino, Caselli, and Spada (2017) reported that two different thinking styles, food thoughts suppression and desire thinking, predict binge eating.

Pinto et al. (2017) emphasized symptoms related to self-criticism, negative internal experiences, and lacking in psychological flexibility in managing weight and eating. The authors reported that shame is a significant predictor symptom severity, impacts binge eating even controlling depressive symptoms, predicts body image-related cognitive fusion, and is viewed as an avoidance strategy from negative self-evaluations.

Cognitive fusion is the degree one's internal experiences are perceived as trustworthy regarding reality and actions upon those perceptions rather than as a transitory and subjective mental state (Ferreira, Trindade, Duarte, & Pinto-Gouveia, 2015; Gillanders, Bolderston, Bond, Dempster, & Flaxman, 2014). Cognitive confusion leads to avoidance behaviors and negative consequences.

Instruments:

1. Eating Disorder Examination 17. OD (EDE 17. OD; Fairburn, Cooper, & O'Connor, 2008)
   EDE 17. OD measures frequency and severity of four scales (restraint, eating concern, weight concern, and shape concern)
2. Binge Eating Scale (BES; Ferreira, Trindade, Duarte, & Pinto-Guoveia, 2015)
   The BES is a 16-item measure that assesses the severity of binge eating symptoms including emotional and cognitive concerns.

Treatment:

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

Psychotherapeutic approaches found to be effective include:

1. Cognitive behavior therapy (CBT)
2. Interpersonal therapy (ITP)
3. Dialectical behavior therapy (DBT; Schwitzer, 2012)

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

Pinto et al. (2017) reported CBT as the established treatment, and newer approaches such as mindfulness-based treatments, compassion-based therapy, and values-based programs have yielded positive outcomes. Also, integrated approaches such as acceptance and commitment therapy (ACT) and cognitive-behavioral therapy (CBT) and compassion-based components are literature supported.

Sleep-Wake Disorders

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

1. Insomnia disorder, hypersomnolence disorder, narcolepsy
2. Breathing-related sleep disorders include obstructive sleep apnea-hypopnea, central sleep apnea, sleep-related hypoventilation, circadian rhythm sleep-wake disorders (six types): delayed sleep phase type, advanced sleep phase type, irregular sleep-wake type, non-24-hour sleep-wake type, shift work type and unspecified type
3. Parasomnias: nonrapid eye movement (NREM) sleep arousal disorder, nightmare disorder, rapid eye movement (REM) sleep behavior disorder, restless legs syndrome, and substance/ medication-induced sleep disorder. REM sleep behavior disorder and restless legs syndrome have been added to the sleep-wake classification (APA 2013; King, 2014c).

The new disorders of the DSM-5 are obstructive sleep apnea-hypopnea, central sleep apnea, and sleep-related hypoventilation.

Gregory and Sadeh (2016) classified six main categories of sleep disorders for the DSM-5 to include:

1. Insomnia
2. Sleep-related breathing disorders
3. Central disorders of hypersomnolence
4. Circadian rhythm sleep-wake disorders
5. Parasomnias
6. Sleep-related movement disorders

Definition:

Sleep is a state regarding physiological changes in cardiovascular and brain wave activity, posture, mobility, response to stimulation, level of alertness, eyelid movement, respiration, and body temperature (Gregory & Sadeh, 2016, p. 296). Sleep involves patterns of rapid eye movement and non-rapid eye movement. Trouble sleeping is a disturbance in the sleep-wake state.

Trouble sleeping is one of the most common complaints in the general population (Spielman & Glovinsky, 1997). Stepanski, Rybarczk, Lopez, and Stevens (2003) categorized two or more sleep complaints a failure to initiate or maintain sleep at night (insomnia) and an inability to maintain wakefulness during the day (excessive daytime sleeping).

There are over 80 different sleep disorders listed in the International Classification of Sleep Disorders (American Sleep Disorders Association (ADSA), 2001) although these are three main types. The presenting problems are sleeplessness, excessive sleepiness, and episodes (parasomnias). Phillips and Ancoli-Israel (2001) classified primary sleep disorders as sleep-disordered breathing, obstructive sleep apnea (OSA), central sleep apnea, sleep-related hypoventilation, and restless legs syndrome (RLS). Most sleep disturbances affect attention, memory, creative thoughts, decrease in academic performance, behavioral problems, depressed mood, and irritability (Richdale & Wiggs, 2005).

The current section will address the subclassifications of primary sleep disorders, dyssomnias, and parasomnias. Dyssomnias are those sleep disorders that affect the quality of sleep (amount and timing of sleep). Parasomnias are those sleep disorders that are associated with abnormal behavioral or physiological events that occur during sleep.

Incidence:

According to Swanson (1999), approximately 40 million Americans suffer from sleep disorders. Hauri (2000) reported that 30% to 33% of the population in the United States experience sleeping difficulties. The data also indicated that 10% to 12% had chronic sleep problems. Sleep disruption is probably experienced by all individuals at one time or another (Rothenberg, 1997). Prevalence rates of all the sleep disorders across the U.S. population have been reported from 13% to as high as 49% (Bixler, Kales, Soldatos, Kales, & Healey, 1979; Ford & Kamerow, 1989; Rothenberg, 1997; Shapiro & Dement, 1989). Older adult (65 and older) incidence rate was reported by Foley, Monjan, Brown, & Simonsick, 1995) to be 53% experiencing inadequate sleep or daytime alertness. Gregory and Sadeh (2016) reported numerous research articles that suggested that sleep-wake disorders are associated with neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, sleep and bipolar disorders, depressive disorders, anxiety disorders, obsessive-compulsive disorders, trauma and stress disorders, disruptive impulse control disorder, conduct disorder, and substance use disorder.

Interview:

The interview with the client suffering from sleep disruption should begin with a history of sleep complaints. The history should account for two main areas: the part of the night that sleep is most problematic and the type of complaint (e.g., trouble falling asleep, difficulty staying asleep). The clinician should determine the age of onset and extenuating factors surrounding this complaint (Spielman & Glovinsky, 1997). Sleep disorders and sleep deprivation may relate to mood disorders, pain, medical conditions, neurodegenerative disorders, medication effects, respiratory disorders, and congestive heart failure, all of which can cause sleep disturbances and should be questioned during the interview (Stepanski et al., 2003). Other issues to consider in the interview are the daytime consequences of sleeplessness, past treatments, conditions that either promote healthy sleep or exacerbate the problems, medical disorders, medications used, psychiatric disorders, quality and time of work conditions, and family factors. The interviewer should determine if the client experiences early morning headaches, stops breathing during sleep, experienced fatigue during the day, naps during the day, falls asleep during waking hours, and has a history of high blood pressure.

Most individuals with serious sleep problems are encouraged by family members to see their physicians. For example, if the partner becomes aware and concerned that the other person stops breathing (sleep apnea) for several prolonged periods of time during the night and feels compelled to awaken the individual should consult a physician. Assuming obstructive sleep apnea is suspected; the physician will most likely make a referral to a sleep laboratory for analysis of a sleep disorder. If there is a major problem with snoring, the individual may be referred to an ENT (ear-nose-throat) specialist to diagnose for an airway obstruction.

Assessment:

Methods to measure sleep include polysomnography (PSG), actigraphy, sleep diaries, questionnaires, and smartphone applications. It is important to understand the stages of sleep for daytime and eveningness. Eveningness is the preference of an individual who chooses later to bed and later to rise. Assessing evening sleep-wake patterns means checking on behavioral activities associated with sleepiness and alertness at later times during the day. The Epworth Sleepiness Scale is a checklist to identify and isolate those times in which the client falls asleep or experiences behaviorally related sleep issues such as falling asleep while sitting and reading, in public places, as a passenger in a vehicle, talking to someone (drowsing off), after lunch, at a traffic light or after a workout (Johns, 1991).

The DSM-5 provided more focus and detail on comorbidity and co-existing conditions. Time and situation frequency are important, such as insomnia disorder occurring three times a week for at least three months, or hypersomnolence, where the severity is based on the number of days of difficulty maintaining alertness. Rapid eye movement sleep disorder often involves talking and restless movement during the REM phase of sleep and has a prevalence rate of 0.38% to 0.5% (APA, 2013; King, 2014h). The specifiers include episodic, persistent, and recurrent. It is important to keep in mind comorbidity, as depression often accompanies sleep disorders, anxiety, cognitive changes, and comorbidity examples include breathing-related sleep disorders, disorders of the heart and lungs, neurodegenerative disorders, and disorders of the neurodegenerative, and musculoskeletal system (p. 361). A sleep laboratory analysis is recommended (polysomnography). For children or adults, the DSM-5 supports the use of the Level 2 Sleep Disturbance Patient-Reported Outcome Measurement Information System (PROMIS) Short Form. This form can be located online.

During the assessment of a specific sleep-wake disorder, the interviewer is to be aware of neurobiological validators and genetic evidence before and during the data gathering. Validators and genetic findings are important because of the relationship that exists between sleep-wake disorders and mental and medical conditions. King (2014h) reviewed many of those relationships and found embedded sleep problems as an issue with bipolar I, major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, separation anxiety disorder, GAD, PTSD, ASD, alcohol, cannabis, opioid, sedative, hypnotic, anxiolytic, stimulant or tobacco withdrawal, and caffeine intoxication. Mental health disorders also co-exist with sleep-wake disorders such as autism spectrum, ADHD, panic, adjustment, dissociative, somatic symptom, feeding and eating, elimination, amphetamine, neurocognitive, and persistent complex bereavement disorders (DSM-5). The assessment pointed out earlier can include inventories and questionnaires such as:

1. Sleep diary
2. Sleep Disturbance Questionnaire (Espie et al., 1989)
3. Sleep History Questionnaire (Edinger, 1987)
4. Sleep Impairment Index (Morin, 1993)
5. Beliefs and Attitudes about Sleep Scale (Morin, 1993)
6. Pittsburgh Sleep Quality Index (Buysse et al., 1989)
7. Epworth Sleepiness Scale (Johns, 1991)

Morin (1993) developed an interview for identifying sleep issues for insomnia. This interview is also helpful for the treatment phase as the client identifies what he/she thinks may be the cause(s) as well as the sleep disturbance. A client experiencing insomnia may complain about intrusive thoughts, worry, and rumination that often carry over into daytime disruptions in alertness. Along with these issues may be found hyperarousal experiences contributing to daytime and nighttime disturbances for restful sleep.

A symptom checklist may highlight issues such as snoring, leg movements, and daytime fatigue and may alert the assessor to sleep-wake disorders such as sleep apnea, restless legs syndrome, narcolepsy, or co-existing mental disorders. A biologically related issue may be circadian rhythm shifts, the timing of sleep and wakefulness with a 24-hour cycle. These different cycles may reflect sleep-onset insomnia or delayed sleep phase. In other words, the two do not match, rhythm and sleep time.

The sleep analysis should consider the natural aging. Sleep for the older client is often fragmented, broken, poorer sleep (stage 1) with a more extended latency to sleep (stages 3 and 4), earlier morning awakenings, and reduced sleep efficiency. When an individual is suspected of experiencing insomnia and symptoms of fragmented sleep, there are different factors to analyze including age, times of broken sleep, the length of sleep latency, early morning awakening and reduced sleep efficiency.

Treatment:

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

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

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

Sleep education is imperative for most in learning the importance of restful sleep, the sleep stages, sleep routine, sleep logs, and benefits specific to the client's sleep-wake disorder. Sleep restriction is a

therapy that is targeted at those who have an excessive amount of time in bed (more wake time, less deep sleep and more light sleep-stage 1 (Morin et al., 1999; Riemann et al., 2003).

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

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

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

Insomnia Disorder

Insomnia is considered one of the most prevalent sleep disorders (Ohayon & Reynolds, 2009). Three variables are common to insomnia; daytime impairment, accidents, and sickness (Daley et al., 2009). Insomnia is described as client dissatisfaction with initiating and maintaining sleep, and early morning awakenings. Criterion C (APA, 2013) defined insomnia as poor quality and quantity, insufficient, or nonrestorative sleep for a period of three nights per week and persisting for at least three months (APA, 2013; Buysse & Reynolds, 1990). The diagnosis of insomnia disorder is further defined as a sleep disturbance that causes clinically significant distress in some areas of daily functioning and is not caused by a substance. When insomnia goes untreated, the client goes deprived of a pleasant quality of life. Voinescu et al. (2012) reported that insomnia together with abnormal sleep circadian cycles is also associated with a worsening of overall satisfactory rest.

Incidence:

The prevalence rate for insomnia disorder is estimated to be a third of the general population and can be broken down into 10% to 15% experiencing daytime impairment and 6% to 10% symptoms of all sleep disorders (APA, 2013). Among individuals afflicted with sleep disorders, insomnia appears to occur more frequently in women and both sexes with advancing age. Younger individuals tend to have higher rates of complaints about falling asleep, while middle-aged adults and the elderly have a more difficult time maintaining sleep (APA, 2000, 2013). The reported prevalence rate is one-third of adults experience insomnia, 10%-15% daytime impairments, and 6% to 10% experience symptoms of insomnia (APA, 2013, p. 365).

Assessment:

The DSM-5 criteria for insomnia disorder are one or more of the following: (a) difficulty initiating sleep, difficulty maintaining sleep, and early-morning awakening with an inability to return to sleep. The disturbance in sleep is to occur at least three nights per week, (b) and present for at least three months, (c), an impairment in functioning, (d) and not better explained by physiological effects or substance, and (e) or another sleep disorder. Edinger et al. (2011) studied sleep patterns in women who were aged 50 and older and suffered from nonmetastatic cancer. These researchers described diminished sleep quality (particularly when influenced by depression), as characteristic (broken sleep), insomnia symptom severity (nocturnal awakenings were excessive), and daytime sleepiness (onset was longer). Clients assessed with insomnia report concentration problems, irritability, emotional instability, repetitive thinking, worry, and rumination. Rumination consists of repetitive thinking regarding the causes and consequences of negative emotions (Nolen-Hoehsema, Wisco, & Lyubominsky, 2008). Repetitive thinking is defined as the "process of thinking attentively, repetitively, or frequently about oneself and one's world" (Segerstrom, Stanton, Alden, & Shortridge, 2003, p. 909). Lancee, Eisma, van Zanten, and Topper's (2017) compared trait, daytime, and repetitive nighttime thinking and reported that nighttime sleep worry was associated with impairment.

Instrumentation:

1. Insomnia Severity Index (ISI; Bastien, Valliers, & Morin, 2001)

   The ISI is a five-item inventory that assesses for severity of symptoms during the past week.

2. Pittsburg Sleep Quality Index (PSQI; Buysse et al., 1989)

   The PSQI is a 19-item inventory with a global score that measures sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleep medications, and daytime dysfunction.

3. Actigraphy

   A wristwatch-like device, a secondary procedure the client can report a sleep log

Treatment:

Three common treatments for insomnia include behavioral therapy (BT), cognitive therapy (CT), and cognitive-behavioral therapy (CBT). All theories target sleep moderators including nighttime safety and daytime safety behaviors (thoughts, emotions, and behaviors) for sleep incompatibility, bedtime variability, rise time variability, and time in bed (Harvey, Dong, Belanger, & Morin, 2017).

Milner and Belicki (2010) reported that treatment for insomnia should include physical and psychological approaches. Examples of physical approaches included pharmacology and bright light therapy. Psychological approaches for short-term treatment include CBT-I as the most effective (Rieman & Perlis, 2009), sleep diary, sleep education, sleep hygiene, sleep restriction, stimulus control, cognitive restructuring, paradoxical intention and relaxation training therapy.

Goals:

1. decrease dysfunctional or negative thoughts or beliefs (amount of time for sleep (8 hours)
2. increase awareness (reduction in selective attention)

3. decrease the excessive amount of time in bed leading to sleep fragmentation (nighttime safety)
4. avoid daytime napping (daytime safety)
5. decrease (if) use of alcohol or caffeine
6. reduce or decrease daytime tiredness

Techniques or interventions:

Bootzin and Rider (1997) offered several potential psychotherapy treatments for insomnia, including sleep restriction therapy and the prescription of individual sleep-wake schedules (Spielman, Saskin, & Thorpy, 1987). Sleep restriction is especially useful for insomniacs who go to bed early and spend 10 or more hours in fragmented sleep. It consists of limiting clients to spending time in bed to consolidate nighttime sleep. This treatment approach should also eliminate watching television, reading, or other activities while in bed.

CBT is recommended with multi-components that include sleep hygiene education, stimulus control, sleep restriction, and relaxation training (McCurry, Reynolds, & Ancoli-Israel, 2007). The use of daily sleep diaries can also have a therapeutic effect (Bootzin & Rider, 1997). Frequently used interventions related to relaxation training are meditation, progressive relaxation, yoga, hypnosis, and biofeedback training, all of which have reportedly improved sleep (Espie, Lindsay, Brooks, Hood, & Turvey, 1989).

Consistent with relaxation is one of the three types of biofeedback: sensorimotor rhythm (SMR), (EMG), and theta electroencephalography (EEG), all of which have been successful (Sanavio, 1988). Some cognitive therapies have been used to address the cognitive symptoms associated with sleep disorders (Bootzin & Rider, 1997). For instance, Shoham, Bootzin, Rohrbaugh, and Urry (1995) found paradoxical intention to be most effective with clients who are not able to fall asleep in spite of intense efforts to do so. An example of this approach is to encourage these insomniacs to try and stay awake for as long as possible to diminish their performance anxiety, thereby hopefully enabling him or her to fall asleep more quickly. Cognitive restructuring tends to be an effective means of combating a client's faulty beliefs about sleep requirements. Finally, providing education in the form of the following sleep hygiene education tips can be helpful: (a) discontinue caffeine and nicotine late in the day, (b) do not drink alcohol because it produces fitful sleep later during the night, (c) exercise during the daytime but not close to the hour of sleep, and (d) minimize noise, light, and excessive temperatures by using ear plugs, window blinds, air conditioner, or adequate blankets (Buysse, Morin, & Reynolds, 1995). In summary, sleep hygiene includes scheduled sleep times, dietary counseling, environmental alterations, and physical activities (controlled time for exercise).

Treatment of short-term insomnia (transient and short-term typically caused by situational stress) strategy is to eliminate the stress and negative thoughts that are dysfunctional. Some techniques include (Milner & Bilecki, 2010):

1. sleep education- information concerning good and poor sleep, sleep needed, age affects rest, and how insomnia develops and is maintained.

2. sleep hygiene is a self-regulation technique to develop small changes in poor sleep habits using a sleep schedule.
3. sleep-Restriction is to consolidate the clients' sleep by decreasing the time to fall asleep and awakenings after sleep, a deepening process.
4. cognitive restructuring alters the client's belief regarding poor sleep recognizing that previously held consequences are distorted.
5. stimulus control associates the use of the bedroom for sleep-related activities and not for arousal. Any activity other than sleep is not permitted. Stimulus control is considered to be one of the better monitoring recommendations.
6. paradoxical intention goal is to reduce the anxiety with sleep effort, bedtime anxiety, and subjective sleep-onset latency.
7. relaxation training has limited benefit but may be suggested if there are nighttime awakenings or fragmented sleep to reduce physiological tension.
8. mindfulness (Wong et al., 2016)

Monitoring:

Milner and Bilecki (2010) reported that measures used to monitor improvement in insomnia are lacking. Improvement has been based on changes to the clients' sleep (polysomnography or subjective report). There is inconclusive evidence in monitoring. However, the prevailing ideas revolve around changing the client's perception of sleep, subjective reports, and altered daytime functioning (Harvey & Tang, 2003).

Hypersomnolence Disorder

This disorder is associated with excessive sleeping despite the ability to get seven hours of sleep per rest period. Hypersomnolence disorder is divided into apnea, hypopnea, and hypoventilation (APA, 2013). Sleep duration of nine hours is non-restorative, and clients experience difficulty awakening in the morning and report tiredness, sometimes combative, and somewhat confused.

Sleep-disordered breathing in the hypersomniac client is caused by obstructed air passages occurring during sleep, usually resulting in snoring (Rothenberg, 1997). When the obstruction is significant enough to block adequate breathing during the night, sleep apnea results. Individuals with sleep apnea associated with obstructive breathing are at risk for hypertension, pulmonary hypertension, and stroke. Interviewers should note symptoms of loud snoring, reports by others of apnea, and awakenings with choking, coughing, or gasping for breath (Stepanski et al., 2003). These individuals suffer from a reduced oxygen supply to the brain which, when occurring over long periods, may cause changes in the neuron of the hippocampus and the right frontal cortex of the brain. Neuroimaging has revealed evidence of hippocampal atrophy in more than 25% of individuals with obstructive sleep apnea (OSA), resulting in difficulties with nonverbal information, executive functions, and working memory. Because of the adverse effects on cognitive functioning they may also be observed to have difficulty with manual dexterity (APA, 2013).

Criteria A for this assessment is the presence of one or more of recurrent periods of sleep or lapses into sleep within the same day, (1) prolonged main sleep episode of more than nine hours per day that is nonrestorative; (2) difficulty being fully awake after abrupt awakening; and (3) occurs at least three times per week, for at least three months (APA, 2013, p. 368). Also, there is to be impairment in cognitive, social, occupational or other areas of functioning (C) and not explained by another sleep disorder (D) or physiological effects of a substance (E).

The DSM-5 indicated that individuals with this disorder fall asleep quickly and have sleep efficiency but may have difficulty awakening in the morning and may be confused or even irritable and combative. The combination of these activities is referred to as sleep inertia.

Incidence:

The prevalence rate is approximately 5% to 10% for individuals with complaints of daytime sleepiness (APA, 2013).

Assessment:

Sleep breathing disorders are diagnosed with the use of a systematic interview with a checklist of symptoms. A polysomnography and an electroencephalogram (EEG) sleep study are recommended to determine the amount of restful sleep the client is experiencing. This study will ascertain the degree of sleep fragmentations (awakenings) and oxygen desaturation. Obesity is known to be a predictor of OSA.

Hypersomnolence disorder consists of excessive sleepiness (prolonged sleep episodes almost daily) for a period lasting at least seven hours with at least one of the following symptoms: recurrent periods of sleep or lapses, prolonged main sleep episode of more than nine hours per day, and difficulty being fully awake after abrupt awakening. The hypersomnolence causes significant distress in some areas of functioning. Associated symptoms may be when one is unable to stay awake and has a nonrestorative sleep.

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

Narcolepsy

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

Specifically, Criterion A sleepiness occurs at a minimum three times a week for at least three months. One of the following must be present: episodes of cataplexy, hypocretin deficiency, or nocturnal sleep polysomnography (confirmation of reduced REM sleep latency). Subtypes of narcolepsy (specifiers) are important in ruling in/out for hypocretin deficiency, deafness, obesity, diabetes, medical conditions. The most remarkable feature of narcolepsy is that extreme sleepiness can overwhelm a person at any moment, regardless of recent sleep quality (APA, 2013).

Breathing-Related Sleep Disorders

Central Sleep Apnea (CSA)

Central sleep apnea (CSA) is one of three sleep-wake disorders of breathing-related disorders (obstructive sleep apnea, hypopnea syndrome, and sleep-related hypoventilation). Repeated episodes of apneas (the absence of breath) are characteristic of central sleep apnea.

Symptoms usually involve snoring, fatigue or tiredness during the day, waking up with choking or gasping, not feeling rested in the morning, strong desire to take a mid-day nap, and unexplained accidents during the day. The various causes for obstructed airways can be poor muscle tone in the throat and tongue, the hyper-relaxation effect of alcohol and or a sleeping pill, long soft palate, and uvula narrows the passage, deformities, and obesity.

Assessment and treatment:

An interview should include identifying symptoms such as snoring or waking up from sleep times gasping for breath. A physician will, in most cases, refer the client to a neurologist or directly to a sleep laboratory for polysomnography. A central sleep apnea is diagnosed when breathing cessation is longer than 10 seconds. If the client has five or more apneas per hour of sleep and is not explained by another sleep disorder the specific sleep apnea disorder is diagnosed.

Treatment:

Treatment is prescribed according to the diagnosis; however, most likely the use of a continuous airway pressure (C-PAP) machine (Baran & Richert, 2003; Harris, Glozier, Ratnavaclei, & Grunstein, 2009; Rosenberg & Doghramji, 2009). Keeping the airway open avoids obstructive sleep apnea-hypopnea disorder (15 or more obstructive apneas/hypopneas per hour of sleep). Other treatments are nasal airway surgery, palate implants, and the Pillar procedure (three small implants injected into the soft palate), uvulopalatopharyngoplasty (UPPP), tongue base reduction, genioglossus advancement (muscle under tongue), hyoid suspension (bone-larynx/tongue in neck), and tracheostomy (bypass the narrow airway connecting lungs and voice box).

A 2006 evidence-based study by the American Psychological Association reported that helpful treatment included:

1. sleep restriction

2. sleep compression therapy
3. multicomponent cognitive-behavioral therapy met effective criteria (APA, 2006)
4. Support was also noted for stimulus control theory (Morin, 2004). Stimulus control and sleep control were the least time-consuming of the therapies (Whitworth, Crownover, & Nichols, 2007).

Parasomnias

The term parasomnia refers to a wide range of behaviors associated with sleep. Clients with parasomnia disorders all experience an activation of the physiological system (autonomic nervous, motor, or cognitive systems) at inappropriate times during the sleep-wake cycle (APA, 2013). The wide range of behaviors triggers the activation of associated behaviors that can include sleepwalking, sudden or partial awakenings from deep NREM sleep, night terrors (nightmare disorders), and confused awakenings (insomnia disorder). Parasomnia disorder is also characterized by rapid eye movement behavior disorder (RBD). The interviewer should be alert to reports of acting out during which the dreamer has physically hurt a sleep partner (Stepanski et al., 2003). Acting out behaviors consists of flailing arms, kicking, falling out of bed, and vocalizations. The most common parasomnias are nonrapid eye movement sleep arousal disorder (NREM), rapid eye movement (REM), and sleep behavior disorder. Parasomnia is separated into four categories of disorders: REM, NREM, restless legs syndrome, and substance/medication-induced sleep disorder.

Instrumentation:

Inventories, interview rating scales, and paper-pencil tests are not commonly found to be of assistance in making a parasomnia diagnosis

Treatment:

Selected (sedative, antidepressant, antipsychotic, or anticonvulsant) medications for parasomnias have been effective. CBT (stimulus control), sleep restriction therapy, and CBT components that include sleep hygiene education and relaxation training (Stepanski et al., 2003).

Nightmare Disorder

Nightmare disorder consists of repeated frightening dreams that are referred to as nightmares that frighten or scare individuals out of REM sleep into a state of full alertness. Nightmare disorders are complex and consist of story-like series of dream images associated with serious problems such as disturbed sleep, affect cognitive functioning, emotional functioning, and well-being. Nightmare disorder causes significant distress and is associated with PTSD, psychosis, personality pathology, suicide risk, and suicidal ideation, and substance abuse (van Schagen, Lancee, Swart, Spoormaker, & van den Bout, 2017). The APA (2013) reported prevalence rates of 1.3% to 3.9% for preschool children, decreasing for both genders after age 29 and 1% to 2% for adults that experience, with 6% reporting frequent nightmares at least monthly. Nightmares typically include threats to survival, safety, and self-

esteem. Effectiveness studies are few, but some recommendations for treatment are systematic desensitization, imagery rehearsal, relaxation techniques, extinction, and eye movement desensitization (Krakow et al., 2001).

Interview and assessment:

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

Instrumentation:

A detailed clinical history is the most important diagnostic tool and should emphasize eliciting the specific type of sleep complaint, its duration, and course, factors that either help or worsen the problem and responses to previous treatments. An assessment should include obtaining information from daily sleep diaries, if possible, and referral for medical examination. It is important to ask about dreams and the presence or absence of detailed recall. Finally, a sleep-disturbed individual should be referred for examination in a sleep laboratory where detailed all-night neurophysiological monitoring can be done.

1. The SLEEP-50 subscale (Spoormaker, Verbeek, van den Bout, & Klip, 2005) questions (scaling from 1-4) assess for effect on well-being, the number of disturbing dreams in last seven days, and how many disturbing dreams in the last month.
2. The Nightmare Distress Questionnaire (NDZ; Belicki, 1992)
3. The Nightmare Effects Survey (NES: Krakow & Zadra., 2006).
4. The Dutch SCL-90 subscales measure anxiety, phobic anxiety, depression, somatization, cognitive performance deficits, interpersonal sensiitivity0mistrust, acting-out hostility, sleep difficulties, and other problems (Arrindell & Ettena, 2003).

Treatment:

Imagery rehearsal therapy (IRT) is the most extensively researched and treatment of choice (Hansen, Hofling, Krōner-Borowik, Stangier, & Steil, 2013; Kroner-Borrowik et al., 2013, van Schagen et al., 2017).

Restless Leg Syndrome (RLS)

Restless leg syndrome is described as an uncontrollable urge to move the legs and is often associated with a tingling sensation (creeping, crawling, burning or itching) that is usually relieved by movement and getting out of bed and walking to ease the tingling. Criterion A characterizes this urge as the beginning or worsening during periods of rest or inactivity, as becoming partially or relieved by movement, and to move the legs is worse in the evening or night than during the day. The symptoms occur at least three times a week and persist for at least three months (APA, 2013). Possible causes for this syndrome, particularly in older adults, are uremia, iron deficiency anemia, and peripheral neuropathy (Stepanski et al., 2003).

Periodic limb movement in sleep (PLMS) is present in 90% of individuals diagnosed with RLS (previously known as Willis-Ekbom disease) and is supporting evidence for RLS (APA 2013, p. 411). Periodic limb movement is a disturbing foot movement that takes place during circadian sleep disorders, altered or interrupted sleep schedules. Advanced sleep phase syndrome (ASPS) is a disorder of the biological clock that initiates sleep at an earlier time (8 p.m.) then that would ordinarily be recognized (11 p.m.). As a result, the morning rise time also becomes earlier, 4 a.m., rather than 7 a.m. The cause(s) are unknown (Weitzman, Moline, Czeisler, & Zimmerman, 1982).

Incidence:

Restless Leg Syndrome prevalence rate is reported in a range of 2% to 7.2% (APA, 2013).

Treatment:

Dopaminergic medications (similar to those used to treat Parkinson's disease) for RLS.

Medical conditions associated with sleep disorders

The assessor should be mindful that if any of the following neurological diseases are recorded in the medical file, sleep disorders are to be considered.

1. Alzheimer's disease (AD). Treatment issues include the control of the disease severity, medication effects, and "sundowning" (see terms section for definition). Treatment of choice is to slow the cognitive decline with newer medications.
2. Parkinson 's disease (PD). The client experiences an inability to change sleep positions and is prone to suffer leg cramps, night sweats, and excessive nocturia (Lees, 1988).
3. Multiple Systems Atrophy (MSA). MSA is similar to Parkinson's disease but includes Shy-Drager Syndrome, which is a progressive disorder of the central and autonomic nervous system. This disorder often includes striatonigral degeneration—a form of multiple system atrophy involving the loss of connections between two areas of the brain, the striatum and the substantial nigra, which work together to ensure smooth movement and maintain balance. Vocal cord and respiratory dysfunction may occur, which will require a tracheotomy (insertion of a breathing tube into the trachea) to prevent sudden death (Plazzi, Corsini, & Provini, 1997).

4. Cerebral vascular accidents (strokes)
5. Lewy body disease (LBD). The Lewy body disease is known to be associated with Parkinsonism and dementia. The prominent symptoms include visual hallucinations, abnormal movements, and daytime sleepiness (Grace, Walker, & McKeith, 2000).
6. Spinal cord injury
7. Cardiopulmonary disease. Clients with heart failure and severe lung disease including advanced emphysema are at risk for sleep deprivation and sleep-breathing disorders
8. Chronic pain in synovial tissue, bones, joints, or muscle caused by arthritis, diabetic neuropathy, fibromyalgia, dermatomyositis, and bone or synovial disease.

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

There are different treatment options for obstructive sleep apnea depending upon the severity of the sleep apnea as determined by a sleep study, the physical structure of the upper airway, and other medical considerations. All treatment options are intended to prevent obstructions from occurring, usually by widening the airway.

Nonsurgical remedies include instructing the client to avoid sleeping on his or her back to keep the tongue from blocking the airway. For some people, sleeping with the back elevated from the waist up with foam wedges may reduce the collapsibility of the airway and therefore reduce the apneas. Sleep apnea can also be caused by excessive weight or obesity, in which case losing weight can usually be an effective treatment. Avoiding alcohol and central nervous system depressants close to bedtime may be helpful as well. Oral appliances may be effective by keeping the airway open in one of three ways: by pushing the lower jaw forward (a mandibular advancement device or MAD), by preventing the tongue from falling back over the airway (a tongue-retaining device), or by combining both mechanisms. The most common type is adjustable so that the dentist can move the jaw further or reduce the advancement as necessary.

For many clients with obstructive sleep apnea-hypopnea, surgery may be useful to create a more open airway (see central sleep apnea for other surgical procedures). Also, there are other nonsurgical procedures including removing excess or obstructive tissue or hardening the soft palate by inserting small polyester rods. However, for most clients with this obstructive sleep apnea, continuous positive airway pressure (CPAP) is quite effective. CPAP works by gently blowing pressurized room air through the airway at a pressure high enough to keep the throat open. This pressurized air acts as a "splint." The pressure is set at a high enough level according to the client's needs, at a level that will eliminate the sleep apnea and or hypopnea and subsequent sleep fragmentations that cause awakenings and sleep fragmentation, and must be high enough to eliminate the apneas and hypopneas.

Sexual Dysfunctions

Sexual dysfunction disorders include delayed ejaculation, erectile disorder, female orgasmic disorder, genito-pelvic pain/penetration disorder, male hypoactive sexual desire disorder, premature (early) ejaculation, substance/medication-induced sexual dysfunction, specified sexual dysfunction, and unspecified sexual dysfunction (APA, 2013). The DSM-5 has reduced the list of 17 sexual dysfunctions in the DSM-IV-TR to 10. Also, the subtypes are now referred to as specifiers for all sexual dysfunctions. Sexual dysfunctions have a minimum time frame of at least six months except for substance-and medication-induced sexual dysfunction (King, 2014h). Sexual desire and arousal disorders have been combined into one disorder, sexual interest/arousal disorder. Vaginismus and dyspareunia have been combined with a new disorder, genito-pelvic pain/penetration. Sexual aversion disorder has been removed (APA, 2013). Also, subtypes have been added to several of the sexual dysfunction disorders such as lifelong acquired and generalized versus situational.

Sexual dysfunction has been defined by the APA (2013), as a disturbance in a person's ability to respond sexually or to experience sexual pleasure. The dysfunction is defined as impairment in sexual response or with pain associated with sexual intercourse. A sexual dysfunction must be experienced on most or all occasions (75% to 100%) of partnered sexual activity (APA, 2013, pp. 424, 426, 429). The DSM-5 factors that need to be considered during assessment are the partner factors, relationship factors, individual vulnerability, psychiatric comorbidity, stressors, cultural/religious factors, and medical factors (APA, 2013; King, 2014h). Specifiers include lifelong (present from first sexual experience), acquired (developed after a period of relatively normal sexual function), generalized (limited to particular types of stimulation, situations or partners) and situational (only with certain types of stimulation, situations, or partners (APA, 2013, p. 423). It is possible to consider a V or Z code if the relationship is in severe distress, partner violence, or significant stressors better explained by sexual difficulties (King, 2014a, h).

The response cycle is comprised of four primary phases: desire, excitement, orgasm, and resolution. Sexual function is further divided into subtypes that are indicative of onset, context, and etiological factors and which are either lifelong or acquired. Contextual specifiers (subtypes) are generalized and situational, and etiological specifiers (subtypes) consist of psychological causes and combined causes (psychological and general medical conditions).

Definition and Interview:

Psychological factors may be important in all forms of sexual dysfunction, but these factors appear to be the sole cause in fewer cases than were originally posited (Greiner & Weigel, 1996). The most common complaint in women is a decreased desire, followed by orgasmic dysfunctions (Frank, Mistretta, & Will, 2008). While success rates have not been adequately quantified, an attempt should be made to identify concomitant psychosocial stressors and how they could be reduced (Feldman, Goldstein, & Hatzichristou, 1994). Emphasizing treatment of the partners as a couple is still the primary focus, as originally recommended by Masters and Johnson (1970). Couple therapy is sometimes combined with individual therapy for a partner suffering from existing depression and performance anxiety (Emmelkamp, 1994). McCarthy (1990) pointed out that when sexual dysfunction results from

trauma-based dyspareunia (painful intercourse), several potential foci should be considered in a behavioral therapy approach. Maybe, for example, past traumatic events of an emotional nature should be approached therapeutically in the context of the present dysfunction, realizing that such activities affect both the individual and the relationship. Therefore, when past traumatic experiences affect the sexual relationship, the best therapeutic approach is to help both the traumatized client individually as well as the couple.

Health professionals are reluctant to take a detailed sexual history when clients complain of sexual issues. But if they were to do it properly, it would be best to obtain a sexual history composed of two components. Hatzichristou et al. (2004) suggested a strategy for the management and evaluation of sexual issues and sexual history. The first component is the initial PLISSIT (Permission, Limited Information, Specific Suggestions, and Intensive Therapy) and the second component is ALLOW (Ask, Legitimize, Limitations, Open up, Work together). The interaction between the counselor and client proceeds best using open-ended questions.

The Brief Sexual Symptom Checklist can be used in conjunction to history taking. This checklist includes four questions to determine client satisfaction with a particular sexual function, details about specific behaviors of sexual problems, and the willingness of the client to discuss the issues with the interviewer (Potter, 2007).

Assessment:

There are a variety of causative factors for sexual disorders. It is important to rule out interpersonal, intrapersonal, and cultural context (King, 2014h). Frank et al. (2008) charted Berman's (2005) causes, examples, and sexual symptoms. Berman listed causes as hormonal/endocrine, musculogenic, neurogenic, psychogenic, and vasculogenic.

Clients with arousal/interest problems often use inhibition of desire in a defensive way to protect against unconscious fears about sex. Lack or absence of or reduced desire can be the result of sexual conflicts dating back to childhood, chronic stress, sexual trauma, anxiety, or depression. Sexual arousal/interest components include sexual thoughts, dreams, fantasies, and possible cognitive motivation. Abstinence from sex for a prolonged period sometimes results in suppression of sexual impulses. Loss of desire or aversion may be an expression of hostility toward a partner or the sign of a deteriorating relationship. In fact, marital discord is the most common reason for cessation or inhibition of sexual activity. Sexual dysfunction is a mixture of physiologic, psychological, emotional, and relational factors.

Female sexual arousal/arousal disorders are characterized by a persistent or recurrent partial or complete failure to attain or maintain the lubrication and swelling response of sexual excitement until the completion of the sexual act. Criterion A identifies manifestations to be in three of six absent/reduced categories. These absent/reduced activities are: in sexual activity, sexual/erotic thoughts or fantasies, initiation of sexual activity, sexual excitement/pleasure, sexual interest/arousal in response to any internal or external sexual/erotic cues, and genital or nongenital sensations during sexual activity (APA, 2013, p. 433). Female sexual arousal/interest disorder, often underestimated, has dysfunction during the early excitement phase and continuing throughout.

A recurrent and persistent partial or complete failure to attain or maintain an erection to perform the sex act characterizes the male erectile disorder. Criterion A must meet one of three symptoms in the range of 75% to 100% of the time for the marked difficulty areas and persist for six months (B).

Genito-pelvic pain/penetration disorder (painful intercourse) is also frequently associated with a lack of desire. Criterion A defines this persistent or recurrent difficulty meeting one or more of four difficulty areas for pain, during vaginal penetration, vulvovaginal or pelvic pain during penetration or intercourse, fear or anxiety about pelvic pain in anticipation, and marked tensing or tightening of the pelvic floor muscles (APA, 2013, p. 437). Hormonal dysfunction may contribute to women's lack of sexual responsiveness (Kaplan & Sadock, 1998).

Incidence:

In general, there has been a dearth of reliable prevalence rate studies for sexual dysfunction. However, several reviews have yielded the following rates for particular dysfunctions: female orgasmic disorder (5% to 10%), male erectile disorder (4% to 9%), male orgasmic disorder (4% to 10%), premature ejaculation (36% to 38%) and insufficient data exists for female arousal disorder, vaginismus, dyspareunia and hypoactive sexual desire disorder (Spector & Carey, 1990). Recent incidence reported by the APA (2000) is 20% (female orgasmic disorder), 10% (male erectile disorder), 10% (male orgasmic disorder), 27% (premature ejaculation), 15% (female dyspareunia), and 33% (female hypoactive sexual desire disorder) (p. 538).

The DSM-5 cited prevalence rates for delayed ejaculation, the least common male complaint (lack of definition), is less than 1% (p. 425), erectile disorder is unknown, female orgasmic disorder is 10%-42% (p. 431), female sexual interest/arousal disorder is unknown (p. 435, combined disorders), genito-pelvic pain/penetration disorder is 15% in U.S. (p. 438), male hypoactive sexual desire disorder varies according to age: 6% for age range 18-34, 41% for age range of 66-74 (p. 442), premature ejaculation depending on definition is 20% to 30% of men from ages 18-70 (p. 444), and substance/ medication-induced sexual dysfunction varies by medication (APA, 2013).

The sexual disorder receiving most attention appears to be erectile dysfunction (NIH Consensus Conference, 1993). While prevalence rates of sexual dysfunction are difficult to discern due to the vast variability of disorders, assessment methods, definitions used, and sampled population characteristics, erectile dysfunction seems to receive the most attention in the professional literature. According to several sources (Greiner & Weigel, 1996; NIH Consensus Conference, 1993), erectile dysfunction is experienced by 20 to 30 million men in this country, with a 5% prevalence rate for 40-year-olds and up to 15% for 70-year-olds. A number of other medical literature sources have reported prevalence rates of 2% at age 40, 25% to 30% at age 65, and over 50% for men over the age of 75 (Feldman et al., 1994; Jackson & Lue, 1998; Kirby, 1994; Kirby et al., 1994; Morley & Kaiser, 1993).

Treatment:

The foundation for treatment is education and therapy. Client education is often focused on what is 'normal,' the importance of emotional intimacy, and healthy anatomy. Therapy focuses on positive approaches such as positive emotions, including hope, which is an important aspect of treatment. Hope theory, which has been applied to the treatment of sexual offenders, is comprised of cognitive,

affective, and behavioral elements of hope and has contributed to effective outcomes for those individuals who have not been considered worthy of or responsive to treatment. Synder (2000) defined hope as a positive motivational state involving goal-directed energy (agency) and goal planning (pathways). Hope theory is similar to control theory, self-efficacy, and self-esteem; however, it is yet different in goal-directed energy, situation-specific), and the role of emotions.

The Eros Clitoral Therapy Device may be recommended for female sexual arousal disorder to improve arousal by increasing blood flow to the clitoris with gentle suction (Berman, 2005) Treatment for the orgasmic disorder is behavior therapy and sensate focus (Meston, Hull, Levin, & Sipski, 2004).

Pain disorders are treated by first assessing the underlying causes such as infection, vaginal atrophy, and endometriosis (Weijmar et al., 2005). Physiological treatment is usually the first order of intervention followed by counseling for the client's issues that will likely include the partner. These issues for females may involve facing fears of vaginal penetration and encouraging increasing comfort with her genitals (Crowley, Richardson, & Goldmeier, 2006).

If a lifelong/acquired subtype is assessed for genito-pelvic pain/penetration disorder then five factors are to be considered: 1) partner factors; 2) relationship factors; 3) individual vulnerability; 4) cultural/religious; and 5) medical factors (APA, 2013, p. 438).

Research suggests that marital dysfunction is significantly involved in one-third or more of clients experiencing sexual dysfunction (Metz & Weiss, 1992). These authors posit that optimally effective therapy must combine marital therapy as well as sex therapy. According to Metz and Weiss, combination therapy may include:

1. encourage to think, act, and feel more confidently and skillfully
2. consider how the couple thinks and relates and the extent of their intimacy
3. integrate individual and sexual dimensions
4. consider the main goal of therapy as developing cooperation

According to Pollets, Ducharme, and Pauporte (1999), disorders such as erectile dysfunction must include both organic and psychological factors to ensure positive outcomes for clients. However, O'Donohue, Swingen, Dopke, and Regev (1999) argued that there appears to be little evidence that effective psychological interventions exist for males. Segraves and Althof (1998) argued that the lack of evidence for successful psychological interventions has stemmed from methodological problems in sex therapy outcome studies.

Hawton (1995) compiled five criteria for sex therapy clients that were associated with positive outcomes. The five criteria were: (1) the quality of the couple's relationship, particularly the female partner's positive pretreatment assessment of the relationship; (2) the motivation of the partners for treatment, especially the male partner; (3) the absence of severe psychiatric disorder in either partner; (4) physical attraction between partners; and (5) compliance with the treatment program early on in therapy.

In support of Hawton's findings, Zeiss and Zeiss (1999) reported that couples who place a high value on sexual intimacy, regardless of age, can make the necessary adjustments that allow them to continue to be sexually active. However, risks of sexual dysfunction in older adults can be increased by the presence of poor health, negative stereotypes about aging, or lack of flexibility for making needed adjustments to age-related changes in desire or capacity. Furthermore, in a study of nearly 1,000 females, Dunn, Croft, and Hackett (1999) found those emotional factors (anxiety and depression) and age-related physical factors (vaginal dryness and dyspareunia) were associated with sexual problems.

When working with age-related sexual dysfunction, interdisciplinary approaches to treatment are essential (Zeiss & Zeiss, 1999), although the most successful modality for these clients, based on empirical research, has been cognitive-behavioral models (Cyranowski, Aarestad, & Andersen, 1999). Other forms of psychotherapeutic treatment have shown promise as well, including bibliotherapy, about which Van Lankveld (1998) reported a meta-analysis of positive outcomes in the treatment of sexual dysfunction disorders.

In a study of nearly 1,000 females, Dunn et al. (1999) found that all female sexual problems were associated with anxiety and depression. Vaginal dryness and dyspareunia were age-related.

Arentewicz and Schmidt (1983) contended that systematic desensitization might be particularly useful to treat sexual dysfunction associated with pain. For clients whose sexual problems are related to sexual trauma, McCarthy (1990) suggested integrating the treatment of posttraumatic symptoms and sexual dysfunctions. Treatment should include individual and couple cognitive and communication exercises to address the traumatic event in treatment, encourage continued sexual pleasuring, identify problematic areas, and help them respect each other's boundaries and needs for affection.

Gender Dysphoria

Recommended Readings:

1. APA Task Force on appropriate therapeutic responses to sexual orientation (APA, 2009)
2. World Professional Association for Transgender Health's Standards of Care Requirements of Hormone Therapy for Adults with Gender Identity Disorder (Meyer, 2009)
3. Injustice at Every Turn: Department of the National Transgender Discrimination Survey (Grant et al., 2011)
4. Overview of ethical and research issues in sexual orientation therapy (Forstein, 2001)
5. Standards of Care of the World Professional Association for Transgender Health (WPATH; Coleman et al., 2012; Meyer et al., 2001)
6. The National Association for Research and Therapy for Homosexuality (NARTH, 2004)

The subject of transgender or transsexual issues has been surfacing among mental health professionals, most of whom are seeking to improve their understanding of individuals with sexual

uncertainty and transgender identity issues. For clarification, transgender refers to one's internal sense of gender identity while transsexual has been used to describe the subset of transgender people who desire to transition permanently to the gender with which they identify via surgery and hormonal assistance. Transgender people frequently experience emotional distress associated with an identity that is incongruent with their physical bodies (APA, 2013). This distress is referred to in the DSM-5 as Gender Dysphoria caused by "a marked incongruence between one's experienced/expressed gender and assigned gender" (APA, 2013, p. 451; Boskey, 2013) and reflects a revision in DSM-5 from the previous label of Gender Identity Disorder defined as a "strong and persistent cross-gender identification" causing "persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex."

There is controversy as to whether transgender individuals should learn ways to accept their current gender dysphoria or resolve it via a reparative sex change approach or conversion therapy (CT) based on the rationale that sexual orientation is a conscious choice that is amenable to change. Pertaining to this controversy the following professional organizations - The American Psychiatric Association, American Psychological Association, American Counseling Association, the National Association of Social Workers, the American Counseling Association, the National Association of School Psychologists, and the National Education Association - have endorsed a position that the transgender identity is not a conscious choice nor amenable to change. Therefore, these organizations had opposed the use of reparative therapies as early as 1973 when it was determined that homosexuality was not a disorder. However, others have disagreed and have not been willing to accept homosexuality as a normal condition (Drescher, 2001). One of the foremost of these organizations is The National Association for Research and Therapy of Homosexuality (NARTH) which states that individuals have the right to claim a gay identity, or to diminish their homosexuality and to develop their heterosexual potential and can attain this through years of reparative therapy, (also used interchangeably with the terms conversion therapy and sexual brokenness) a practice the American Psychiatric Association has disagreed with because of the possibility it can lead to depression, anxiety, and self-destructive behavior, and may reinforce self-hatred.

The authors recognize the ongoing ethical and scientific debate about the understanding and efficacious outcomes of treatment of Gender Dysphoria and will provide a limited amount of additional information to help counselors understand this discussion.

Conversion Therapy (reparative):

The National Association for Research and Therapy of Homosexuality (NARTH) states that individuals can make a conscious choice to develop their heterosexual potential through a process of conversion or reparative therapy by means of techniques that include behavioral methods, hypnosis, abstinence training, education about gender, and psychoanalysis (Morrow & Beckstead, 2004).

Reparative approaches may be based on religious beliefs, Bible-based convictions, an ideological stance, and a belief that homosexuality is a sin. Techniques utilize a religion-based perspective that includes journaling, prayer, repairing family relationships, Bible reading, enhancing gender identification, modifying nighttime sexual fantasies, group therapy, non-sexual touch, and reliance on the power of God (Flentje, Heck, & Cochran, 2013; Morrow & Beckstead, 2004).

Reparative or conversion therapies that rely on clinical interventions have been reported between 1995 and 2000. These interventions include individual psychotherapy, cognitive-behavioral therapy, psychoanalysis, aversive conditioning, clinical/religious individual therapy, group therapy, hypnosis, couples therapy, psychotropic, clinical/religious group therapy, and inpatient treatment (Shidlo & Schroeder, 2002).

Several authors have pointed out that there are a limited number of studies, most of which have lacked rigor, reporting on the effectiveness of conversion therapy (Byrd & Nicolosi, 2002; Cramer, Golom, LoPresto, & Kirkey, 2008). A study of 202 clients authored by Shidlo and Schroeder (2002) did not report significant change in sexual or gender orientation but did communicate psychological benefits including the experience of relief, increased hope, elevated self-esteem, increased sense of belonging, improved relationships with family, improved feelings of spirituality, and acquiring new coping tools for their identity struggle.

There have been some studies that reported on safety and ethical difficulties when CT was the primary intervention (Haldeman, 2004, 2001; Moor, 2001). For example, there were reports of decreased sexual arousal and increased feelings of shame and fear (Haldeman, 1994). Beckstead and Morrow reported harm to be: (a) decreases in self-esteem, declines in familial affiliation, decreases in the sense of spirituality and same-sex intimacy; (b) being less true to oneself; (c) loss of loved ones; (d) wasted time and resources; and (e) slowing of the "coming out" process (Cramer et al., 2008, p. 101). The APA, Haldeman (2002), Schneider, Brown, and Glassgold (2002) have not endorsed reparative (sex-reassignment, or conversion) therapies because of a lack of rigorous impact research studies. Other authors have maintained that conversion treatment is immoral, harmful, lacks client safety, causes an increase in distress, has not defined success, reinforces a negative-self-image, and appears to devalue homosexuality and bisexuality (Beckstead & Morrow, 2004; Morrow & Beckstead, 2004; Shidio & Schroeder, 2002).

Drescher (2001, 2015) has expressed concern about ethical issues and reported violations of inadequate informed consent, breaches of confidentiality, the undue pressure applied to clients, and relinquishment of fiduciary responsibility. Ethical considerations also include a therapist's failure to provide correct information regarding sexual orientation, failure to provide alternative treatment information, inability to be free of prejudice, failure to adhere to principles of integrity, a disrespect for the rights and dignity of the client, the promotion of prejudice on a societal level, and a failure to maintain social responsibility (Halpert, 2000). On the other hand, Benoit (2005) has reported the opposite: that sexual orientation therapists do respect the clients' needs, goals, values, and self-determination. Cramer et al. (2008, p. 104, 115) summarized 16 ethical considerations and comparisons for CT and AT therapists who either meet or do not meet APA standards.

Affirmative Therapy (AT):

According to Milton, Coyle, and Legg (2002), there are two types of affirmative therapies (AT). The first is psychological approaches that include humanistic, nurturing, supportive stance, explicit acceptance, and recognition of the worth of the individual. The second AT approach excludes focusing on sexuality as the primary issue. Rather, it includes specific interventions involving cultural and societal values, raising consciousness, and challenging negative beliefs. This approach focuses on

coping with the secondary distress of living in a heteronormative environment. Langdridge (2007) described two forms of AT. The first focuses on valuing both homosexual and heterosexual identities as being equal while recognizing LGB cultures. The second form is more radical and involves an active affirmation of the specific expressions of LGB identities. The therapist understands and values the LGB identity to decrease or eliminate the effects of heterosexism.

The APA (2009) recommended affirmative therapeutic interventions for gender dysphoria disorder that include acceptance, comprehensive assessment, active coping, social support, and identity exploration and development. These interventions affirm the use of client-centered (Glassgold, 2008) and multicultural (Bartoli & Gilliam, 2008) approaches grounded in scientific facts.

Assumptions underlying affirmative therapies include counselor "acceptance that LGB and heterosexual identities are equally valid and that specific counselor knowledge is necessary to include awareness, and skills to ensure competent counseling for same-sex attracted individuals" (Morrow & Beckstead, 2004, p. 645). Counselors "challenge oppressive stereotypes and systems of thought, including religious thought" (p. 645).

According to Forstein (2001), basic ethical guidelines must include informed consent, counselor's current level of knowledge and scientific basis for intervention, providing information to make the client aware of counselor's current status in the profession and his or her belief whether homosexuality is acceptable or unacceptable. This information should be made clear to the client. Furthermore, it would be advisable for a counselor who is not certain what he believes or what is best for his or her client to obtain a second opinion from another who holds views of the mental health association, and a fiduciary responsibility (do no harm). It is important that the counselor not restricts the client's capacity to work through an understanding of his or her own identity, which is a unique difference from the AT approach (Cross, 2001).

Definition, Interview, and Assessment:

Gender dysphoria refers "to an intense feeling of depression and discontent that individuals experience when their physical bodies are incongruent with their manifest genders, as opposed to having psychological confusion regarding their gender identifications" (King, 2014a, b, p. 13). Gender dysphoria is the subjectively negative experience of the discordance (Money & Lehne, 1999). The discordance exists between the changes occurring in the person and the sex identified at birth.

An essential sense of self as a male or female is the public manifestation of gender identity (Money & Lehne, 1999). The DSM-III used the term transsexualism to mean the desire to live permanently in the social role of the opposite gender via sex reassignment surgery (SRS; Caldwell, 1949). The term gender identity disorder (GID) replaced the term transsexualism and is defined as "individuals who show a strong and persistent cross-gender identification and a persistent discomfort with their anatomical sex or a sense of inappropriateness in the gender role of that sex, as manifested by a preoccupation with getting rid of one's sex characteristics or the belief of being born in the wrong sex" (Cohen-Kettenis & Gooren, 1999, p. 316).

The DSM-5 defined gender dysphoria as the "stress that may accompany the incongruence between one's experienced or expressed gender, and one's assigned gender" (APA, 2013, p. 451). The

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

Adolescents and adult criteria symptoms are to be manifested at least six months and meet at least two of the six symptoms. A specifier exists for post-transition. The assessment is to note that incongruence has existed for a six-month duration and is manifested by six of eight criterion measures in Criterion A (APA, 2013, p. 452).

Money and Lehne (1999) recommended an open-ended nonjudgmental interview when conducting the assessment. The interview is to include history, sex history, and function. Each family member is to be interviewed separately, in dyads with the child, and as a group. A systematic schedule of inquiry is necessary to follow its logical sequence and to ensure that no questions or topics are omitted. The interviewer must also safeguard against collusion between family members to provide inaccurate or biased information. Some interviewers include waiting room observations and drawings from projective techniques such as The Draw-A-Person-Test.

Assessment:

The diagnostic criteria for gender dysphoria disorder must have the client's strong desire to be of the other gender or an insistence that one is the other gender and meets six of eight symptoms in Criterion A. The client declares (1) persistent discomfort about one's assigned sex, (2) persistent preoccupation with getting rid of one's sex characteristics and acquiring the sex characteristics of the opposite sex, and (3) the individual must have reached puberty. The DSM-5 for adolescents and adults indicated that two of six symptoms must be met to apply the term GID. The first component of the DSM-5 classification is incongruence between one's experienced/expressed gender and assigned gender, for at least six months' duration. Criterion B is a significant distress in social, occupational, or other important areas of functioning (APA, 2013, p. 453).

Cohen-Kettenis and Gooren (1999) believed it is impossible to conduct a diagnosis of GID (gender dysphoria) strictly on objective criteria. Subjective information is especially difficult to trust because some dysphoric clients will distort or manipulate their life histories and feelings regarding gender to have sex reassignment surgery. These authors indicated from the onset that this interview is very time-consuming and should be extensive. To do this effectively, they recommend a two-phase procedure. The procedure is derived from the 1998 Standards of Care of the International Harry Benjamin Gender Dysphoria Association.

The quality of the mother-child relationship is significant in establishing first gender identity. Gender problems also become related to abnormal separation and individuation issues so that the failure to achieve separation/individuation leads to the use of sexuality to remain in symbiotic relationships. Some children are given the message that they would be more valued if they were to

change their gender identities (Kaplan & Sadock, 1998). The message of value is especially so for abused children. The death of the mother may also cause a boy to incorporate his mother as a primary part of his own identity as a way of perpetuating her existence.

According to the diagnostic manual, the essential feature of a gender dysphoria disorder is a person's persistence and intense distress about his or her assigned sex (gender dysphoria) and a desire to be, or an insistence that he or she is of, the other sex (APA, 2013). The following diagnostic considerations should be considered when assessing an individual with gender dysphoria (Schaefer, Wheeler, & Futterweit, 1995, p. 2019):

1. primary and secondary transsexualism
2. transvestism with depression or regression
3. schizophrenia with gender identity disturbance
4. homosexuality with adjustment disorder
5. homophobic homosexuality
6. career female impersonators
7. borderline personality disorder with severe gender identity issues
8. body dysmorphic disorder
9. gender identity disorder, nontranssexual type
10. atypical gender identity disorder
11. ambiguous gender identity adaptation
12. malingering

Phase One of the Standard of Care assessment is to interview for the presence of the DSM-5 criteria. Several factors must be considered for Criteria A, and B. Risk factors associated with Sex Reassignment Surgery (SRS) have to be weighed slowly, as well as how capable the person is to live in the desired role. During this phase, information gathering is essential. The following areas need to be explored:

1. general and psychosexual development
2. subjective meaning of their cross-dressing
3. sexual behavior and sexual orientation
4. body image
5. social network
6. informed about the possibilities and limitations of SDS
7. risk factors for postoperative failure
8. differential diagnoses

The same procedure is utilized for children, although it is more extensive and time-consuming than for adolescents and adults (Cohen-Kettenis & Gooren, 1999).

Phase Two is to assess and inform family members of a life of permanence in the desired sex. Family members are informed of all known changes, including such items as a name change, hormone treatment, psychotherapy, doubts and any known prognosis for the SRS.

Instrumentation:

Money and Lehne (1999) indicated that some questionnaires and checklists screen for masculinity, femininity, or androgyny. These questions should be followed by an assessment that includes history, sex history, function, and observations of gender-related behaviors. A specific assessment schedule may be necessary (checklist/instrument). They do indicate that The Draw-A-Person Test can be helpful. This projective should request the drawing of a person, opposite sex, yourself, a friend and your family (Money & Lehne, 1999).

Instruments for assessing gender dysphoria disorder include:

1. The Age-Universal Intrinsic/Extrinsic Scale-Revised (Maltby & Lewis, 1996)

   (19-item measure of religious orientation is applicable for both religious and nonreligious respondents. Two scales intrinsic and extrinsic religiosity)
2. The Age Universal Quest Scale-Revised (Maltby & Day, 1998)

   (12 items and measures "an open-ended, responsive dialogue with existential questions raised by the contradictions and tragedies of life."
3. The Lesbian Identity Scale (LIS; McCarn & Fassinger, 1996)
4. Gay Identity Scale (GIS; Fassinger & Miller, 1996)

   (40 items measuring eight phases in development.)
5. Internalized Homonegativity (Mohr & Fassinger, 2000)

   (5 items measuring degree of gay, lesbian, or bisexual individuals have internalized anti-gay beliefs and values.
6. Propensity to Seek Conversion Therapy (PSCT)

   (9 item to measure propensity to seek conversion therapy)
7. Klein Sexual Orientation Grid (KSOG) (Klein, Sepekoff, & Wolf, 1985)

   (Classifies regarding sexual orientation. Seven components of sexual orientation include sexual attraction, sexual behavior, sexual fantasies, emotional preference, sexual preference, self-identification, and hetero/gay lifestyle.
8. Social Desirability (Reynolds, 1982)

   (Assesses the degree the participant responds in a socially desirable manner)
9. Rosenberg Self-Esteem Scale (Rosenberg, 1965)

   (Scale measures self-perceived worth)
10. Lesbian Internalized Homophobia Scale (LIHS) (Szymanski & Chung, 2001)
11. Lubben Social Networks Scale (Lubben et al., 2006)

    (Scales include support from relatives and support from friends)

12. Cohen's Perceived Stress Scale (Cohen, Kamarck, & Mermelsteing, 1983)
    (Most widely used measure of perceived stress over the previous month)
13. Gender Identity/Gender Dysphoria Questionnaire-Adolescent-Adult (GIGDQ-AA) (Deogracias, 2004; Deogracias et al., 2007; Singh et al., 2010), (both adolescent and adult-with male and female pole)

Incidence:

The DSM-5 (APA, 2013) estimated prevalence range for natal adult males is from 0.005% to 0.014% and females from 0.002% to 0.003%. In children, there is a ratio of 2:1 to 4.5:1 of boys to girls. The DSM-IV (APA, 1994) does not list a prevalence ratio for gender identity disorder (GID). Ettner (1999) estimated that 3% to 5% of the U.S. population has some form of gender dysphoria. The APA (1994) estimates a rate of one per 30,000 adult males and one per 10,000 adult females based on European data. Bakker, van-Kesteren, Gooren, and Bezemer (1993) suggested a male to female ratio of three to one. Adolescent clients 15 years and older seen in a clinical setting who have characteristics of GID have revealed a history of cross-gender interest before the age of 6 and more so between the ages of 2 and 4. Money and Lehne (1999) indicated that this disorder in children is rare. The Harry Benjamin International Gender Dysphoria Association (Levine et al., 1998) estimated an undocumented 3,000 to 6,000, as of 1979, had undergone hormonal and surgical sexual reassignment. The association estimated that between 30,000 and 60,000 individuals in the United States considered themselves strong candidates for sex reassignment (Meyer et al., 2001).

Treatment:

Based on standards of care that have been developed, psychotherapy is required for individuals suffering from gender dysphoria and may take such forms as an individual, group, behavioral, family, or a combination of all of these (Schaefer, Wheeler, & Futterweit, 1995; Walker et al., 1985). For the individual experiencing gender dysphoria, group therapy has been recommended (Keller, 1980). Individuals who are confused about having a complete gender identity change may benefit from psychodynamic psychotherapy. For those who desire sex-change surgery, psychotherapy has only been successful in informing and educating clients to provide some relief pre and postoperatively. Hormone therapy in conjunction with the social role changes has been helpful in real-life tests. Specific hormones will suppress sex characteristics such as facial hairs, penile erections, and appetite for a male-to-female change. Speech therapy may be necessary for prospective sexual reassignment surgery (SRS) candidates to learn to use their vocal cords like females or males. If the real-life test is successful for a social role change, the next step is surgery.

Treatment of gender dysphoria disorders is complex and not usually successful when the goal is to reverse the disorder. Green (1985) has developed a treatment program designed to inculcate culturally acceptable behavior patterns in boys and uses role modeling to teach male behavior.

Children

Treatment for children has been helpful through behavior therapy by rewarding sex-appropriate behaviors and nonrewarding sex-inappropriate behaviors (Zucker & Bradley, 1995). Psychotherapy can help children deal with peer rejection, teasing, self-image problems, and unresolved trauma (Money & Lehne, 1999). Ongoing sex education is important for children, adolescents, and adults. Pharmacotherapy is helpful for children when depressed but not for secondary sexual characteristics.

Disruptive, Impulse-Control, Intermittent Explosive Disorder, Conduct Disorder and Oppositional Defiant Disorder

Disruptive, impulse-control, and conduct disorders define and characterize problems in emotional and behavioral self-control. This category includes oppositional defiant disorder, intermittent explosive disorder, antisocial personality disorder, pyromania, kleptomania, other specified disruptive, impulse-control and conduct disorder, and unspecified disruptive, impulse-control and conduct disorder.

Intermittent Explosive Disorder

Definition, Interview, and Prevalence:

The DSM-5 reported the prevalence for IED in the United States is approximately 2.7% and is more prevalent among younger individuals (APA, 2013). Kessler et al. (2006) reported IED prevalence using two published studies, the first study of 1300 patients a 3.1% and the second study of 253 found a lifetime and 1-month prevalence of 4.0% and 1.6%.

Assessment:

Anger and aggression may be significant behaviors regarding the onset and maintenance of IED. IED may be present in individuals with internalizing stress such as anxiety disorder, OCD, depressive disorders, trauma-related disorders, borderline personality disorder, and eating disorders (ED) especially bulimic spectrum disorder (Cassiello-Robbins, & Barlow, 2016; Jenning, Wildes, & Coccaro, 2017). Studies report that individuals with ED have a higher prevalence of anger attacks (Fava, Rappe, West, & Herzog, 1995). IED is prominent in 50% of clients reported with bulimia nervosa or binge eating disorder.

The interviewer should be knowledgeable regarding the definitions of anger, hostility, irritability, aggression, anger attacks, trait anger, and state anger. Criteria A stipulates that symptoms present include recurrent behavioral outbursts and failure to control aggressive impulses by verbal aggression

(temper tantrums, tirades, verbal arguments or fighting) and three behavioral outbursts involving damage or destruction of property within a 12-month period. The client is at least six years of age (APA, 2013, p. 466). The IED core features can be met by the presence of verbal (twice weekly for at least one month) and non-destructive/no-assaultive aggressive outbursts (twice weekly for three months (DSM-5).

Conduct Disorder

Definition and Interview:

The DSM-5 (APA, 2013) described conduct disorder as a repetitive and persistent pattern of behavior in which the basic rights of others or dominant age-appropriate societal norms or rules are violated (pp. 469, 93). Fifteen specific criteria are unchanged and divided into four categories: (1) aggression to people and animals, (2) destruction of property, (3) deceitfulness or theft, and (4) severe violation of rules (APA, 2013, pp. 469-470). This criteria list includes behaviors such as bullying, initiating physical fights, using a weapon to cause serious physical harm to others, perpetuating physically cruel acts on people and animals, stealing, running away from home, and deliberately destroying property. As in several other disorders, the child or adolescent's disturbance in behavior must include impairment in social, academic, or occupational functioning. The clinician specifies whether the disorder is childhood-onset or adolescent-onset (no behavioral observations before age 10) and whether the behaviors are considered mild, moderate, or severe (King, 2014m).

The assessment interview should include questions to elicit the emotion of anger and rumination often prominent in aggressive behaviors that cause harm to self and others (Smith, Stephens, Repper, & Kistner, 2016). The emotion of anger has a restricted range for a fast or rapid response by the angered person. Anger has associated emotions of fear, disgust, and guilt (Ekman, 2003). Rumination is a cognitive response to negative affect found to be repetitive and intrusive thoughts that focus attention on one's feelings. Rumination leads to more intense, sustained negative affect and maladaptive behaviors and displaced aggression (Peled & Moretti, 2007).

New in the DSM-5 are examples of the severity specifiers (mild, moderate, moderate-severe, severe). Examples of mild are lying, truancy, staying out after dark without permission and another rule breaking. Examples of moderate are stealing without confronting the victim and vandalism, and severity, i.e., forced sex, physical cruelty, use of a weapon, stealing while confronting the victim, and breaking and entering (p. 471). At least 3 of the 15 criteria must be met within a 12-month period and at least one criterion in the last six months. It should be noted that oppositional defiant disorder is closely related but less severe than conduct disorder. Conduct disorder overlaps and includes many symptoms of ADHD, suggesting a need for the clinician to assess the presence of attention difficulty and hyperactive symptoms. Finally, gender differences appear to be significant. The DSM-5 criteria indicate that males are more aggressive and confrontational compared with females, who tend to act out delinquency behaviors by lying, truancy, running away, substance use, and prostitution (Frances & Ross, 1996). Specifiers or subsets include childhood onset, adolescent onset, and unspecified onset. The assessor should specify one of the following five subsets: limited prosocial emotions, lack of

remorse or guilt, callousness (lack of empathy), unconcerned about performance, or with shallow or deficient affect.

Criterion C indicates that if the individual is 18 or older, and criteria are not met for antisocial personality disorder, the assessor should also designate an additional specification for childhood onset, adolescent onset, or unspecified onset as well as specifying the presence of one of the following: with limited prosocial emotions, callous-lack of empathy, unconcerned about performance, or shallow or deficient-affect (APA, 2013, p. 470).

In most cases, the assessment of children with conduct disorder can be complicated and confusing because of incongruent parent and teacher misinformation, counselor countertransference, comorbidity, and confounding cultural and situational factors (Sommers-Flanagan & Sommers-Flanagan, 1998).

According to Frick et al. (1994), children and adolescents with conduct disorder tend to have deceitful and manipulative behaviors. They minimize their difficulties, deny personal responsibility, and blame others for their social and academic problems. They cannot be trusted to provide accurate information about themselves on self-reporting instruments or structured interviews. However, during the data-gathering process, the interviewer can use these reports to highlight or reveal the client's capacity for lying and deceiving by comparing and validating the self-assessment data with other, more objective, information.

The parent and teacher observations as reported on paper-pencil forms, at best, are highly suspect. Reliability coefficients characteristically have been very low (Kazdin, 1995) because supervision of children has tended to be minimal so that many delinquent behaviors are concealed from adult awareness.

Counselor countertransference reactions can provide a clue during the assessment interview. The interviewer may feel angry, rejecting, or retaliative during the interview (Willock, 1987). The inexperienced interviewer may overlook or minimize the client's destructive behaviors (Sommers-Flanagan & Sommers-Flanagan, 1993). Sommers-Flanagan and Sommers-Flanagan (1998) stipulated that comorbidity is commonly associated with the following conduct disorder:

1. Attention-deficit/hyperactivity (45%-70%; Fergusson, Horwood, & Lloyd, 1991)
2. Oppositional defiant (84%-96%; Hinshaw, Lahey, & Hart, 1993)
3. Substance abuse and dependence disorders (52%; Frances & Ross, 1996; Meyers, Burket, & Otto, 1993)
4. Depressive disorders (15-35%; Harrington, 1993)
5. Anxiety disorders (15%; Cohen et al., 1993)

The therapist is cautioned not to make a diagnosis of conduct disorder too quickly unless the behaviors are symptomatic of the underlying dysfunction and not a function of or reaction to socio/cultural context or gender differences (APA, 1994). Sommers-Flanagan and Sommers-Flanagan (1998) suggested the following as a guide to the interview process for conduct disorder:

1. be familiar with DSM-5 behavioral criteria
2. use multi-method, multi-rater, multi-setting assessment procedures
3. be familiar with the literature on differential diagnoses and develop checklists
4. obtain historical information before completing assessment interviews
5. rule out adverse family environments, social forces, and cultural circumstances
6. consult with colleagues

The actual interview may take a combination of one of four forms: (1) structured, (2) unstructured, (3) attachment-oriented, and (4) morality-values-oriented (Sommers-Flanagan & Sommers-Flanagan, 1998).

The structured interview is frequently used to obtain the presence or absence of the 15 criteria of the DSM-5. The structured interview is considered an effective method to obtain the developmental history (Sommers-Flanagan & Sommers-Flanagan, 1993; Tolan & Cohler, 1992). The interview is to be structured because clients with a conduct disorder are known to attempt to control the interview through the manner of presentation. Since the criteria have not changed for conduct disorder in the DSM-5, it would appear this instrument remains valid. Often the interviewer can expect the client to use threatening behaviors (Yates, 1995). Answers to the developmental history are important to determine reactive or proactive aggressive behaviors of the client (Vitiello & Stoff, 1997). According to Costello et al. (1984), this type of interview for conduct disorder has many limitations as well as low correlation coefficients.

The unstructured interview is useful in obtaining historical information such as antisocial or illegal behaviors. The interviewer cannot only observe how the client reports involvement with others but also use the information gained as a reliability measure. The unstructured interview allows for observation of the client's emotional responsiveness and the manner in which he or she relates to the examiner. Its reliability can be determined later when compared to information obtained from other sources.

The attachment-oriented interview, which can be useful for a variety of disorders, focuses on observing the opportunities and abilities the child or adolescent has with forming attachments. These attachments can be observed through the client-counselor interactions. According to Bradford and Lyddon (1994), one of four types usually is apparent. First, note whether he or she is disrespectful to the interviewer. Second, assess his or her ability to form attachments by asking an open-ended question such as, "If you were asked to choose someone to eat a meal with, who would you choose? Your mother, father, brother, sister, friend, another adult, or would you prefer to eat by yourself?" This allows the child to hypothesize, in a given situation, the person he or she would choose to be with. Third, listen for themes such as harm-protection-safety, lack of intimacy-closeness, dependence-independence, and attitudinal information. Fourth, assess for morality and values through the use and involvement in simulations.

Culture:

Studies in 1995 revealed that, in comparison to other cultures, adolescent conduct disorders were highest in the United States (Dishion, French, & Patterson, 1995). Rising rates of legal and illegal immigration have probably contributed to increasing amounts of cultural clashes within American cities. Shaffer and Steiner (2006) pointed out that many immigrants feel trapped between two cultures and experience acculturative stress, accounting for a disproportionate number of conduct disorders for 'clients of culture.' For example, Hispanic, Asian, or Middle Eastern adolescents thrust into a less constrained and morally declining American culture may engage in a moral or even anti-social behavior. Adolescents and children from families with strict cultural values encounter more liberal ones in public schools and the media. Adolescents in the major urban areas may become part of gangs that commit violent crimes against a culture they think of as foreign. Immigrant children and adolescents from impoverished families may rebel with antisocial behavior against the 'wealthy' society in which they feel alienated. The failure of these culturally alienated youth to integrate their ethnic identities, for whatever reasons, is paralleled by an inability to integrate self-identities (Phinney & Rosenthal, 1992).

Training in assessing for ethnic, linguistic, and culturally diverse populations is a recognized need. When assessing for cultural factors, it is recommended the following be addressed: (1) cultural identity of the client, (2) cultural explanations of the client's illness, (3) cultural factors related to psychosocial environment and levels of functioning, (4) cultural elements regarding the relationship between the client and counselor, and (5) overall cultural assessment for diagnosis and care (APA, 1994). Szapocznik Arturo, Perez-Vidal, and Kurtines, (1986) recommended Bicultural Effectiveness Training (BET), an intervention for helping a family struggling with intercultural conflict.

Incidence:

The DSM-5 prevalence rate estimated for one year was in the range from 2% to more than 10% (APA, 2013, p. 464), while the DSM-IV-TR (APA, 2000) had previously indicated that conduct disorders were much higher in males than females and prevalent in the general population from less than 1% to more than 10% (p. 97).

Instrumentation:

Assessment of conduct disorder usually involves gathering data from the family, child, school, and community. One or two instruments will be listed for each source or area.

1. Minnesota Multiphasic Personality Inventory, Adolescent Form (MMPI-A; Butcher & Williams, 1992; Butcher et al., 1992)
2. Adolescent Antisocial Behavior Checklist (Ostrov, Marohn, Offer, Curtiss, & Feczko, 1980)
3. Child Behavior Check List (CBCL; Achenbach, 1992; Achenbach & Edelbrock, 1991)

Parent, Teacher, Family Members

1. Dyadic Parent-Child Interaction Coding System (Eyberg & Robinson, 1983)
2. Family Intake Form (Horne & Sayger, 1990)

3. Genogram (McGoldrick & Gerson, 1985)
4. Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1987)
5. Teacher Report Form (Achenbach & Edelbrock, 1991)
6. Medical Records

Projective Instruments

1. Rorschach Inkblots (Exner, 1993)
2. Child Apperception Test (Murray, 1943)

Treatment:

While developing a treatment plan, the clinician will want to keep in mind that individuals with a history of behavior problems commensurate with conduct disorder have exhibited those behavioral patterns for a long time. Kazdin (1995, 1996, 1998) and APA (1994) pointed out that clients experiencing conduct disorder are typically resistant to treatment, especially outpatient therapy. Yates (1995) reported that during treatment adolescents with conduct disorder frequently exhibit transference issues because they feel threatened, manipulated, and will often emotionally 'seal off' to the therapist or examiner. If these individuals have a second comorbid DSM-5 disorder such as ADHD and anxiety disorder, they are more likely to experience improvements with treatment than if they have conduct disorder as the only diagnosis (Bernstein, 1996; Biederman, Baldessarini, Wright, Keenan, & Faraone; 1993; Frances & Ross, 1996). Some youth with conduct disorder can be successfully treated on an outpatient basis if firm behavioral controls are maintained at home. It is also beneficial if they have other positive attributes such as a high level of ego integration (usually not the case), the capacity to experience guilt, the ability to feel empathy, and the capability of forming relationships (Yates, 1995). Also, for the very young (pre-and early school) a previously favorable response to treatment using cognitive-behavioral theory (social learning theory) is a positive predictive factor (Kazdin, 1993).

Research has indicated that children with severe conduct disorder problems may respond to long-term, highly structured residential treatment facilities that emphasize respect for authority and peer-monitored behavioral interventions. However, as these children move from early to late adolescence, the effectiveness of these treatments is diminished. The Multi-Systemic Treatment (MST) reported that the average therapy session time was approximately 55 hours over 155 days (Curtis, Ronan, & Borduin 2004; Stevens, Ronan, & Davies, 2017). The MST evidenced-based format consists of a time-limited approach (24 hours, 7-day-per-week) in-home program. A new family-centered feedback informed element was added to the MST format which includes the family set of values emphasizing family control and choice (Dunst, Trivette, & Hamby, 2007; Stevens et al., 2017). Last, functional family therapy using behavioral, structural, strategic, and communication techniques is recommended for the entire family. Generally speaking, the earlier and more aggressive the interventions the better the prognosis.

Treatment (efficacious-children and adolescent):

Eyberg et al. (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.

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

Oppositional Defiant Disorder

Definition, Interview, and assessment:

"The essential feature of the oppositional defiant disorder is a recurrent pattern of angry/irritable, argumentative/defiant behavior, or vindictiveness lasting at least six months combined with at least four symptoms from criteria A" (APA, 2013). An assessment will reveal a pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures in the last six months. The eight symptoms are clustered to reflect both emotional and behavioral symptomatology. This list is divided into three segments: angry/irritable, argumentative/defiant behavior and vindictiveness. The descriptors include negativistic, defiant, loses temper, annoys others, touchy, disobedient and hostile behavior toward authority figures that persists for at least six months (APA, 2013, p. 462). The angry/irritable mood symptoms are: (1) often loses temper, (2) is often touchy or easily annoyed, and (3) is often angry and resentful. The word "by others" was removed. Also, the frequency and severity of violations are different for children younger than five years of age (most days for six months) than those children older than five years of age (once a week for six months). At least four of the following behaviors must be present: (1) losing temper, (2) arguing with adults; added "with authority figures", (3) actively defying or refusing to comply with the requests or rules of adults; added "with authority figures", (4) deliberately doing things that annoy other people, (5) blaming others for his or her own mistakes, (6) being easily annoyed by others, (7) being angry and resentful, and (8) being spiteful or vindictive. The client is to be spiteful or vindictive at least twice within the past six months.

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

The frequency and intensity of the behaviors must be greater than for those typically found in children of comparable age and development. The individual must experience impairment in social, academic, or occupational functioning. "The diagnosis is not made if criteria are met for conduct disorder or if symptoms occur in conjunction with psychosis, antisocial personality disorder, or mood disorder in an individual over 18 years of age" (APA, 2013, p. 462).

Three ratings for severity are based on pervasiveness: mild (one setting), moderate (at least two settings), and severe (present in three or more settings). Those children who display oppositional defiant behaviors in multiple settings are more symptomatic than those children presenting in one setting.

The oppositional defiant disorder is characterized by the client's deliberate intent to annoy, to be resistant, and to resist compromise. It is possible these defiant behaviors may not be apparent in the interview. Distinctive features are as follows: oppositional defiant clients have less-serious physical aggression than conduct disorder clients, behaviors are more evident at home than at school, and the opposition is directed at known individuals.

Incidence:

The incidence of the oppositional defiant disorder is reported to be in the range of 1% to 11% of the population (APA, 2013). The onset may occur as early as five to six years of age but can be apparent even in preschool children. However, it is more likely to surface in late or early adolescence. This behavior is more common in males than females, but by the teenage years, there seem to be as many females as males.

Instrumentation:

As with conduct disorder, attention deficit hyperactivity disorder and social phobias, behavioral checklists are available, including the following:

1. Child Behavior Checklist (CBCL; Achenbach, 1991a)
2. Parent Report Form (Achenbach, 1991b)

Treatment (efficacious-child and adolescent):

Eyberg et al. (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.

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

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

Substance-Related and Addictive Disorders

There are ten separate classes of drugs for the substance-related and addictive disorders category. The drugs are alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, tobacco, and other substances. Gambling is also covered within this category (King, 2014o).

The new classifications found in the DSM-5 are as follows. Two classifications exist for substance-related disorders: substance-use disorders (SUDs) and substance-induced disorders (SIDs). Substance-induced disorders include intoxication, withdrawal, and other substance/medication-induced mental disorders. Substance abuse and substance dependence were combined into a single use disorder with a continuum from mild, moderate, or severe use; legal consequences were removed, and craving was added as a symptom.

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

Definition and Interview:

Substance-induced disorders cause symptoms which include anxiety disorder, delirium, hallucinogen persisting perception, intoxication, mood disorder, persisting amnestic disorder, persisting dementia, psychotic disorder, sexual dysfunction, sleep disorder, and withdrawal.

A cluster of cognitive, behavioral, and physiological symptoms is employed to define substance dependence (substance use disorder). Dependence is a repeated pattern of self-administration resulting withdrawal, intolerance, and compulsive drug taking behavior. Many substances potentially cause both dependency and abuse. Nicotine and caffeine are both associated with withdrawal symptoms and nicotine with extreme dependence, but neither has been linked to abuse. According to the DSM-IV (1994) dependence is characterized by a cluster of three or more symptoms during a 12-month period. Some of these symptoms are tolerance, withdrawal, substance consumption in more substantial amounts over a more extended period, a persistent desire to cut down or control the substance, a great deal of time spent in acquiring the substance, and the abandonment of important social, occupational, or recreational activities. Craving, which may be associated with dependence, is

described as an intense subjective drive to use the substance. Tolerance is the need for substantially increased amounts of the substance to achieve intoxication or controls disordered mood and withdrawal symptoms (p. 176).

A specifier termed "on agonist therapy" indicates that the client who has not used the addictive substance for at least a month is receiving a prescribed agonist medication (i.e., a drug which mimics the action of the substance such as methadone, which mimics heroin) or "on antagonist therapy", indicating that he or she is receiving an antagonist medication such as naltrexone, which blocks the effects of an opiate. A second specifier is "in a controlled environment," which refers to a location (e.g., jail, therapeutic community, or hospital unit) where access to alcohol and controlled substances is restricted.

Clients who abuse substances develop a maladaptive pattern of substance use that causes impairment or distress in at least one of the following: social, physical, legal, vocational, and educational functioning and has occurred in the last 12 months (Evans, 1998). Substance abuse does not have to meet the criterion of tolerance, withdrawal, or compulsive use. The distinction between substance abuse from substance dependence should be quickly ascertained during interview procedures. While it is of significant clinical interest to understand the differences between abuse and dependence, these two are combined into one diagnostic category--use disorder--in the DSM-5 for coding purposes.

Assessment:

Substance use disorder symptoms are tolerance, withdrawal, more use than intended, excessive time in the acquisition, activities are given up, and failure to meet obligations, use in dangerous situations (risky), and use despite impairment (harm).

Step 1: Make a tentative diagnosis. Evans (1998) suggested the use of a behavioral observation, intake interview, and the mental status examination. Evans (1998) and Caetano (1992) stressed the importance of careful wording and avoiding the use of negative connotations with questions, as that may cause clients to become defensive. The counselor should be aware that substance abusers might not be truthful in their answers. Therefore, obtaining information from a variety of resources is required. The interview should include assessing for frequency, quantity, setting, and effects, as well as recent or history of using or abusing other substances or prescription drugs. The interviewer should attend to behavioral characteristics such as body language, the presence or lack of affect, and particularly the level of agitation. Evans recommended the use of a technique to minimize defensiveness by requesting the client to describe someone else who is a user.

Another useful interviewing technique is to phrase questions in an open-ended manner, rather than close-ended. An indirect question such as "I am interested in knowing whether you have ever used drugs or alcohol" allows the client to approach the subject without denying substance abuse. But if the client were asked, "Do you abuse drugs or alcohol?" the easy answer is "no." The interviewer may also get more accurate information when asking, "When was your last drink?" rather than "Do you have a problem with alcohol?" which is easier to deny. The interviewer may then continue to proceed with more open-ended questions that presume the use of a substance until more evidence is acquired.

Step 2: Have a thorough knowledge of the ten classes of substances previously mentioned, effects of each, how each cause their effects, and the physical and behavioral tolerance, cross-tolerance, and synergism.

Step 3: Interview for the past and current use of substances, including prescription medications that have become a more frequent source of dependency and abuse. This step should include the client's expectations about the use of the substance and the setting in which the substance is used. The interviewer also should apply techniques like direct questioning, confrontation, clarification, awareness of counter-transference (frustration and anger in the interviewer), and eliciting a response to critical moral and ethical issues. Substance abusers frequently are unable to change their behaviors, maintain good health, and escape encounters with the law, work, family, and interpersonal relationships.

Step 4: Be aware of the most frequently utilized forms of noncompliance, such as denial, rationalization, justification, and minimization.

Step 5: Assess the physical history of the client and determine if any of the drugs or prescription medications have caused symptoms that mimic those caused by substance use, abuse, or other mental disorders.

Diagnosis:

A diagnostic interview is to determine information for:

1. duration
2. frequency
3. type of alcohol and amount
4. time of drinking
5. setting
6. attempts to alter state of mind or mood
7. attempts to induce relaxation and sleep
8. attempts to fit in with peers
9. associated with driving problems
10. associated with criminal behavior or arrests
11. causes family distress or abuse
12. causes problems on the job
13. causes health problems

Criteria for Acute Intoxication

A. Dysfunctional behavior—manifested by at least one of the following:

    1. disinhibition
    2. argumentativeness

3. aggression
4. lability of mood
5. impaired attention
6. impaired judgment
7. interference with personal functioning

B. At least one of the following signs must be present:

1. unsteady gait
2. difficulty in standing
3. slurred speech
4. nystagmus (rapid eye movements)
5. decreased level of consciousness (e.g., stupor, coma)
6. flushed face
7. conjunctival injection (redness or inflammation in the eyes)

Criteria for Pathological Intoxication:

The general criteria for acute intoxication must be met, except that pathological intoxication occurs after drinking a small amount of alcohol. Drinking alcohol triggers verbal aggressiveness or violent behavior not typical when the individual is sober, usually occurring within a few minutes after the drink (APA, 2013). Also, at least one or more of the following symptoms occur shortly after alcohol use: slurred speech, incoordination, unsteady gait, stupor/coma, impaired memory, and drowsiness (nystagmus).

Alcoholism

"Substance-use disorders affect virtually every sector of society" (O'Brien & McKay, 1998, p. 127) and are the most common of mental disorders. Alcoholism, a term with multiple and sometimes conflicting definitions, historically refers to any condition resulting in the continued consumption of alcoholic beverages despite the health and social consequences it causes. Alcoholism, now referred to as alcohol use disorder in the DSM-5™, has been defined for many years either as alcohol abuse or alcohol dependence on a continuum, both of which are major public health problems in the United States. Their destructive effects are not limited to adverse health consequences (Burge et al., 1997). The social, occupational, legal, and psychological costs alcoholics forge upon themselves are as severe as the physical costs. While the percentages of health care resources used up by alcoholics' inpatient and outpatient clinical visits comprise more than 50% and are substantial (approximately 50% to 60%), the rates of diagnoses of alcohol dependence and abuse are less than 50% of all clinical visits in most settings, while the rates of successful interventions are a dismal 5% to 10% (Clement, 1986). Although healthcare providers have tended to avoid asking probing questions or intervening with clients about possible drinking problems (Burge et al., 1997), a number of studies investigating intervention effectiveness have shown that early-stage problem drinkers respond well when health care providers

make straightforward drinking-focused interventions such as, "I'm concerned that alcohol is having detrimental effects on your health, your family, and your life in general. In my professional opinion, you should take the necessary steps to stop using alcohol, even if it means seeking professional help or attending AA meetings" (Persson & Magnusson, 1989).

Alcohol Use Disorder

Interview and Definition:

Alcohol use disorder in the DSM-5 includes the following types of alcohol problems: alcohol use disorder, alcohol intoxication, alcohol withdrawal, other alcohol-induced disorders, and unspecified alcohol-related disorder. According to Rienzi (1992), the interview and diagnostic procedures by mental health clinicians often are problematic about alcoholism. She reported that clinicians did not uniformly ask clients if they used or abused substances during the intake interview, nor did they attempt to address it in the treatment plan, even when alcohol abuse or dependence was diagnosed. Substance use combines substance abuse and dependence although the legal problem was removed from the criteria. Abuse is a behavioral pattern that is recurrent and with significant adverse consequences with repeated use of substances. Criteria five, six, and seven are characteristic of this behavioral pattern (APA, 2013). Consistent with the description of this maladaptive pattern, alcohol users (abusers) may repeatedly fail to fulfill obligations, use alcohol in dangerous situations, and experience drinking-related legal, social, and interpersonal problems. To qualify for a diagnosis of alcohol use disorder (abuse), individuals must have these problems repeatedly in the same 12-month period and suffer from the development of tolerance, withdrawal, and compulsivity of use.

Alcohol use disorder criteria are defined as a problematic pattern of alcohol use leading to clinically significant impairment or distress, manifested by at least 2 of 11 symptoms over a 12-month period (APA, 2013). Symptoms include alcohol taken in larger amounts, persistent desire to cut down, great deal of time in activities to obtain, craving, recurrent alcohol use, continued alcohol use, social, occupational, or recreational activities given up, alcohol use is continued despite physical or psychological problems, tolerance (increased amounts and diminished effect), and withdrawal (withdrawal syndrome and alcohol use to avoid withdrawal symptoms (APA, 2013, pp. 490-491).

Assessing tolerance or withdrawal can indicate dependence on alcohol. Withdrawal is the development of withdrawal symptoms after the reduction of intake following heavy use. While withdrawal symptoms may be severe (e.g., delirium tremens (DTs), grand mal seizures), only about 5% of alcohol-dependent individuals ever experience withdrawals so severe (APA, 2000).

Alcohol Intoxication

The diagnosis of alcohol intoxication is defined and assessed as recent ingestion of alcohol and problematic behavioral or psychological changes that developed during or shortly after the alcohol ingestion. One or more of the following symptoms are associated with alcohol intoxication: slurred

speech, incoordination, unsteady gait, nystagmus, impairment in attention or memory, and stupor or coma (APA, 2013, p. 497).

Alcohol Withdrawal

Alcohol withdrawal occurs after the cessation of heavy and prolonged alcohol use and at least two of the following symptoms apparent within several hours to a few days after the reduction in alcohol: sweating or pulse rate greater than 100 bpm, increased hand tremors, insomnia, nausea, visual, tactile or auditory hallucinations or illusions, psychomotor agitations, anxiety and generalized tonic–clonic seizures. These symptoms cause significant impairment in social, occupational or recreational activities (APA, 2013, p. 499).

Incidence:

According to the APA (2013), alcohol use disorder is among the most prevalent disorders in the general population. APA (2013) cites prevalence to be 4.6% among 12 to 17-year-olds and 8.5% among adults age 18 years and older. Statistics reported by the APA (2000) for the 1990s were a rate of 5% and lifetime risk for alcohol dependence to be 15% in the general population.

Instrumentation:

Some instruments attempt to assess alcoholism from non-alcoholism, including the following:

1. The Mac Andrew Alcoholism Scale-Revised (MAC-R), a supplemental scale of the MMPI-2 (Newmark, 1996)
2. Michigan Alcohol Screening Test (MAST; Pokorny, Miller, & Kaplan, 1972; Zung & Charalampous, 1975)
3. Drug Abuse Screening Test (Skinner, 1982)
4. CAGE Alcohol Interview Schedule (Schutte & Malouff, 1995). E. W. Ewing and B. A. Rouse developed the CAGE to assess alcohol abuse (Ewing, 1984). The CAGE is a four-item interview schedule, and the letters stand for cut, annoyed, guilty and eye-opener (Mayfield, McLeod, & Hall, 1974).
5. The Addiction Severity Index (McLellan, Loborsky, Woody, & O'Brien, 1980)
6. The Inventory of Drinking Situations (IDS; Victorio-Estrada, & Mucha, 1997)
7. Substance Abuse Subtle Screening Inventory-3 (SASSI-3; Lazowski, Miller, Boye, & Miller, 1998)
8. Alcohol Use Disorders Identification Test (AUDIT)

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

Treatment:

The standard treatment for alcohol use disorder begins with the acute management of withdrawal symptoms in detoxification programs. Acute management is followed by long-term management of

dependence and prevention of relapse (Klerman et al., 1994). In a review of empirical studies on treatment effectiveness, Finney and Moos (1998) summarized that cognitive behavioral strategies are more effective in alcoholics with antisocial personality disorders or more impaired individuals in general, whereas relationship-oriented approaches are more effective for clients who are functioning better (i.e., weaker urges, lesser psychiatric severity, and better social skills).

Counselor variables also have been studied in the treatment of alcoholism as early as 1972 (McLellan, Loborosky, Woody, & O'Brien, 1980). Najavits and Weiss (1994) reported from reviews of previous studies that clients of therapists who were more interpersonally skilled, less confrontational, more empathic, or had all of these traits experienced better outcomes.

The duration of treatment appears to have a significant effect on the outcome. Lengthier treatments result in better outcomes. Lower intensity over a longer period of time appears to be the most effective treatment strategy (Finney & Moos, 1998). Additionally, the quality and effectiveness of the treatment site or program also seem to affect the outcome significantly. Finney and Moos (1998) recommended the following suggestions from a compilation of previous studies:

1. provide outpatient treatment for most individuals with sufficient social resources and no serious medical/psychiatric impairment;
2. use less costly intensive outpatient treatment options for clients who have failed with brief interventions or for whom a more intensive intervention is warranted but who do not need the structured environment of a residential setting; and
3. retain residential options for those with few social resources and environments that are serious impediments to recovery and maintain inpatient treatment options for individuals with serious medical/psychiatric conditions (pp. 162-163).

Historically, the 12-Step program developed by Alcoholics Anonymous was the first recovery approach that offered any hope for alcoholics to maintain sobriety. In recent years, the professional community has developed excellent treatment programs for the more severely impaired alcoholics, particularly those with another diagnosis (i.e., alcohol use disorder, alcohol dependence or abuse plus anxiety disorder, mood disorder, behavior disorder or psychotic disorder). Some researchers believe that cognitive behavioral approaches are equally effective with 12-step programs if they include the common threads of providing coping skills, social support over time, and a general orientation toward life (Finney & Moos, 1998). The 2006 Cochrane Review using a meta study found no evidence for treatment as did the Campbell Collaboration (Bog. Filges, Brannstrom, Klint Jorgensen, & Karrman Fredriksson, 2017).

Teaching ways to cope with cravings and the relapse process should be a component of the treatment program for addictive disorders. Relapse studies exist not only for substances but also for nonaddictive disorders such as depression, obesity, compulsive disorders, schizophrenia, panic disorder, bipolar disorder (Witkiewitz & Marlatt, 2004). Relapse prevention (RP) has been studied for nicotine, alcohol, marijuana, and cocaine addiction and has looked at such things as the relationship of relapse to high-risk behaviors and or situations, poor self-efficacy, the probability of relapse, the first use of the addictive substance, abstinence, and ineffective coping responses. Witkiewitz and Marlatt

(2004) described the specific behaviors and components of an RP program, which include self-efficacy, positive outcome expectancies, report onset of craving, motivation, effective coping techniques, recognizing emotional states and being aware of positive and negative interpersonal factors.

Substance Use in Adolescents

Definition and Interview:

Substance use disorder criteria remained the same for children and adolescents except for the removal of legal problems. The use of abuse and dependence in the DSM-IV-TR has been removed and replaced with Substance Use Disorders. In reviewing the DSM-5, symptoms 1-3 and 8-10 refer to the term dependence and symptoms 5-7 to abuse. Adolescent substance use (abuse) has significantly increased over the last several years. It is, therefore, important for practitioners to understand the importance of an effective interview process with adolescents. Jaffe (1988) recommended some factors to consider in the interview as well as specific questions to ask that should include the following:

1. Do you drink on school grounds?
2. When you are truant, do you ever go drinking?
3. Do you miss school because of drinking or having a hangover?

A "yes" answer to any of these questions indicated an alcohol problem (Jaffe, 1998, p. 72). Additional questions were offered by Bergman, Smith, and Hoffman (1995): (a) Do you prefer to go to places where alcohol is available? (b) Do you ever drink more than you planned? (c) Does it take you more alcohol to get you "high" than it used to?

It is also important for the interviewer to be aware that adolescents and pre-adolescents suffering from learning disorders are more vulnerable to substance use (abuse), a comorbid factor that has often been overlooked (Karacostas & Fisher, 1993; Yu, Buka, Fitzmaruce, & McCormick, 2006).

Treatment (efficacious-adolescents)

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

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

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

Three theories are well known to be treatment effective. The theories include cognitive behavior therapy, acceptance and commitment therapy, and dialectical behavior therapy. Mindfulness is a technique used in each of the three therapies that is helpful to reduce stress and enhance regulation of the sympathetic nervous symptom (Jacques, 2017).

Non-Substance-Related Disorders

Gambling Disorder

Gambling is a new category that was listed within impulse-control disorders and is now a new behavioral addiction (King, 2014o). The description of maladaptive gambling behavior that characterizes this diagnosis is similar in many ways to the description of substance dependence and abuse. The newer definition highlights the risk involved in the persistent and recurrent problem in gambling (SAMPSA, 2014). The person risks something of value for a greater value. The gambling addiction can result in some destructive behaviors including deception about the extent of losses caused by gambling, family and job dysfunction, theft, repeated high-risk gambling, and repeated futile attempts to recover losses while gambling (APA, 1994, 2013). Illegal acts are no longer a symptom of a gambling disorder.

Interview and Assessment:

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

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

Incidence:

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

Instrument:

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

Treatment:

Gamblers Anonymous, with its 12-step program, has been a popular source of help for compulsive gamblers and is quite helpful when the client remains with the program (Petry, 2003; Petry et al., 2006).

There have also been some treatments developed for compulsive gamblers to help them develop skills to prevent relapse and manage high-risk situations and moods. Walker (1992) reviewed results across and between treatment modalities (e.g., Gamblers Anonymous, psychotherapy, psychoanalysis, behavior therapy, win therapy, case studies). Of the 2,031 individuals treated, 72% were in control of their gambling at six months post-treatment (based on a subsample of 1,568), 50% were in control at one-year post-treatment (based on a subsample of 225), and 27% were in control at two years post-treatment (based on a subsample of 237).

Treatments found to be most helpful were behavioral and cognitive interventions such as exposure-response prevention, group cognitive restructuring, and combined treatments such as cognitive interventions and pharmacological treatments, which used serotonin reuptake inhibitors to reduce compulsivity. Of interest is the fact that cognitive-behavioral therapy had the best overall success in treating gambling disorder (Petry et al., 2oo6; Toneatto & Ladouceur, 2003). SAMSHA (2014) listed behavioral, cognitive therapy, and cognitive-behavioral therapy as most effective treatments.

Neurocognitive Disorders

Neurocognitive disorders (NCD) replace the DSM-IV-TR category of delirium, dementia, amnestic and other geriatric cognitive disorders (King, 2013f). A primary deficit in cognition and disorders associated with a cognition deficit are what distinguish them from a neurodevelopment deficit from birth and early childhood. The major neurocognitive disorders are delirium, major neurological disorders, and minor neurological disorders. Subclassifications by cause or etiology are Alzheimer's disease, Lewy body disease, frontotemporal neurocognitive impairment, vascular neurocognitive impairment, traumatic brain injury, HIV infection, Huntington disease, substance use disorders, Prion disorders, and other causes (APA, 2013). This category contains only disorders with cognition as a core feature. Dementia is renamed as major or mild neurocognitive disorder. Delirium and dementia are common causes of cognitive decline or impairment. Delirium and dementia occur independently but do coexist.

Delirium

Disorders of cognition include delirium and major and minor neurological disorders (NCD). These disorders are defined as NCD due to another medical condition, use of a substance or medication, or combination of the two.

Making a diagnosis of the cognitive disorder is often more difficult for the elderly because it may be challenging to differentiate the ordinary vicissitudes of emotional and cognitive changes caused by aging from the abnormal cognitive functioning typical of dementia and other mental disorders can cause cognitive dysfunction (Gintner, 1995).

Definition and Interview:

The APA (2013) defines delirium as a disturbance in attention or awareness and further defined as a reduction in the ability to direct, focus, sustain and shift attention (Criterion A, p. 596). APA (2000) defined delirium as a disturbance in consciousness (i.e., reduced ability to focus, sustain, or shift attention) and disturbance in cognition affecting memory, orientation, language, or perception. These symptoms are commonly accompanied by disorientation (for the correct year, month, day, or hour) and labiality of mood (i.e., crying or irritability). The disturbance has a rapid onset (hours to few days, Criterion B) and may fluctuate with periods of normal mental functioning or may continue for days or weeks. There is typically evidence that delirium is a physiological consequence of an underlying medical condition, substance intoxication or withdrawal, use of medication, or a toxin exposure (APA, 2013, Criterion E).

The causes of delirium can be a general medical condition, substance use or withdrawal, multiple etiologies, and unspecified etiology. Specifiers include substance intoxication, substance withdrawal, medication-induced delirium, delirium due to another medical condition, and delirium due to multiple etiologies. The specifiers usually last about one week in a hospital setting (APA, 2013). Delirium types commonly are referred to as central nervous system disorders (i.e., head trauma), metabolic disorders (i.e., hypoglycemia), cardiopulmonary disorders (i.e., respiratory failure), substance-induced (i.e., alcohol withdrawal) and systemic or central nervous system illnesses (i.e., encephalitis; APA, 1999). Reactions to prescribed medications or combinations of medications are not uncommon sources of delirium in the elderly.

Gintner (1995) described four steps to follow or questions to ask during a differential interview for delirium. Step 1 is to determine if the psychological symptoms are accompanied by any metabolic or infectious problem, such as uremia caused by kidney failure, fluctuating blood sugars found in poorly managed or previously undiagnosed diabetes, or an acute urinary tract infection. Step 2 is to determine if there is a worsening, chronic physical disorder such as a cardiovascular or respiratory problem causing diminished oxygenation of the brain. Step 3 is to determine if a prescription drug (or unprescribed substance) could be inducing the symptoms, and Step 4 is to determine what cognitive impairments are present.

Incidence:

Community rates for prevalence are considered low (1% to 2%) although increases with age to approximately 14% by age 85 (APA, 2013). The prevalence of delirium varies considerably when reviewing different populations. For example, the APA (2000) reported ranges for the hospitalized medically ill patients to be 10% to 30%, hospitalized elderly 10% to 15% on admission, and 10% to 40% may be diagnosed with delirium while in the hospital. Prevalence rate indicated that in the

general population is low, 0.4%; however, this increases with age and by 55 years old is 1.1% (APA, 2013).

Typical delirium symptoms resolve within 10 to 12 days, yet for some disorders such as prolonged renal failure, may last up to 6 months. Elderly patients are likely to experience more prolonged symptoms.

Treatment:

Delirium is considered a medical emergency with a high mortality rate if the client is not correctly referred for medical diagnosis and treatment. In most situations, the risk to clients with delirium can be reduced if the condition is promptly diagnosed, treated, and managed in an orderly manner. The procedure involves searching for the underlying cause, treating the condition, monitoring the client's safety, developing alliances, educating the client and family members regarding the illness, and providing for environmental and supportive interventions. Wise (1995) views delirium treatment as reversing the reasons for delirium by treating the underlying medical condition and controlling any agitation that may accompany the client's confusion and paranoia.

Treatment requires the presence of a physician to determine the cause of the delirium and prescribe treatment, including pharmacological intervention. It is important that an individual suffering from a delirium be sheltered from excessive stimulation, supported by familiar people and surrounded by usual things. Psychoeducation, i.e., information about the disorder and symptom management, is recommended for the client and family members. Effective treatment for delirium is unknown at this time. Therefore, delirium strategies prevention is the treatment of choice. The Hospital Elder Life program is one such approach (Fong et al., 2017).

Instrumentation:

Instruments to consider in assessing delirium (APA, 1999):

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

Major or Mild Neurocognitive Disorder (Alzheimer's)

Definition and Interview:

Major or mild neurological disorders (MND) include Alzheimer's, frontotemporal lobar degeneration, Lewy body disease, vascular disease, traumatic brain injury, substance/medication use, HIV infection, Prion disease, Parkinson's disease, Huntington's disease, another medical condition, and multiple etiologies, unspecified (APA, 2013, p. 603). Major or mild neurocognitive disorders are progressive, multifocal cognitive deterioration that impairs daily activities (Klein & Kowall, 1998).

According to the APA (2013), MND (dementia) is a cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning, and memory, language, perceptual-motor, or social cognition (APA, 2013, Criterion A, p. 602).

The decline is associated with the concern of the individual and close family members, becoming aware of significant impairment of cognitive performance based on the concern of the individual or a substantial impairment in cognitive performance. Criterion B stipulates that the decline interferes with independence in daily living; however, these deficits do not occur in the context of delirium and are not explained by another mental condition. MND is an ongoing decline of multiple cognitive deficits with the preserved consciousness that can be due to a general medical condition, the persisting effects of a substance, or multiple etiologies (e.g., the combined effects of cerebrovascular disease and Alzheimer's disease) (APA, 2013, pp. 627, 632). A clinical description of major or minor neurological disorder frequently included inappropriate and disorganized behavior, retarded and impoverished thinking, speech typified by meaningless noises and lost words, and mood characterized by episodic anxiety, depression, and irritability.

Mild NCD features frequently accompany psychosis, paranoia and other delusions (disorganized speech and disorganized behavior are not characteristic of psychosis), mood disturbances, depression, anxiety, and elation. Additional symptoms can be agitation, confusion, frustration, sleep disturbances, apathy, wandering, disinhibition, hyperplasia, and hoarding (King, 2013o).

Diagnosis:

Memory loss and cognitive deficits are priority symptoms for assessment. Behaviors that disrupt the daily living of the client are issues for treatment and are to be included in the assessment.

Assessment:

The assessment for Alzheimer's dementia should include a thorough mental status examination with emphasis on the client's orientation to time, place, person, and purpose, and particular attention to memory. The interviewer should also assess for receptive and expressive language deficits, which are also common to dementia. Receptive language deficits are apparent when the client has difficulty understanding words while expressive language deficits are manifested by difficulty in speaking words (anomia—the name of an object), describing ideas and later identifying objects (agnosia). Demented individuals also lose the ability to sustain attention, lose the ability to start a task (inertia), and lose the ability to end a task (perseveration). Other areas of assessment include deficits in insight, judgment, abstraction, perception, and motor organization. It is also important to assess the degree of deterioration. The most severe loss of function will result in the client eventually losing all capacity to understand what he or she hears, follow instructions, and communicate needs.

Assessment of dementia is usually conducted in phases. The first phase often referred to as a neuropsychiatric assessment, involves interviewing the client and one or more individuals who are aware of the changes in the client's cognition. The second phase is a family assessment, and the third phase involves diagnostic testing. During the fourth phase and concluding phase, the counselor holds a conference to report the evaluation results and recommendations for treatment.

When interviewing Alzheimer's disease as a cause of dementia, memory impairment is a first-order question. Short-term memory is noted in the early phase of Alzheimer's disease, although long-term memory is eventually affected along with agnosia, apraxia, and loss of executive functioning (Benson & Cummings, 1986; Cummings & Benson, 1983). Because memory disturbance is the most common initial symptom, Alzheimer's clients have an impaired ability to learn new information or to recall previously learned material. There are also difficulties acquiring and retaining information as well as impairment in the recollection of short-term and recent events (Parker & Penhale, 1998). One or more of the following cognitive abnormalities must also be present in advancing Alzheimer's: aphasia (language disturbance), apraxia (sequential motor activities), agnosia (familiar objects), and disturbances in executive functioning (i.e., abstract thinking, organizing; APA, 2000, p. 148).

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

Orientation becomes increasingly disturbed (i.e., disruption in the client's sense of time, place, and person). Judgment and problem-solving abilities become more severely impaired, and the client has difficulty in making sense of events taking place. Individuals with dementia also develop abnormal behaviors, incontinence, wandering, noisiness, aggression, vacant facial expressions, and the loss of capacity to self-monitor, speak coherently, and interact normally.

Whenever dementia is suspected, the client may be too impaired cognitively to provide an accurate personal history. In that case, the counselor should interview a family member or other caretaker about the client's abilities, deficits, and daily functioning. Because dementia may not be present in a pure form, the interviewer needs to be familiar with the different types of neurocognitive disorders (delirium, delusions, depressed mood, and uncomplicated). It is also important to know that symptoms of dementia can be superimposed on other disorders such as delirium, depression, and physical conditions such as hypothyroidism and Parkinson's disease that may also cause depression and dementia (Cummings, 1992).

Incidence:

Reviewing data from the APA 2013 and 2000 reports indicated that the data varies. APA (2013) cited prevalence rate by etiological type, and estimates are only available for older populations. The data cited by APA shows dementia to be 1% to 2% at age 65 and as high as 30% by age 85 (APA, 2013). It is estimated that between 2% and 4% of the population over 65 has dementia of the Alzheimer's type, the most common subclassification of NCD form of MND (APA, 1994). The incidence of dementia in the 85 and older age group is reported to be approximately 23% and increasing to 58% in those over 95 (Ebly, Parhad, Hogan, & Fung, 1994). Kukull et al. (2002) indicated that an estimate for dementia at age 70 is approximately 6% of the population but increases to 50% at age 85. The second

most common form of dementia is caused by strokes and is referred to as multi-infarct or vascular dementia (Read, 1991).

Treatment (Dementia):

Logsdon et al. (2007) conducted a review of evidence-based treatments for disruptive behaviors about psychosocial (caregiver support and education, environmental modification, and caregiver counseling) and psychological intervention (based on behavioral and social learning theory). The authors reviewed the effects of environmental interventions, including bright light therapy, pet therapy, aromatherapy, and music or white noise therapy; educational interventions (in residential care settings) involving nursing staff assisting with dressing, bathing, and providing other miscellaneous interactions. Their findings indicated that these interventions did not lead to any significant change in the incidence of disruptive behaviors. It was also reported that individualized treatment plans and in-home counseling designed to support cognitive limitations and provide pleasant activities in a structured setting with regular routines resulted in a significant reduction in disruptive behaviors.

Logsdon et al. (2007) concluded that behavioral and social learning theory programs typically used structured treatment manuals. The structured guide specified goals, homework assignments, and handouts. The programs effectively reduced disruptive behaviors of patients with dementia by teaching problem-solving and behavioral-activation and training family members or staff to note and observe problem behaviors and adjust or modify the environment (developing a schedule and contributing to interpersonal interaction).

The Peaceful Mind Manual is an evidence-based cognitive-behavioral intervention workbook (Stanley et al., 2009) used by a collateral and the client to reduce anxiety-accompanying dementia and to reduce the distress of the caregiver. The approach is designed to teach skills of awareness, breathing, calming self-statements, coping self-statements, increasing activity, and sleep management. The emphasis is a behavioral rather than cognitive intervention, slowing the pace, limiting the material to be learned, and increasing repetition and practice, using cues to stimulate memory (Paukert et al., 2013).

Finally, the individual suffering from progressive dementia eventually loses all capacity for daily living and becomes so impaired that hospitalization or direct personal care is required. However, this slow demise does not occur when individuals suffer from rapid onset cognitive impairment caused by a vascular catastrophe or stroke. Rapid onset of signs and symptoms (i.e., the sudden loss of ability to recall common words used the day before or the loss of capacity to perform everyday tasks such as driving a car) are more often associated with vascular dementia (APA, 1994). Family members may observe silent strokes or mini-strokes not easily recognized by the individuals affected. Finally, a high percentage of persons who have dementia also suffer from depression, psychosis, or delirium, which can complicate their diagnoses.

Instrumentation:

Caution should be exercised when using performance-oriented tests with older adults. These types of instruments may not consider sensory or psychomotor deficits (Hinrichsen, 1990). Depression

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

The Mini-Mental Status Questionnaire (Folstein, Folstein, & McHugh, 1975) is often used to screen for cognitive functioning, which includes orientation, attention, memory, language, ability to identify objects, and the ability to perform different types of sequential movements. The Clock Drawing Task (Clock Test) is a useful initial screening instrument for dementia (Mendez, Ala, & Underwood, 1992; Tuokko, Hadjistavrpoulos, Miller, & Beattie, 1992). The Blessed-Roth Dementia Scale, as Strang, Bradley, and Stockwell (1989) pointed out, can be used for assessing competence in personal, domestic, and social activities as well as changes in personality, interests, and drive.

Some specific instruments for assessing sensory-perception, attention, memory, language, manipulatory, motor output, and neuropsychological functioning are available. Some are:

1. Luria-Nebraska Neuropsychological Battery (LNNB; Macciocchi & Barth, 1996): motor, touch, rhythm, visual, speech, writing, reading, arithmetic, memory, and intelligence
2. Bender Gestalt Test (BGT; Hutt, 1977): brain impaired, apraxia
3. Halstead-Reitan Test Battery (Reitan & Wolfson, 1993)
4. Blessed-Roth Dementia Scale (Strang et al., 1989)
5. Cornell Scale for Depression in Dementia (Alexopoulos, Abrams, Young, & Shamoian, 1988)

Treatment: (Alzheimer's):

Major or mild neurological disorder due to Alzheimer's dementia is a persistent, progressive, and eventually life-threatening disorder. Treatment with selected medications, when prescribed during the very early stages of the disease, has been shown to reduce the progression of the symptoms and prolong functional memory, possibly slowing the deterioration process but never curing it. Although medication may slow disease progression, there is no known cure.

Donepezil (Aricept), rivastigmine (Exelon), and galantamine (Reminyl) are the most frequently prescribed medications, called acetyl cholinesterase inhibitors. These medications delay the breakdown of acetylcholine in the brain, a key neurotransmitter that is important for memory. The acetylcholinesterase inhibiting group of medications is most commonly prescribed in early stages of Alzheimer's dementia. Another type of medication, memantine (Namenda), commonly used to treat moderate to severe forms of dementia, shields the brain from a neurotransmitter called glutamate which ordinarily takes on a stimulating function to improve learning and form memories. In individuals with Alzheimer's glutamate becomes an 'exitotoxin' which contributes to the death of brain cells. Clients with Alzheimer's disease may be prescribed an acetylcholinesterase alone, memantine alone, or both together to reduce disease progression.

The preferred treatment for individuals with dementia is to provide a caring, predictable, structured, and orienting environment–-preferably in the family home for as long as possible. As the disease progresses, it typically is more difficult for family members to continue home care without help. Professional caregivers should regularly assess the patient for self-care and daily living abilities

within the environment and, based on the severity of the progression of the disease, be ready to transition him or her to more structured personal care.

Cohen-Mansfield, Hai, and Comishen (2017) recommended the comprehensive process model of group engagement often group structured recreation activities to counteract boredom, negative affect, and aggression and to increase a feeling of belonging, esteem, and self-actualization needs. The engagement recreational activities examples include reading, choral, baking, creative story-telling, brain games/fitness, active games, exercise, poetry, holiday newsletters and holiday discussions. Different activities can be developed depending on environmental attributes, personal attributes, and stimuli attributes of the person-person interactions.

Personality Disorders

This supplement presents a limited amount of information regarding personality diagnoses. The overall prevalence of these disorders is probably unknown; however, at some time approximately all adults have experienced depersonalization, as well as one-third of those exposed to life-threatening dangers and 40% of hospitalized clients with mental disorders (APA, 2013, p. 531). The ten personality disorders were left untouched regarding symptoms and definitions. The DSM-5 lists ten personality disorders, which result in impairments in social and occupational functioning. This diagnostic category uses a polytheism approach that utilizes taxonomy for diagnosis, which is based on a clustering of traits. According to the DSM-5, personality disorders are defined as "inflexible and maladaptive patterns of behavior of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress" (APA, 2013, p. 647).

Individuals with personality disorders suffer from stable patterns of behavior that adversely affect how they relate to others, how they think about themselves and the world around them, how they experience emotion, how they function socially, and how well they can control their impulses. Personality disorders are characterized by the chronic use of inappropriate, stereotyped, and maladaptive ways of responding to other people and stressful circumstances. Personality disorders are enduring and persistent styles of behavior and thought, not atypical episodes, which encompass a group of behavioral disorders that are different and distinct from the psychotic and neurotic disorders.

The DSM-5 official psychiatric diagnostic manual defined a personality disorder as an enduring pattern of inner experience and behavior that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

The general diagnostic criteria for a personality disorder are an enduring pattern of behavior whereby the client markedly deviates in two of four areas (cognition, affect, interpersonal functioning and impulse control). The enduring pattern is characterized by a long-lasting inflexible and pervasive impairment in personal, social, and occupational situations that is likely to have started during

adolescence or early adult years. The behavior is not the result of a substance or a medical condition (APA, 2013, p. 648).

Turkat (1990) estimated that at least 50% of clients who have a clinical diagnosis concurrently have a personality (previously referred to as an Axis II) disorder. In assessing a personality disorder, behaviors must be manifested by abnormalities in two or more of the following: cognitive, interpersonal functioning, affect, or impulse control. Also, there is an inflexibility and pervasiveness to the disorder, which has to cut across personal and social situations. Finally, a resulting impairment in functioning occurs in social, occupational, and other important areas of life (APA, 2013, p. 646). An important goal in assessing for a personality disorder is to determine that it is manifested by trait-enduring characteristics rather than a state (transitory feeling, i.e., fear or worry; Gregory, 2000). Fong (1995) identified two other features necessary for the diagnosis of a personality disorder. The first is to determine if the problem is perceived by the client as ego-dystonic (not part of self) or ego-syntonic (the integral part of self). Clinical problems, as opposed to personality disorders, are ego-dystonic, whereas personality disorders are ego-syntonic. The second feature is to determine if the personality disorder reveals a dysfunction in occupational or social functioning. Finally, Overholser (1989) noted that personality disorder clients will repetitively utilize the same maladaptive coping skills.

Fong (1995) stated that during the interview the counselor should be aware of the manner in which personality disorder clients present the problem and the context in which they seek help. Furthermore, the following signs should be suspect: (a) the client with a personality disorder is likely to abruptly discontinue therapy if some progress is made, (b) is unaware of his or her impact on others, (c) is unresponsive or noncompliant to the schedule or terms of the treatment, and (d) becomes entangled in some manner with institutional systems.

Distinctive features of personality disorders are early onset (childhood), chronic course (patterns) and ego-syntonic features (Widiger, 2003). Ego-syntonic features are a part of the identity.

There are ten recognized personality disorders, typically arranged into three clusters.

1. Cluster "A"- Paranoid, Schizoid, and Schizotypal Personality Disorders
2. Cluster "B" - Antisocial, Histrionic, Narcissistic and Borderline Personality disorders
3. Cluster "C" - Avoidant, Dependent and Obsessive-Compulsive Personality Disorders

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

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

Comorbidity:

Cluster A: delusional disorders, schizophreniform disorder, schizophrenia

Cluster B: mood and impulse control disorders, substance use disorders, and bulimia

Cluster C: anxiety disorders, agoraphobia, social phobia, obsessive-compulsive disorders

Differential Diagnosis:

The primary purpose of making a differential diagnosis of personality disorder is to determine whether the individual's symptoms represent a state or trait disorder. The critical feature of a state personality disorder is episodic personality dysfunction while trait personality disorder is non-episodic and reflects a stable personality disorder.

Interview Process:

A diagnosis of personality disorder, although sometimes suspected during a first interview, is made in phases or increments and confirmed only after several clinical interviews. The person doing the interviewing begins to identify the cluster and disorder by the end of the first interview. In most cases, the interviewer will defer making a specific personality diagnosis to refrain from labeling or establishing a bias, although identifying a cluster diagnosis can sometimes be made to facilitate treatment.

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

Adler (1990) highlighted that clients diagnosed with a personality disorder experience interpersonal and occupational impairments (inability to find success or satisfaction in loving and working-demanding, intolerant, competitive, or even oppositional).

Everly (1989) identified primarily for Clusters B and C markers such as cognitive distortions, irrational expectations, and rigid coping mechanisms, and susceptibility to major stress-related syndromes.

Personality disorder clients do not provide objective data regarding their personality traits so the interviewer should obtain objective information from external sources as well as by observing patterns of behaviors in the areas of social relations and work functioning (Western, 1997). Some possible external sources might include the use of instruments. Instruments may include The Personality Inventory for DSM-5 (PID-5)—Adult. Structured interview instruments may include the Personality Disorders Questionnaire-4 (Hyler, 1994), the Millon Clinical Multiaxial Inventory-III (Millon, Millon, & Davis, 1997), and the Minnesota Multiphasic Personality Inventory-2 (Somwaru & Ben-Porath, 1997). Clinical interviews may be the Structured Interview for the DSM-IV Personality Disorders (Pfohl, Blum, & Zimmerman, 1997) the International Personality Disorder Examination (Loranger, 1999), and Structured Interview for the DSM-IV (assesses all 10 personality disorders and uses a five-year window), personality disorders (First, Gibbon, Williams, & Benjamin, 1997) and the Personality Disorder Interview-IV (Widiger & Sanders, 1995). The Diagnostic Interview for DSM-IV Personality Disorders assesses 10 DSM-IV-TR personality disorders.

Of importance to clinicians considering a personality diagnosis is ethnicity. Chavira et al. (2003) researched four personality disorders (borderline-BPD, schizotypal-STPD, avoidant-AVPD, and obsessive-compulsive-OCPD) across three cultural groups (African Americans, Hispanic Americans, and Caucasian Americans). Their subjects (554) were drawn from the Collaborative Longitudinal Personality Study. Their findings indicated that there are higher rates of BPD in Hispanics than in Caucasians and African Americans and higher rates of STPD among African Americans than Caucasians. The concluding comments showed that Caucasians, African Americans, and Hispanic Americans may show different patterns of personality pathology and that caution should be exercised until additional research is available.

In assessing for pathology with culture and ethnicity, it is important to understand how the individual perceives and expresses a problem, the interaction between the clinician and the person, and if the person decides to seek treatment. Therefore, it is essential for the clinician to become familiar with the language, behavior, and the interpersonal style of clients of culture. The Cultural Formulation Interview is recommended (APA, 2013).

Evaluation and Instruments/Inventories:

Clinicians who evaluate personality disorder clients are faced with limited objective data and must rely on their observations of behavioral patterns and reports of social relations and work functioning (Western, 1997). The use of instruments and structured interviews can improve the diagnostic process.

Following are instruments, screeners, questionnaires, and inventories that are used for personality disorders.

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

1. Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998)
2. The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; DiNardo et al., 1994)
3. The Inventory of Interpersonal Problems (IIP-64; Horowitz et al., 2000)
4. The Personality Disorders Questionnaire-4 (Hyler, 1994)
5. The Millon Clinical Multiaxial Inventory-III (Millon et al., 1997)
6. The Minnesota Multiphasic Personality Inventory-2 (Somwaru & Ben-Porath, 1997)
7. The International Personality Disorder Examination (Loranger, 1999)
8. The Structured Interview for the DSM-IV (assesses all ten personality disorders and uses a five-year window; First, Spitizer et al., 1997; Pfohl et al., 1997)
9. The Personality Disorder Interview-IV (Widiger & Sanders, 1995)
10. The Diagnostic Interview for DSM-IV Personality Disorders assesses 10 DSM-IV-TR personality disorders

11. The Coolidge Axis II Inventory (CATI; Coolidge & Merwin, 1992)
12. The Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley & Jackson, 2004), a self-administered questionnaire
13. The Narcissistic Personality Inventory (Raskin & Hall, 1979; Raskin & Terry, 1988), a self-administered questionnaire
14. The Wisconsin Personality Inventory (Klein et al., 1993; Smith, Klein, & Benjamn, 2003), a self-administered questionnaire
15. Miville-Guzman Universality-Diversity Scale (Miville et al., 1999). This scale will monitor for adaptive narcissism

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

Cognitive features:

Paranoid-301.0 (F60l0): A pervasive distrust and suspiciousness of others.

Schizoid-301.20 (F60.1): Cognitive functioning is somewhat restricted, although individuals with this disorder tend to have a rich fantasy life without any apparent overt cognitive abnormalities. Because they cannot establish interpersonal relationships, their speech tends to be impersonal and with little or no emotional content.

Schizotypal-301.22 (F21): These individuals have thinking peculiarities with illusions and a vivid fantasy world. Speech may be idiosyncratic with unusual phrasing or terminology.

Antisocial-301.7 (F60.2): Cognitive patterns are marked by poor decision-making but often typified by glib and sometimes persuasive speech. Researchers have found neurophysiologic findings that confirm the presence of deficiencies involving the prefrontal cortex associated with stimulation seeking, bad decision-making, rule-breaking, and irresponsible behavior (Raine, Lencz, Bihrle, LaCasse, & Coletti, 2000).

Histrionic-301.50 (F60.4): The cognitive style of individuals with HPD is manifested by superficial thinking that lacks detail. Speech patterns are also vague and devoid of specificity.

Narcissistic-301.81 (F60.81): Cognitive styles of narcissistic individuals reflect a grandiose sense of self, fantasies of unlimited success, power, brilliance, beauty, and uniqueness.

Borderline-301.83 (F60.3): Borderline traits are reflected in cognitive styles that reveal no apparent abnormalities except for dramatic shifts between over-idealization and devaluation of people with whom they are intensely involved.

Avoidant-The cognitive style of this disorder reflects a negative self-image accompanied by verbiage that indicates feelings of ineptness and inferiority.

Dependent-301.6 (F60.7): Dependent personality traits are reflected by a lack of self-confidence and inability to make decisions.

Obsessive-Compulsive-301.4 (F60.5): Individuals with obsessive-compulsive personality traits are rigid in their thinking and focus on details, rules, lists, and order (Skodol, 2005).

Affective features:

Paranoid: Paranoid individuals are emotionally over-reactive and have a pervasive distrust and suspiciousness of others.

Schizoid: Schizoid individuals lack affective responsiveness, and their speech tends to be impersonal and with little or no emotional content.

Schizotypal: These individuals have inappropriate or constricted affect, thinking peculiarities with illusions and a vivid fantasy world. Speech may be idiosyncratic with unusual phrasing or terminology.

Antisocial: Individuals with this disorder may mask a hidden aspect of the personality by appearing credible and calm while beneath that veneer is often tension, irritability, and even rage.

Histrionic: This disorder is characterized by shifts from shallowness to exaggerated and highly reactive and emotionally dramatic expressiveness.

Narcissistic: Narcissistic personality traits are characterized by haughty self-absorption with an inability to be emotionally empathic toward others.

Borderline: Borderline traits include labiality of mood and outbursts of anger, particularly when threatened with loss or separation.

Avoidant: Avoidant personality traits are characterized by anxiety, shyness, and emotional distance from others.

Dependent: This disorder is characterized by superficial compliance due to a fear of offending others and by anxiety when threatened with or experiencing separation from a significant other.

Obsessive-Compulsive: Obsessive individuals reflect troubling feelings such as apprehension, anxiety, disgust, tension, or a sensation that things are "not just right." Compulsive behaviors are directed at attempts to relieve anxiety. Individuals with this disorder also have difficulty expressing affection and loving feelings toward others and often demonstrate excessive rigidity and an unwillingness to discard worthless items (Skodol, 2005).

Interpersonal features:

According to Widiger (2003), all individuals with personality disorders experience interpersonal difficulties. Interpersonal difficulties manifest themselves in two oppositional relationship styles: dominance versus submission and affiliation versus detachment. Interpersonal dominance is noted for antisocial, histrionic, narcissistic and obsessive-compulsive personalities. Individuals with avoidant and dependent personality disorders are prone to submissive behaviors. Individuals with histrionic, narcissistic and dependent personality disorders have a greater degree of affiliation behaviors that

reflect more distress when threatened by the loss of relationships. Individuals who guard against affiliation and remain detached are those with paranoid, schizoid, schizotypal, avoidant, and obsessive-compulsive personality disorders.

Attachment features:

Research studies have been done to measure attachment styles associated with differing personality disorder clusters. Some studies have also shown that Cluster A (odd or eccentric disorders) and Cluster C (anxious or fearful disorders) pathologies are more strongly associated with attachment than Cluster B. However, interpreting personality data as either dimensional or categorical is of significant importance to the conclusions that can be drawn. Last, it is important to control for the influence of comorbid personality pathology when examining the relationship between Cluster B personality pathology and attachment.

Control features:

Individuals with personality disorders display behavioral and emotional symptoms that can be categorized as either over-control or under-control.

Over-control:

Dependent personality disorder (DPD) is characterized by behaviors reflecting excessive control in the areas of decision making and starting new projects.

Avoidant personality disorder (AvPD) is characterized by behaviors reflecting excessive control in the areas of emotional expression and healthy risk-taking.

Obsessive-compulsive personality disorder (OCPD) is characterized by behaviors that often reflect excessive control in the areas of flexibility and 'letting go' that causes excessive rigidity and an unwillingness to discard worthless items (Skodol, 2005).

Under-control:

Antisocial personality disorder (ASPD) is characterized by insufficient control of anger as reflected by angry outbursts.

Borderline personality disorder (BPD) is characterized by insufficient control of anger and sexuality as reflected by inappropriate behaviors of anger and episodes of hypersexuality.

Defense Mechanisms:

'Normal' individuals use 'mature' psychological defense strategies based on accurate understanding of social reality and ability to cope with life in flexible ways, while individuals with personality disorders use more primitive and less adaptive defensive modes that lack flexibility. One example of a mature defense is the use of humor to break up negativity and force people to look at a brighter side of their predicaments while maintaining distance from negative emotions.

Primitive psychological defenses are used to cope with reality and avoid negative memories or emotions. Among the more primitive psychological defenses is denial, the most famous of the classical

defense mechanisms when individuals refuse to accept matters of truth about themselves in spite of any reality that states otherwise. Examples of denial are individuals with dependent (DPD), histrionic (HPD), avoidant (AvPD) or borderline personality disorder (BLPD) who deny feelings of helplessness or fear of separation or evidence of a relationship about to break apart. Individuals with BLPD who use splitting as a defense tend to over-idealize rather than deny the presence of negative qualities in self and others.

Acting out is considered a psychological defense when negative emotions are impulsively converted into destructive or self-destructive behaviors, as seen when an individual with antisocial personality disorder acts out with an offensive rage attack. Individuals with borderline traits may act out sexually or have episodes of self-mutilation and explosive tempers.

Projection is a psychological defense mechanism wherein individuals project onto other people the feelings they deny exist within themselves. For example, individuals with personality disorders (DPD, OCPD, BLPD, and ASPD) often have problems accepting their angry feelings while accusing others of being angry.

Displacement has been described as a "kicking the dog" defense. For example, an individual who was provoked on the job displaces his or her anger by taking it out on a friend or family member, thus transforming his or her psychological position from one of powerless humiliation to dominant control. This defense can occur with any individuals, particularly those who tend to repress or suppress their angry feelings.

Repression was initially described by Freud as an unconscious psychological defense that held uncomfortable thoughts beneath the surface of consciousness. Repressed thoughts or memories of unacceptable or traumatic events from the past might result in anxiety or depression in individuals with HPD or OCPD, for example.

Suppression is a more voluntary defense whereby an individual consciously pushes thoughts out of consciousness. Suppression might occur, for example, in someone with OCPD or DPD who suppresses thoughts of retaliation after being criticized by someone.

In intellectualization, individuals tend to cope with painful or anxiety-producing events by retreating into a cognitive analysis of the event and thus maintain distance from the emotions surrounding the event. A similar defense, rationalization, occurs when people make up reasons after the fact to explain away a course of action they have taken about which they feel conflicted. Individuals with OCPD, APD, and BLPD often use these defenses.

Reaction formation is manifested by behavior that is in stark contrast to that which an individual believes about himself or herself. For example, individuals with DPD may tend to be excessively dominant and controlling in their relationships although, at the same time, denying they are afraid of losing those relationships.

Splitting occurs when positive and negative representations of self and others are dissociated or 'split' apart inside a person's mind. This is a mental mechanism, frequently associated with child abuse that enables an abused child to 'split-off' painful and negative images of self and parent. This defense

makes it possible for the child to over-idealize the parent who abused, neglected, and abandoned him or her and maintains the image of the over-idealized 'good parent' within consciousness while splitting off the 'bad' parent along with the 'bad self' associated with negative feelings. That splitting defense persists into adult life in those individuals with the borderline personality disorder, and the split-off bad parent will be projected onto individuals perceived as abusive or neglectful. As a result, someone with BPD may begin a relationship by over-idealizing the other person via the splitting defense but will not be able to sustain that over-idealization. In psychoanalytic object relations theory, this is referred to as an attempt to maintain an over-idealized 'self' ('good' self-other object representations) while splitting off the devalued 'self' ('bad' split-off self-other object representations) associated with negative feelings of fear, anger, guilt, and grief. However, it is not possible for these individuals to sustain stable behaviors, emotions, or relationships. Individuals with BLPD or NPD tend to view others in either 'black or white' terms and also tend to 'split' members of a therapeutic team into either good or bad therapists or therapeutic team members. They will begin therapy by over-idealizing their therapists or team members until feelings of anger or disappointment emerge, at which point, they will suddenly devalue those individuals and break off the relationships or terminate therapy.

Dissociation is a psychological defense that disconnects certain unpleasant memories and emotions from conscious awareness. Dissociation is a typical response to severe traumatic experiences and is also associated with near-death experiences (NDEs). Individuals who have experienced dissociation as a response to severe trauma or abuse may have a particular disorder such as acute stress disorder (Millon, 1981).

In summary, defense mechanisms typically found in specific personality disorders include splitting, 'acting out' and displacement with APD and BLPD and dissociation with BLPD and in some individuals with NPD. Narcissistic individuals are prone to acting out and using denial and splitting. Individuals with DPD use denial and sometimes dissociation while individuals with AvPD have traits that include reaction formation, denial, and dissociation (Vaillant & Drake, 1985). Defense mechanisms employed by obsessive-compulsive personality disorder are reaction formation, isolation and undoing (Millon & Davis, 1996b) and those with the histrionic personality disorder may use dissociation, repression, and displacement.

Instruments for Specific Personality Disorders

1. Antisocial Personality-Composite International Diagnostic Interview (CIDI; Robins et al., 1988)
2. Avoidant Personality Disorder- The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV). The ADIS screens for all mood and anxiety disorders with a rating from 0-8 and clinical thresholds.
3. The Inventory of Interpersonal Problems (IIP-64) is a screening tool for AVPD and provides a rating on affiliation and dominance. The disorder is associated with interpersonal behaviors that are low in dominance and low in affiliation (Leising, Rehbein, & Eckardt, 2009).
4. Borderline Personality Disorder-The Revised Diagnostic Interview (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989; Zanarini, 2009). This instrument provides scales for impulse action patterns, affect, cognition and interpersonal relations.

5. Narcissistic Personality Disorder--The Diagnostic Interview for Narcissism (Gunderson & Ronningstam, 1990). This instrument measures for grandiosity, interpersonal relations, reactiveness, affect, and mood states and social and moral judgments.
6. Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First, Spitzer, & Williams, 1997)
7. Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5PD; First, Williams, Benjamin, & Spitzer, 2016)

Treatments:

Clients diagnosed with a personality disorder often seek treatment for symptoms such as depression and anxiety rather than a personality disorder. When those symptoms subside, clients diagnosed with a personality disorder frequently interpret this as a sign of progress and will abruptly quit therapy. These clients may also feel threatened by a reality-based therapeutic process that challenges their beliefs and behaviors. Thus, they typically prefer to avoid testing their beliefs to sustain their behaviors as normal rather than disorders.

It will be a challenge for a counselor to help a client feel validated and agree to pursue more adaptive strategies when he or she maintains an attitude of denial about his or her maladaptive behaviors. Counselors must be careful to demonstrate genuine nondefensiveness and noncompetitiveness while, at the same time, remaining sensitive to how the client perceives the counselor's verbal and nonverbal communication. If the client perceives the counselor as critical, he or she will feel rejected and become defensive.

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

Couple's therapy may be somewhat effective when one member can be objective toward understanding the problems and need for change when the other member has been diagnosed with a personality disorder (Links & Stockwell, 2002). Glikauf-Hughes and Wells (1995) recommended the importance of first assessing workability when one member of the couple has a narcissistic disorder. Workability has to do with the capacity to resolve or ameliorate four characteristics: acting out, defensiveness, vulnerability, and narcissistic gratification.

Ronningstam, Gunderson, and Lyons (1995) identified three specific events that have been found to have a positive impact on an individual with a narcissistic personality disorder: (a) corrective achievements, (b) corrective disillusionments, and (c) corrective relationships. If a narcissistic individual reflects on and chooses to value one or more of these achievements, he or she may be receptive to accomplishing change in the narcissistic self-concept. The authors suggested that if these achievements take place, a realistic self-evaluation will lessen the need for fantasies and exaggerations. Also, correcting narcissistic traits includes learning to change destructive ways of relating to establishing stable, mature relationships rather than dependent or dominating ones.

The following treatments have been recommended for some personality disorders where there is a reasonable likelihood that trust and a degree of an alliance between the counselor and client can be established.

1. Schema therapy is an innovative psychotherapy developed by Jeffrey Young. The schema questionnaire measures for 18 schemas and integrates elements of cognitive therapy, behavior therapy, object relations, and gestalt therapy into one unified approach to treatment. This therapeutic approach has recently been blended with mindfulness meditation for clients who want to add a spiritual dimension to their lives. The four themes of schema therapy are early maladaptive schemas, core emotional needs, schema mode, and maladaptive coping (Young et al., 2003).

   Schema therapy is recommended for clients whose disorders are significantly impacted by underlying personality disorders, of which BLPD is a prime example (Young & Brown, 2001). Treatment is usually mid-term or long. According to Young, a core theme is an early maladjustment from early childhood with an emphasis on interpersonal relationships. Three concepts of this approach are coping styles, schemas, and models. Modes represent the coping responses and schemas presently active. Schema healing represents a diminishing of memory intensity, emotional charge, bodily sensations strength, and maladaptive cognition attached to the schema. Behavioral changes are targeted at learning new coping styles to replace the three maladaptive styles that are surrender, avoidance, and overcompensation. Research on the effectiveness of treatment has focused primarily on mood and social functioning.
2. Dialectical behavior therapy (DBT), developed by Marsha Linehan at the University of Washington (Linehan, 1993b), is a biosocial treatment approach which focuses on helping clients stabilize psychophysiological dysregulation by applying modalities of Zen mindfulness meditation, problem-solving, exposure techniques, skills training, contingency management and cognitive modification. This treatment approach combines standard cognitive-behavioral techniques for emotion regulation and reality testing with concepts of distress tolerance, acceptance, and mindful awareness mostly derived from Buddhist meditative practice.

   DBT is the only therapy that has clinical trials for borderline personality disorder (BLPD). Mindfulness is used within the framework of DBT as the basis for regulating emotions by controlling one's attention to become more aware of current thoughts and feelings. A successful, mindfulness intervention will increase an individual's ability to manage negative emotions, decrease physical symptoms, and increase coping skills and a sense of well-being. Regulating emotions is a major component of DBT since it is a treatment modality for BLPD that focuses on reducing vulnerability to negative emotions by increasing feelings of competence and enhancing positive emotions.
3. Interpersonal psychotherapy (IPT): IPT has literature-based support to treat some diagnoses--mood disorders, chronic depression, bulimia, and anxiety disorders (Bleiberg & Markowitz, 2005, 2008; Weissman, Markowitz, & Klerman, 2000). IPT is a time-limited, manual-based diagnosis-targeted, life-event-based treatment (Markowitz, 2003, p. 847). The primary focus of IPT is to emphasize skill building for social and interpersonal experiences (Seligman &

Reichenberg, 2012). However, there is limited support for IPT's effectiveness to treat personality disorders (Markowitz, 2005), although it has been found to be somewhat more useful for Clusters B and C. The research has been more associated with theoretical rather than treatment outcome.

4. Psychodynamic psychotherapy has been a successful treatment approach when the following factors are present: (1) the patient's motivation for profound change with accompanying psychological mindedness, (2) a capacity for transference work, (3) a propensity to regress, (4) an ability to control impulses, (5) adequate frustration tolerance and (6) ample financial resources (Gabbard, 2002). Clients diagnosed with a personality disorder who are candidates for psychodynamic therapy are obsessive-compulsive, hysterical, narcissistic, avoidant, and dependent personality disorders. Randomized controlled trials demonstrate effectiveness support for Cluster C personality disorders (Gottdiener, 2006).
5. Attachment-based psychotherapy is recommended for Cluster B personality disorders (Bateman & Fonagy, 2003, 2006a, b). Treatment is directed at a more secure attachment through stabilization of the self-structure, formation of a coherent sense of self and enhanced capacity to form relationships.
6. Transference-Focused Psychotherapy (TFP) is a highly structured, twice weekly-modified psychodynamic treatment based on Kernberg's object relations model of borderline personality disorder (Clarkin, Yeomans, & Kernberg, 2006). TFP views the individual with borderline personality organization (BPO) as holding unreconciled and contradictory internalized representations of self and significant others that are affectively charged. The defense against these different internalized object relations leads to disturbed relationships with others and with self. The distorted perceptions of self, others, and associated affects are the focus of treatment as they emerge in the relationship with the therapist (transference). The intended aim of the treatment is focused on the integration of split-off parts of self and object representations, and the consistent interpretation of these distorted perceptions is considered the mechanism of change. While TFP represents one of some treatments that may be useful in the treatment of BPD, only TFP has been shown to change how patients think about themselves in relationships (Levy et al., 2006).
7. Mentalization-based psychotherapy (MBP) is a type of psychotherapy that focuses on the ability to "mentalize," or recognize thoughts, feelings, wishes, and desires, and see how these internal states are linked to behavior.
8. Supportive Psychotherapy: Supportive therapy aims to relieve anxiety. Goals of supportive psychotherapy are restorative and maintenance of functioning. The therapist should respond to the client's questions, avoid confrontation and interpretation, foster verbal expression of thoughts and feelings, and find something for the client to like and respect. Histrionic clients respond best to supportive therapy when compared to other personality disorders (Blum, 1973).
9. Group Treatment: Group treatment provides a cohesive social milieu and interpersonal learning. There is a lack of randomized control studies for group effectiveness. For those studies that have been conducted, the support mostly favors the borderline, avoidant and

dependent personality disorders. Different personality disorders present specific issues for group process, including a dislike for or competition about sharing the leader, outbursts, aggressive behaviors, safety, confidentiality, understanding, and even suicidal threats (Piper, Ogrodiniczuk, Lamarche, & Hilscher, 2005).

10. The therapist during group treatment is likely to see demonstrated the pattern behaviors of personality-disordered individuals. Therapists will observe interpersonal behaviors that typify individuals with dependent, histrionic, or borderline personality disorder. Some personality-disordered clients challenge the norms and guidelines, weakening the cohesion for group work (antisocial, borderline, obsessive-compulsive). The most difficult to treat in a group are individuals with borderline and narcissistic personality disorders. Avoidant personality disordered clients fear the possibility of humiliation and criticism in the group setting. If they are motivated to be in a group, friendship formation can be observed and reinforced. The settings and types of group work include short-term outpatient, long-term outpatient, day treatment and inpatient/residential. For each personality disorder, a rating for group suitability is as follows: Cluster B: borderline (effective), narcissistic (problematic), histrionic (helpful), antisocial (not suitable). Cluster C: avoidant (effective and useful), dependent (effective and treatment of choice), obsessive-compulsive (helpful for some)
11. Family Therapy: There is limited research using family or couple's therapy to treat personality disorders. Obsessive-compulsive personality disorder and histrionic personality disorders were first studied in families because of the belief that the OCPD member would provide organization and intellect to the marriage while the histrionic would provide the vitality (Berman, Lief, & Williams, 1986). Sholevar (2005) described Cluster B as the primary personalities studied in families because family members within this cluster are most highly resistant to interventions. Individuals with borderline personality disorder have been helped to modify behaviors that are disruptive to the family used dialectic behavioral approaches within a family therapy setting (Fruzzetti, Santisteban, & Hoffman, 2007).
12. Psychoeducation: There are no effective psychoeducational programs for Cluster A personality disorders. Limited numbers of effective psychoeducation programs have been developed for some Cluster B personality disorders such as avoidant (social skills training) and borderline (mindfulness, emotion regulation, distress tolerance, interpersonal effectiveness), which utilize a psycho-educational component in DBT. There are no studies referencing psychoeducation for antisocial personality disorders. A 2010 review of different types of psychotherapy for borderline personality disorder found that the highest quality evidence from clinical trials of psychotherapeutic interventions supports dialectical behavior therapy and mentalization-based therapy (Paris, 2010).

Specific Personality Disorders

Avoidant Personality Disorder

Definition:

Avoidant personality disorder (AvPD) (301.82) is a Cluster C personality with features of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluations (APA, 2000). Shyness, fear, and isolation begin in early childhood. AvPD clients reported that their parents' discipline style was to make statements that induce shame and guilt and interact with very little warmth and tolerance (Meyer & Carver, 2000). A pattern of avoiding interpersonal interactions that result in a heightened social withdrawal can be observed in work and school activities. The pattern will include avoiding occupational activities because of a fear of criticism, disapproval or rejection, unwillingness to get involved with others unless he/she is liked, restrained intimate relationships for fear of being shamed or ridiculed, preoccupation with rejection or criticism in social situations, and feelings of inadequacy in new interpersonal situations. The AvPD client frequently feels inept, unappealing, or inferior to others and is reluctant to take personal risks.

The client diagnosed with an AvPD has a chronic and pervasive fear of negative evaluations by others and characteristically will avoid interpersonal interactions, revealing a psychosocial impairment or deficit. Features common to AvPD clients include shyness, social inhibition and anxiety, interpersonal reticence, and social avoidance. The client has difficulties recognizing and discriminating emotions as expressed by others. Rosenthal et al. (2011) in their study of facial recognition specific to emotions of anger, disgust, sadness, fear, surprise, and happiness found that AvPD clients were less accurate than controls.

Incidence:

Prevalence of AvPD in the general population is between 0.5% to 1.0% and as much as 10% in outpatient centers (APA, 2000). Herbert (2007) cited several studies suggesting that AvPD ranged from 5% to 6.6% and may be the most common of the personality disorders receiving treatment in mental health centers.

Interviewing:

Clinicians interviewing individuals with AvPD should consider the following as critical to the evaluation: establishment of rapport, psychodiagnostic, assessment of symptom pattern, phobic stimuli, and impairment in functioning (Herbert, 2007). During the initial interview, the client is likely to be guarded, disengaged, circumstantial, anxious, hypersensitive to rejection, and observing the counselor's proclivity toward being accepting or rejecting. Although this client has a consistent style of responding regarding acting, feeling, coping and defending, it is possible to establish some degree of trust. Cooperation will come as the process reveals the client's testing of the counselor, who successfully responds with empathy and support. After the trust is developed, the client will share some of his/her fears. But if the trust fails to develop, the treatment may terminate early.

Diagnosis:

The definition of avoidant personality disorder (301.82) involves four of seven symptom criteria: (1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection; (2) is unwilling to get involved with people unless sure of being liked; (3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed; (4) is preoccupied with being criticized or rejected in social situations; (5) is inhibited in new interpersonal situations because of feelings of inadequacy; (6) views self as socially inept, personally unappealing, or inferior to others; (7) is unusually reluctant to take personal risks or to engage in any new activities because they prove embarrassing (APA, 2013, p. 673).

The AvPD individuals with the self-deserting characteristics draw more and more into themselves as a means of avoiding the discomforts of relating to others. As a result, they become aware of their inner psychic content. Turning inward causes them to center more on the pain and anguish of past issues as they create a protective barrier from the real world. The self-deserting type merges avoidant and depressive features, which leads to social aversion and self-devaluation (Millon & Davis, 1996a).

Comorbidity with the personality disorder is greatest with schizoid, depressive, dependent, and paranoid personalities. Comorbidity exists with social phobia and social anxiety disorder, anxiety syndromes, phobic syndromes, obsessive-compulsive syndromes, somatic symptom syndromes, dissociative syndromes, depressive syndromes and schizophrenic syndromes (Millon & Davis, 1996b).

The differential diagnosis of avoidant personality disorder is most commonly with anxiety disorders (social phobia) because the two diagnoses are difficult to differentiate. Typically found during assessment are clients with social phobia who are strongly associated with panic disorder, while AvPD clients are often associated with eating disorders (Hummelen, Wilberg, Pedersen, & Karterud, 2007). Individuals with AvPD are also linked with some anxiety disorders including panic disorder, agoraphobic disorder, obsessive-compulsive disorder, generalized anxiety disorder and social anxiety disorder (Herbert, 2007). The assessor should also be alert to panic disorder and agoraphobic disorder. Avoidance of humiliation and rejection are common behaviors that set AvPD apart from a dependent personality disorder, whereas they both share common characteristics of inadequacy, hypersensitivity to criticism, and a need for reassurance.

Instruments:

The most common instrument for interviewing all personality disorders is the Structured Interview for Axis II Personality Disorder (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). A self-report inventory for AvPD is the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, Millon & Davis, 1994). The Inventory of Interpersonal Problems (IIP-64) is a screening measure for AvPD affiliation and dominance (Leising, Rehbein, & Eckardt, 2009).

Treatments:

There are very few studies regarding the treatment of AvPD. Most of the literature studies of treatment outcome are with generalized anxiety and social anxiety disorder. The treatment of individuals with AvPD is long in duration, and the focus is improving social inhibition, feelings of inadequacy and hypersensitivity to negative criticism. The prognosis has been poor, and the

challenges are to retain the client in therapy and to be aware of transference-countertransference issues associated with the client's need to be liked and not receive negative evaluations. The counselor should frame all interventions in a way that reduces the client's fear of rejection. Sperry (1999) recommended schema therapy for change and a style skill change because individuals with this diagnosis labor with the self-perception of defectiveness, inadequacy, and unlikability. As a result, they find it difficult to show their feelings, approach others closely, or establish intimacy. The change process is initiated through experiments, guided observation, and reenactment of early schema-related incidents (Sperry, 1999). A first treatment goal is to increase emotional tolerance. The interviewer during assessment may find the client's lack of emotional self-awareness reflected by statements such as 'my mind went blank,' I don't know what I felt,' or 'I'm not sure what I felt.' The next step in therapy is regulation training, whereby the client is taught to experience awareness and stay with the distressing thoughts. The cognitive style of clients with AvPD is hypervigilance and cognitive avoidance. Thus, treatment should include teaching the client to reduce hypervigilance through social skills training and assertive communication.

Alden (1992) recommended a four-step integrative approach to treatment which includes the following: (1) recognition of treatment process issues (withhold information), (2) increased awareness of cognitive-interpersonal patterns (self-observation-self-protective behaviors), (c) recognize and understand his/her cognitive interpersonal patterns and styles (try new behaviors), and (d) behavioral experimentation and cognitive evaluation.

Group treatment is difficult because the client fears risks involved in the interaction with others. If the client can be encouraged to participate and will participate in a therapy group, this can be an effective change agent. A critical issue in the group work is self-disclosure and is usually facilitated through structured activities.

The most effective treatments for this disorder are behavioral and cognitive-behavioral techniques (Brown, Heimbert, & Juster, 1995). However, psychotherapy may be helpful if the therapist can form a good therapeutic relationship with the client. Individuals who have avoidant personality disorder will often avoid treatment sessions if they distrust the therapist or fear rejection. Treatment can employ various techniques, such as social skills training, cognitive therapy, exposure treatment to gradually increase social contacts to challenge exaggerated negative beliefs about themselves, group therapy for practicing social skills, and sometimes prescribed psychoactive medication (Comer, 1996a, b).

Monitoring for social anxiety involves activities related to monitoring and blunting. Blunting is seeking out information for distraction while monitoring is seeking out information about threat situations. The Coping Styles Questionnaire for Social Situations is considered a monitoring tool for monitoring and blunting (Mezo, McCabe, Antony, & Burns, 2005).

Borderline Personality Disorder

A borderline personality disorder is a Cluster B category personality disorder. A borderline personality disorder is characterized by repetitive self-defeating or self-destructive behavioral patterns, unstable interpersonal relationships, and negative self-image beginning in early childhood

(APA, 2013). There are frequently concomitant symptoms, including substance abuse, anxiety, mood swings, and frequent behavioral changes (Kaplan & Sadock, 1998). Typically, individuals with BLPD are argumentative one moment, depressed another, sometimes panic-stricken, and emotionally numb at other times. Their emotional roller coasters are related to the fact they cannot tolerate being alone but also cannot tolerate close relationships. They try to fill chronic feelings of boredom in destructive ways, frantically searching for someone to fill the emptiness, yet provoking others in ways that precipitate loss or victimization. Thus, borderline individuals suffer repeatedly the pain of destructive and tumultuous interpersonal relationships. These individuals often have a history of an early-life abandonment or victimization and abuse by a parent (Kaplan & Sadock). Borderline Personality Disorder is a noted risk for suicide (10%) and marked for chronic instability in emotional dysregulation, self-harm, impulsivity, and identity disturbance (Giesen-Bloo et al., 2006).

Historically, the diagnosis of borderline personality disorder (BLPD) was initially used over 30 years ago for clients with symptoms that vacillated between psychosis and neurosis, the only two diagnostic categories that were used before 1980. Uncertain as to which of those two diagnoses could be used for individuals with unstable moods and brief psychotic episodes, clinicians used a variety of other diagnoses such as pseudo-neurotic schizophrenia and ambulatory schizophrenia for clients' unstable affects and behaviors, primitive defense mechanisms of denial and projection, and severe identity disorders. Thus, borderline personality was originally a broad diagnostic category that was refined into a more specific diagnosis using observations from psychoanalytic object-relations theory as described in the psychodynamic literature (Masterson, 1981; Rinsley, 1981) and it eventually became standardized in the DSM-IV (APA, 1994). This diagnosis eventually became refined even further and standardized in the APA DSM-IV-TR (APA 1994).

Individuals with a diagnosis of BLPD almost always appear to be in a state of crisis. Their behaviors can change quickly, ranging from angry outbursts, depression, helplessness, or emotional coldness, too blasé indifference. Short-lived breaks from reality may be associated with self-destructive acts and self-mutilation. Their interpersonal relationships are usually tumultuous because they are very dependent and cannot tolerate being alone, yet will withdraw or angrily provoke friends or spouses, from whom they fear rejection or abandonment. Because of this, it is not uncommon for clients with BLPD to have repeated brief sexualized relationships with self-destructive consequences as an attempt to cope with the intense need for emotional closeness. Their personality disorders do not stand alone and are commonly associated with other diagnoses, particularly mood and anxiety disorders, including bipolar disorder and posttraumatic stress disorder. Individuals with BLPD also frequently use or abuse drugs or alcohol as an attempt to control symptoms.

Etiology:

The etiology of BLPD may include the following: familial trauma, loss or separation during the first three years of life, adoption, incest, violence, hostile environments, and ADHD (Gunderson & Zarini, 1987).

Incidence:

The prevalence of borderline personality disorder is estimated to be 1.6% to 5.9%, 10% in outpatient clinics, and 20% among psychiatric inpatients (APA, 2013, p. 665).

Instrument:

The Personality Inventory for DSM-5 (PID-5) dimensional assessment in Criteria B includes negative affectivity, detachment, and antagonism, disinhibition, and psychoticism domains, personality features for BPLD. Seven trait factors defining BPLD were found to be correlated and included emotional lability, impulsivity, depressive, and hostility (Calvo et al., 2016).

Treatment:

Individual psychotherapy has been called the cornerstone treatment for this disorder. Important parallel treatment components are protective 'holding environments' that are necessary from time to time, including hospitalization or partial hospitalization. Treatment is long-term with an experienced therapist who can establish an empathic relationship with the client, meet regularly, set limits and structure, maintain stability over time, uncover and resolve past traumatic emotions, conflicts, and disturbing emotions. Therapeutic techniques involve dealing with resistance, transference, and counter-transference, while providing critical interventions along a continuum ranging from supportive interventions such as advice, praise, validation, and affirmation to more expressive interventions such as interpretation, confrontation, and clarification (Gabbard, 1994).

The therapist's work is to help borderline individuals learn to integrate (good-self and bad-self). Because they have never experienced self-acceptance, borderlines are driven by a compulsive need to change (Linehan, 1993a) and find healing for the internal 'split' between an over-idealized (good-self) and a devalued (bad-self). The borderline individual, who failed to experience normal separation-individuation, perpetually seeks out an idealized relationship to replace the rejecting mother who failed to provide adequate emotional nourishment. For this reason, the therapist's challenge is to initially be the 'good-enough mother' and accept the projected over-idealized good-self; but to be able to set limits and manage the fractured relationship that inevitably results when the projected bad-self emerges during therapy.

An example of how this could unfold may be a female borderline client who appears to have established a relationship with her therapist and others, succeeds in her life for a period but then becomes self-defeating, unreasonably angry toward the therapist, and threatens the therapeutic process, thus losing whatever success gained. The therapeutic task is to help the client learn to recognize the emergence of the bad-self, which causes self-defeating behavior, and the projection of unreasonable anger toward the therapist. It will be a tough task, but if this borderline client remains in therapy long enough, she will be able to learn how to maintain a range of valid emotional experiences while learning to interpret those experiences differently (Linehan, 1993a).

Dialectic behavioral therapy (DBT), a recommended treatment for individuals with a borderline personality disorder, has been described more extensively in this report on personality disorders. DBT has also been used for clients with 'borderline traits, drug abuse, eating disorders, and antisocial personality disorders. The research on DBT effectiveness has primarily been conducted with women.

DBT focuses on helping the client learn ways to stabilize her emotional instability that requires a year or more of commitment by the client and counselor. Linehan (1993b), who uses a manual and a structured approach in DBT, developed a program that has the following components:

1. Weekly individual therapy sessions - a combination of one to two sessions per week for 50-60 minutes or longer
2. Weekly didactic skills training groups and the use of a training manual. Skills training include shaping, modeling, repeated practice, behavioral rehearsal, homework, reinforcement of socially appropriate behaviors, mindfulness training, distress tolerance training, emotional regulation, and teaching interpersonal effectiveness, limits set, and contingency management skills for suicidal ideation.
3. Telephone contact, as needed, for clients to call therapists at any time to avoid self-harm and sustain or repair therapeutic relationships.
4. Consultation meetings for individual therapists and skills trainers to meet and review the treatment.

Since there are several types of treatments for BLPD, Waldinger and Gunderson (1987) have identified the following areas of agreement regarding essential components of treatment:

1. Providing a stable treatment framework
2. Having highly active and involved therapists
3. Establishing a connection between the client's actions and feelings
4. Identifying adverse effects of self-destructive behaviors
5. Paying careful attention to counter-transference feelings

Several therapeutic principles have been found to be useful (Gunderson & Links, 1995):

1. Therapists should identify, confront, and treat a comorbid substance abuse disorder or major depression.
2. Clinicians need to develop a means for differentiating non-lethally motivated self-harm from real suicidal intention because the lifetime risk of suicide in these patients is 10% (Malin, 2012).
3. While establishing the importance of safety, the therapist must stress that psychotherapy is a collaborative enterprise and that the therapist is not all-powerful.
4. Management of counter-transference is significant, and the therapist must be on guard against harboring, acting out, or expressing seductive, passive-aggressive, or angry feelings toward the client. The failure to do this is detrimental to the client, who may act out destructively or self-destructively.
5. The therapist should provide a different means of interacting with the patient than what has been the client's previous experience. The therapist should be aware of the possibility that he or she may tend to 'hold, contain, or cleanse' the client's projections, rather than responding more directly and therapeutically. The patient's self becomes transformed by the corrective effect of the new interaction in the therapeutic relationship.

6. The therapist should seek consultation readily.

Antisocial Personality Disorder

An antisocial personality disorder is one of four Cluster B disorders. The other three in this personality cluster are borderline, narcissistic and histrionic. These four disorders share behavior descriptors of dramatic, erratic and emotional qualities (APA, 2000, 2013). The DSM-5 defines the APD as a pervasive pattern of disregard for and violation of the rights of others and begins typically after age 15. The client is to be at least 18 years of age, and there is evidence of conduct disorder before age 15. This client typically reveals manipulation, deceitfulness, irresponsibility, reckless safety issues, and failure to conform to social norms, decisions made on the spur of the moment, blame others and minimize consequences.

The DSM-5 diagnostic manual further described the disordered anti-social individual as reflecting an enduring pattern of antisocial perceptions and ways of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts (APA, p. 659).

Incidence:

The 12-month prevalence rate as cited in the DSM-5 is approximately 0.2% to 3.3% (APA, 2013). A family predisposition appears to exist because there are five times greater first-degree males with the disorder than with controls (Kaplan & Sadock, 1998).

Prognosis:

The prognosis for individual therapy is poor; however, when clients are on probation or receiving court-ordered treatment the prognosis is improved (Dolan & Coid, 1993). Furthermore, well-motivated clients with impulsive character traits who seek treatment voluntarily in outpatient group therapy show improvement (Lion & Bachy-Rita, 1970).

The prognosis is poor for individuals who experience severe dehumanizing experiences during the formative years. Hatchett (2015) reported that therapeutic, psychosocial interventions have a minimal treatment effect. These youngsters grow up with reduced chances of healthy socialization, and they frequently go on to experience antisocial personality traits or antisocial personality disorder (ASPD) (Stone, 2006). Critical factors for improvement during therapy are motivation, the accuracy of self-awareness, safety, relational development, and positive risk-taking to change.

Individuals with anti-personality disorder typically have no regard for the rights of other people and their behavior does not conform to established laws and social norms. They tend to be deceitful and take advantage of or 'con' others without any concern except for their profit. They are irresponsible and cannot sustain any consistent work pattern or honor financial obligations. Instead, they tend to make impulsive decisions and fail to plan. They have a reckless disregard for the rights or safety of others. They tend to be selfish, cannot make meaningful relationships and may pick fights to establish power over others. They cannot experience remorse or shame or to express guilt feelings about

destructive behaviors. Instead, they are indifferent and rationalize those behaviors that hurt, mistreat, or steal from others. As young adolescents, they had likely displayed similar behaviors and been diagnosed with conduct disorder before becoming 18 years of age when the diagnosis of antisocial personality disorder became applicable.

Case reports frequently mention a strong need for stimulation such as novelty seeking and risk-taking behavior (Cloninger, 1986), low harm avoidance, lack of remorse (not all clients), violation of social norms and a repeated tendency to break the law. They are likely to commit economic crimes and be potentially dangerous. The underlying issue is a blatant disregard for others. Hare (2003), at the severe end of his Psychopathy Checklist-Revised (PCL-R), described the antisocial personality client representative of a risk taker, a repeat criminal, stock-fraud swindler, arsonist for hire, and serial killer.

Instruments/Assessment:

The ASPD client are capable of masking sanity by appearing credible and calm. Beneath that veneer is often negative traits such as tension, irritability, and even rage. When assessing for ASPD the examiner should be aware of comorbidity with other disorders like substance use disorder, depression, and anxiety, and most prevalent is another Cluster B disorder. Kaplan and Sadock (1998) recommended a full workup including a neurological examination. Research findings from EEG and soft neurological signs suggested that an individual with this disorder might have suffered minimal brain damage during childhood.

Symptoms likely to be found in a person diagnosed with ASPD include a pervasive disregard for and violation of the rights of others, lack of empathy, callous demeanor, cynical worldview, contempt for the feelings of others, arrogance, inflated self-image, opinionated viewpoints, cockiness, glibness, a charming facade, verbally facile, impulsivity and a history of aggressive or violent behavior (Rodgers & Maniacci, 2006).

Hare, Hart, and Harpur (1991) utilized the Cleckley descriptors and developed the Psychopathy Checklist-Revised (PCL-R). The PCL-R is a 20-item list of valid descriptors of personality that has two factors. Factor I traits consist of aggressively narcissistic traits (superficial charm, grandiose self-worth, pathological lying, manipulative behavior, lack of remorse, shallow affect, lack of empathy, failure to accept responsibility); Factor 2 traits reflect a socially deviant lifestyle (need for stimulation/proneness to boredom, parasitic lifestyle, poor behavioral control, lack of realistic long-term goals, impulsivity, irresponsibility, juvenile delinquency, early behavior problems and revocation of conditional release). Traits not correlated with either factor are sexual promiscuity, many short-term marital relationships, criminal versatility, and acquired behavioral sociopath.

Diagnosis:

An adult client diagnosed with ASPD is likely to have displayed behaviors before age 15 that include lying, truancy, running away from home, thefts, fights, substance abuse, illegal activities and been diagnosed with conduct disorder. Upon reaching 18 years of age or more, if this person demonstrates such behaviors that include conning, swindling, manipulating, promiscuity, spousal abuse, child abuse, drunk driving, irresponsibility, shameless behaviors that do not meet social norms and run into conflict with the legal system, the client meets criteria for the diagnosis of ASPD.

Clients diagnosed with ASPD tend to be covetous, reputation-defending, risk-taking, nomadic and malevolent (Millon, 1996). ASPD frequently overlaps with narcissistic and sadistic patterns.

Prognosis:

The prognosis for antisocial personality disorder is poor and considered to be chronic and lifelong. The degree of chronicity can be modified regarding the gradient of severity for this disorder. Stone (2006) indicated a direct relationship using the range of deviation along the range of severity in the diagnosis. Stone contends that clients with a combination of 2-3-6 of deceitfulness, impulsiveness, and irresponsibility, respectively, pose less threat of harm while clients are manifesting 4-5-7 (irritability, reckless, and the lack of remorse) are prone to assaultiveness. Stone developed a graduation of antisociality on an 11-point scale, starting with some antisocial personality traits (1) to psychopathy with prolonged torture followed by murder (11). Motivation is a crucial factor in the desire and willingness to see self as the issue and for change while the lack of motivation is a poor prognostic factor.

Treatment:

Treatment depends on the motivation and the ability to take seriously the destructive nature of his/her antisocial attitudes and behavior seriously. Clients who are potentially treatable require the absence of (a) pathological lying/deceitfulness, (b) callousness/lack of compassion, (c) lack of remorse or guilt, and (d) absence of conning/ manipulativeness (Gunderson & Gabbard, 2000). These authors recommended that the therapist who attempts to treat the violent client include an awareness of a difficult pattern of behavior that includes: (a) history of sadistic behavior with injury, (b) complete absence of remorse, (c) an IQ that is either superior (a higher IQ equates to more covert deceitfulness) or retarded, (d) a lack of ability to make attachments, and (e) intense therapeutic countertransference (primarily anger or predation). Strasburg (1986) pointed out situations that are difficult for the therapist: (a) fear of assault or harm; (b) helplessness or guilt; (c) loss of professional identity; (d) denial of danger; (e) rejection of the patient; and (f) a wish to destroy (p. 297). Strasburg goes on to indicate that the harder core antisocial patient is often one who inspires hatred or fear, commits offenses of shoplifting, driving under the influence, and evokes counter-transference reactions in the therapist such as contempt, envy, and annoyance.

Cognitive therapy is a preferable approach, with the major focus on helping the client understand how to create ownership of the problem and how distorted perceptions prevent the client from seeing himself the way others view him. This effort to develop responsible behavior is often ineffective, however, since APD clients devalue the therapist, blame others, have a low tolerance for frustration, are impulsive and have difficulty forming trusting relationships. Therefore, doing therapeutic work with these individuals is difficult. Furthermore, APD clients often lack the motivation to improve and are notoriously poor self-observers and do not see themselves as others do. Therapists undertaking such a treatment process must be aware of their feelings and remain vigilant to their negative counter-transference (emotional responses to their patients) and not allow it to disrupt the therapy process. Generally speaking, only therapists with a special interest and experience with ASPD will have any success.

Hatchett (2015) reported that ASPD clients do not respond well to psychosocial interventions. Those clients with comorbid substance use disorders do respond to substance abuse treatment.

Beck, Freeman, and Davis (2004) used cognitive therapy to improve social functioning, social problem solving, moral functioning about others, and confront cognitive distortions. Six examples of cognitive distortions include (1) feeling justified in getting what one wants, (2) thinking is believing, (3) personal infallibility, (4) unquestioning acceptance of one's feelings as providing a correct basis for action, (5) view of others as impotent or worthless and (6) minimization of possible untoward consequences. The authors contend that the ASPD client is capable of making risk-benefit evaluations of life situations.

An antisocial personality disorder may not be amenable to psychoanalytic-based therapies. According to psychodynamic psychotherapists, the background history for many clients diagnosed with ASPD is filled with childhood physical and psychological abuse, broken or nonexistent relationships and poor if any attachments to parents or other caregivers. These broken forms of development result in fragmented traumatic memories and their associated affective contents. Psychodynamic psychotherapy can potentially provide emotional healing. This would require establishing trust in the therapist to not abandon or torture him/her, setting boundaries to control fragmentation and destructive behaviors based on repetition compulsion, containing the emerging repressed or split-off affect, facilitating integration of cognition with un-verbalized affect, processing the affect and returning the affect to the client within an environment wherein the client feels safe and is motivated to make healthier new attachments.

Benveniste (2006) cited van der Kolk's (1994) trauma theory's concept of derailment where memories are stored in the primitive brain and not accessible to the frontal cortex as an important consideration for therapy in the individual who has suffered early life trauma and lacks conscious access to the effects of traumatic memories. When asked to talk about a traumatic event, the client with this disorder expresses no emotion because it remains buried due to primitive psychological defenses of splitting and dissociation until a provocative event triggers an explosion of terrifying emotion. Such emotion is not subject to regular processing within the frontal cortex and is not anchored in time. All affects and memory fragments feel as if they are occurring in the present but simultaneously as if they have always been there. Additionally, defenses used to repress traumatic events prevent the person from relating in a genuinely and spontaneously way. Dysfunction occurs because of a lack of adequate attachments; therefore, relationship development is a goal of therapy. Therapeutic work focuses on dealing with attachment difficulties and dysfunctional relationships.

Benveniste suggested that attachment, relational, and object relations each have significant contributions for therapy in treating antisocial disordered clients. The focus of relational therapy is on the transference-countertransference interplay within the therapeutic relationship. The therapist's means of communicating his or her affective countertransference responses to the client is considered as integral to the client's improvement and healing as the client's communications to the therapist. Since behavioral dysfunction in ASPD is closely linked to abnormal attachments and dysfunctional relationships most of the therapeutic task involves helping the client establish functional relationships interpreting transference pertaining to past attachments as they relate to boundary problems, veiled

aggression, the use of seduction as a means of complementing and gaining control, and other behaviors intended to induce humiliation.

Other treatment approaches include the therapeutic community in which individuals with ASPD can receive treatment utilizing a multi-modal model approach with group therapies, individual cognitive therapy and skills training. The skill training involves a five-step model including recognition, motivation, understanding, and insight and testing (Dolan, 1997). Cognitive behavioral therapy combined with hormonal pharmacotherapy to reduce libido has sometimes been recommended, or even ordered by the court, for clients guilty of sexual offenses (Gunderson & Gabbard, 2000). Unfortunately, individuals with ASPD are likely to prematurely discontinue voluntary therapy (Hilsenroth, Holdwick, Castlebury, & Blais, 1998).

Histrionic Personality Disorder

Histrionic personality disorder (HPD) is categorized as a Cluster B personality disorder (dramatic, emotional or erratic) characterized by enduring patterns of self-centeredness, seductiveness, shifting emotional expressiveness, over-dramatization, superficial expressions of intimacy, excessive suggestibility, and over-generalizations of speech. The core components are egocentricity, seductiveness, theatrical emotionality, denial of anger and hostility and a diffuse cognitive style (dichotomous thinking) (Horowitz, 1991). Traits such as gregariousness, manipulativeness, low frustration tolerance, pseudo-hypersexuality, suggestibility, and somatizing tendencies have also been identified (Andrews & Moore, 1991).

Assessment and Interviewing:

According to Horowitz (1997), the histrionic client uses the defense mechanism of denial and ignores detail during an assessment interview. Of interest is the fact that this client will often present with depression during the intake interview rather than typical histrionic characteristics. Feelings of loneliness, isolation, and despair about feeling lost may also be present (Kellett, 2007). The histrionic individual is apt to have an exaggerated emotional reaction to even the mildest form of confrontation. He or she tends to dominate social interactions through attention seeking, theatrical behaviors, and unusual personal presentations.

Nichols (2007) described the client with histrionic personality as portraying a confident and self-assured manner that often masks underlying shallow feelings and deep insecurities. In displaying a need for affection, attention, and approval the client with this disorder will demonstrate temper tantrums, charm, and drama. Horowitz (1997) also portrayed the HPD individual as being prone to shifting ego states, i.e., moving from victim to aggressor to rescuer. Turkat (1990) characterizes the HPD interactional style as controlling interpersonal and reactive approval seeking.

According to Renner, Enz, Friedel, Merzbacher, and Laux (2008) the HPD client will present with as-if behaviors that construe or shape daily events and interactions as opportunities for dramatic situations and the purpose of impression management. The HPD client's as-if behaviors can also be viewed as acting out 'make-believe' roles to create or reduce tension.

The DSM-5 lists eight symptoms that form the diagnostic criteria for HPD:

1. Center of attention: Clients with HPD experience discomfort when they are not the center of attention.
2. Sexually seductive or provocative: Clients with HPD display inappropriate sexually seductive or provocative behaviors toward others.
3. Shifting emotions: Their expressions of emotions tend to be shallow and to change rapidly
4. Physical appearance: They consistently employ physical appearance to gain attention to themselves
5. Speech style: Their speech patterns lack detail, as they tend to generalize and try to please and impress others
6. Dramatic behaviors: Clients with HPD display self-dramatization and exaggerated emotional expressiveness.
7. Suggestibility: They are easily influenced by others and by circumstances
8. Overestimation of intimacy: Clients with HPD tend to overestimate the level of intimacy they have established in relationships. (APA, 2013, p. 667)

Incidence:

APA (2013) cited data from the National Epidemiologic Survey to be 1.84%. Studies have shown HPD to occur more frequently in females than males. Female characteristics are also found in samplings of HPD more frequently than male characteristics. This supports arguments that there is sex-bias in the diagnosis of HPD. The estimated incidence is approximately 2% to 3% of the general population and 10% to 15% of the mental health population (Nichols, 2007).

Types:

1. The following list includes HPD sub-types (Millon, 1996):
2. Theatrical histrionic--especially dramatic, romantic, and attention seeking
3. Infantile histrionic--including borderline features
4. Vivacious histrionic--synthesizes the seductiveness of the histrionic with the energy level typical of hypomania
5. Appeasing histrionic--including dependent and compulsive features
6. Tempestuous histrionic--including negativistic (passive-aggressive) features, out-of-control, stormy, impassioned, and turbulent manner.
7. Disingenuous histrionic–-egocentric, antisocial features, a coating of friendliness and sociability, impulsive tendencies, and relationships are shallow

Instruments:

1. The Shedler-Westen Assessment Procedure-200 (SWAP-200 Shedler & Westen, 1998)
2. Shedler-Westen Assessment Procedure (SWAP-II; Westen & Shedler, 2007)
3. The MMPI (Hysteria Scale; Gordon, 1983, 2006)

4. Millon Clinical Multiaxial Inventory (Millon, 1983)
5. Psychopathic Personality Inventory (PPI; Lilienfeld & Andrews, 1996)
6. Personality Diagnostic Questionnaire (PDQ-4+; Hyler & Rieder, 1994)
7. Coolidge Axis II Inventory (CATI; Coolidge, 1993)

Treatments:

Few, if any, empirical clinical trials of the treatment of HPD are evident in the literature. However, therapists have learned that in preparation for treatment it is important to be aware of the client's interpersonal style, maintain empathy with stated issues, and avoid responding to his/her emotional and seductive behaviors. The therapist should also be aware that the client would demonstrate difficulties with facts, details, and decision-making (Ward, 2004). Intervention strategies also include maintaining awareness of the therapeutic alliance and the client's physical appearance, interpersonal style, emptiness, and child-like feelings.

Horowitz (1997) recommended a three-phase approach to include: (1) stabilization, (2) modifying communication style, and (3) modification of interpersonal reactions, patterns, and schemas.

These clients (unlike those with other personality disorders) much quicker to seek treatment and tend to be more emotionally needy. Solution-focused supportive therapy with the short-term alleviation of difficulties within the person's life is preferable to long-term psychotherapy. Clinicians should be alert to counter-transference issues and not be 'seduced' to the possibility of being placed in a rescuer role where they are asked directly or indirectly to constantly reassure and rescue clients from daily problems which are often expressed in dramatic ways. Therapists will frequently be over-idealized by histrionic clients and perceived as sexually attractive, so that boundary issues and a clear delineation of the therapeutic framework are relevant and important aspects of therapy.

Cognitive-behavioral and psychodynamic oriented outpatient individual therapies are recommended. These treatment approaches have been reported by Leichsenring and Leibing (2003) to be helpful and reduce symptoms of personality pathology and increases or improve social functioning.

Functional Analytical Psychotherapy: Functional Analytic Psychotherapy (FAP), developed by Kohlenberg and Tsai (1991) at the University of Washington, is based on Skinner's behavior analytic, or functional contextualistic approach to human behavior. FAP results in psychotherapeutic relationships that are more intense and personal than are typically found in cognitive-behavioral treatments. It is an interpersonal oriented psychotherapy that uses basic behavioral concepts to specify the process of clinical change as a function of the therapeutic relationship. Using this therapy Callaghan, Summers, and Weidman (2003) were convinced that the interpersonal problems clients experience with others outside of session could also arise during the session with the therapist. Also, the therapist has direct access and the best ability to help change client behaviors that occur during the therapy hour. The therapist does not confront the interpersonal dynamics but rather assists in shaping appropriate responses. The therapist responds to clinically relevant behaviors (CRBIs) such as interpersonal difficulties the client demonstrates during therapeutic sessions by pointing out that these are the same as experienced on the outside with others.

Cognitive Analytic Therapy (CAT): CAT treatment has been described by Kellett (2007) as being somewhat successful to reduce HPD symptomatology. The distinctive value of CAT is due to its intensive use of reformulation, its integration of cognitive and analytic practice and its collaborative nature, involving the patient very actively in his/her treatment. It is a time-limited focal psychotherapy with procedures that will help clients identify target problems (Ryle, 1997, 2004). These, as described to the client, include a need to be noticed (attention), relationship issues, physical appearance, trust issues, and any other characteristics observed during the assessment. Clients receive 24 weekly sessions and four sessions of follow-up spread over a 6-month period. Psychotherapeutic effectiveness is enhanced when therapists adhere to the following guidelines: (a) listen with respect, (b) help the client become more logical and focused on problem-solving, (c) empathize with emotional pain or distress but remain clinically objective about the client's descriptions of alleged injustice/abuse, and (d) avoid over-reacting to intense emotions.

In addition to individual psychotherapy, other treatment approaches have included group psychotherapy, outpatient individual psychotherapy, day hospital psychotherapy, and inpatient psychotherapy.

Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder (OCPD) is a Cluster C disorder that includes some features meant to reduce or control anxiety. Eight symptoms describe the disorder. These include inflexibility, lack of spontaneity, excessive orderliness, perfectionism, and need to maintain mental and interpersonal control (APA, 2000, 2013).

Obsessive-compulsive personality disorder (OCPD) clients seek to control, display stubbornness, and tend to focus on work and productivity rather than friendship and interpersonal contact and are concerned with perfectionism. As a result, they prefer to work alone or delegate the work to others. Control is frequently at the forefront of their behaviors, and they can become cognitively preoccupied and consumed by detail, rules, procedures, lists, and schedules. If they lose something, the search for the lost object can dominate every action to the point that frustration and anger can become the outcome unless or until the lost object is found. They tend to control all emotional expression, however, so that angry outbursts may erupt that are out of proportion to the event or circumstances. The OCPD client tends to restrict any display of emotions and is not comfortable in the presence of someone who has no difficulty expressing or showing emotions. Perfection drives his/her behaviors to the point the OCPD client will hold back until such time he/she can perform to his/her standard. While individuals with OCPD tend to be perfectionistic and excessively orderly, they can also save items for possible use even when considered worthless, sometimes to the point of becoming hoarders. Access and control are associated with internal and external standards toward perfectionism so that the result for many enterprises is a lack of decision-making and uncompleted tasks.

Assessment:

The DSM-5 (APA, 2013) and DSM-IV-TR (APA, 2000) criteria for OCPD are a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense

of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four or more of the following: (1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost; 2) shows perfectionism that interferes with task completion; (3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships; (4) is over-conscientious, scrupulous, and inflexible about matters of morality, ethics, or values; (5) is unable to discard worn-out or worthless objects even when they have no sentimental value; (6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things; (7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes; (8) shows rigidity and stubbornness (APA, 2013, pp. 678-679). Suggestions for interviewing the OCPD client and instruments that assess for OCPD are found within the previous section on instruments and interviewing.

A prominent OCPD clinical feature regarding expressive behavior is a disciplined seriousness. The client is rigid and tense in posture and mannerisms. Obsessively compulsive individuals usually relate to others with respect yet they tend to expect others to conform to their rules and style. They often seek approval from authority figures with whom they feel submissive but will resist the authority figures that have contrary opinions or have less power in their view. As a result, they want to know how they stand with authority figures. The cognitive style is constricted, and they will be uncomfortable when confronting unsure directions or new events. Time standards are adhered to with rules and regulations. Recreational and leisure activities are of lesser importance than work. The OCPD client views self as industrious, loyal to the work standards, but also can be self-denigrating. The typical defense mechanisms are reaction formation, isolation, rationalization, intellectualization, and undoing (Kaplan & Sadock, 1998). The mood is usually solemn, joyless and grim.

Comorbidity for other diagnoses includes anxiety, phobic, mood, compulsive-obsessive, somatic symptom, and dissociative disorders.

Differential Diagnosis:

Obsessive-compulsive and obsessive-compulsive personality disorder. The focus for a differential diagnosis is to review occupational and social effectiveness. Millon (1996) categorized adult compulsive types as conscientious, puritanical, bureaucratic, parsimonious or bedeviled.

Treatment:

Treatment is often prolonged, and transference issues are common and should be addressed during the therapeutic process. Millon (1996) recommended treatment modalities in the form of goals: re-establishing polarity balances (self-identity from the perception of others, a self-other balance), countering self-critical tendencies (self-criticism, guilt indecision, anxiety), and modifying domain dysfunctions (cognitive, expressive behaviors and interpersonal conduct). Millon stated that the OCPD client prefers a structured therapy so that progress can be measured. Specific therapy models include behavioral methods for phobic avoidance and ritualistic, restrictive and rigid behaviors.

Traditional psychotherapy based on psychoanalytic principles has rarely been successful. Understanding and working through the symbolic meaning of obsessions may improve a client's

understanding but is insufficient to change obsessive-compulsive behavior. Rather, as discovered by the English psychiatrist Isaac Marks, behavioral techniques of exposure and response prevention turned out to be more effective. Exposure consists of confronting the client with situations that evoke obsessional distress; response prevention consists of teaching clients with OCD features to abstain from compulsive rituals and helping them learn how to master anxiety provoked by obsessions without performing rituals until the obsessions eventually disappear.

Cognitive reorientation therapy is recommended (over-intellectualization) to address emotional reactivity, and relaxation training may be useful to diminish tension, and psychodynamic approaches can be helpful to uncover early life conflicts. Pharmacological intervention can reduce the intensity of compulsive symptoms and alleviate anxiety and depression (Millon, 1996).

Couples and family therapy are recommended to come to grips with early family interactions, misunderstandings, and problematic relationship issues. Group therapy is not recommended because the OCPD client aligns with the group leader therapist (Kaplan & Sadock, 1998).

Dependent Personality Disorder

The DSM-5 defines a dependent personality disorder as a "pervasive and excessive need to be taken care of that leads to submissive and clinging behaviors and fears of separation beginning in early adulthood" (APA, 2013, p. 675). It is a Cluster C personality. Five of eight symptoms are to be met for this diagnosis. Millon (1996) categorized the dependent and histrionic personality styles or patterns as need-directed toward others while the narcissistic and antisocial are needed-directed toward self (selfish). These are imbalances and problems for each of these four patterns. Social approval and affection needs are priorities achieved through the desires of others. This client will bend over backward to see that someone else is not displeased and rarely will allow him or herself to make demands or attempt to take control directly. Instead, the dependent individual is likely to take a passive stance.

Dependency and submissive behaviors are pervasive features, along with a strong need to please and be accepted by others. The dependent client is likely to enlist the support of others to make decisions or manage his or her life decisions. This client will avoid disagreeing with others because of a fear of losing support or approval. A lack of self-confidence is evident as the client has difficulty in assuming or initiating projects or doing things on his or her own. The client will do undesirable tasks just to maintain the approval and nurturance of others, even if it is unpleasant. Loneliness is unwanted and will be quickly replaced with a relationship. Frequently this client is self-deprecating, self-effacing and diminishing of self or accomplishments. If this client finds an all-purpose partner to depend on, he or she will more likely appear to be functioning well socially, reveal warmth, affection, and generosity. If the partner abandons or is not available the dependent characteristics will resurface, and a replacement partner will be sought out to avoid a pronounced fear of abandonment.

In summary, deriving from attachment theory, the critical elements of the dependent personality are the need to elicit guidance, assistance, and approval from others (Livesley, Schroeder, & Jackson, 1990). Beck described the DPD as exhibiting inadequate and helpless behavior with an inability to

move toward self-direction. The DPD individual sees the world as cold, lonely or dangerous. Beck's second characteristic is to find someone who can protect and manage the cold, lonely, and dangerous world. Leary's term for the DPD was the 'docile-dependent' (Leary, 1957). Another characteristic of the DPD is agreeableness (Costa & Widiger, 1993).

The DPD client may surface in the counseling office after experiencing rejection and abandonment, and the internal and external threats are ever more prominent. The counselor becomes the immediate replacement.

Prevalence and Frequency:

The APA (2013) cited data from the 2001-2002 Epidemiologic Survey to be 0.49%. DPD is the most frequently reported personality disorder. The DSM-IV-TR (2000) reported a frequency rate of 15% and 25% in the hospital (Oldham et al., 1995) and 0% to 10% in outpatient (Klein, 1999). In 1997, the rate for women was 11% and 8% for males (Bornstein, 1997). Torgersen et al. (2000) in studying clients diagnosed with a dependent personality disorder in monozygotic and dizygotic twin pairs found that a greater likelihood was to be found in monozygotic twins. This study supported a genetic factor and reason to consider family predisposition. Further studies point out that parenting styles of over-protectiveness and authoritarianism are associated with increased likelihood for DPD later in life (Head, Baker & Williamson, 1991).

Assessment and diagnostic criteria:

This disorder, as described in the DSM-5 (APA, 2013), is manifested by a pervasive and excessive need to be taken care of, along with submissive and clinging behavior and fear of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following eight:

1. has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. needs others to assume responsibility for most major areas of his or her life
3. has trouble expressing disagreement with others because of fear of loss of support or approval
4. has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than to a lack of motivation or energy)
5. goes to excessive lengths to obtain nurturance and support from others to the point of volunteering to do things that are unpleasant
6. feels uncomfortable or helpless when alone, because of exaggerated fears of being unable to care for himself or herself
7. urgently seeks another relationship as a source of care and support when a close relationship ends
8. is unrealistically preoccupied with fears of being left to take care of himself or herself (pp. 678-679)

The adult subtypes (Millon, 1996) include disquieted (submissive dependent, self-effacing, non-competitiveness), accommodating (agreeableness, need for affection, nurturance, security), immature

(childlike, lack of ambition, passive), intellectual (lack of vitality, low energy level, fatigability) and selfless (gives up identity, submit to beliefs and values of others).

There appears to be an unusual parent-child attachment during the early years and has been characterized as a separation-anxiety (APA, 1980) and child symbiosis (Mahler, 1967).

Interview:

Sperry (1999) reported that individuals with dependent personality disorder tend to bond easily during the initial interview and first therapy hour. They can describe the conditions and situations very well but tend to go silent and wait for the assessor or therapist to ask questions. They become uncomfortable when therapists pursue the subject of submissiveness. If interviews with dependent individuals do not go well, they are likely to change therapists. One of their positive characteristics, however, is a willingness to reveal deep feelings and accept confrontation. Interpretations are more challenging.

Interviewing techniques include observing posture, voice, and mannerisms as signs of self-confidence since self-image is typically weak and inadequate, childlike, lonely and abandoned (Millon, 1996). The interviewer should also observe for a possible attitude of acquiescence, an excessive need to be agreeable and avoid the risk of rejection, and the presence of helplessness or a clinging quality toward the counselor. Similarly, the interviewer should determine the client's boundaries that may be narrow and reflect a limited self-awareness with a cognitive style that is naïve, unperceptive, and uncritical. Furthermore, in keeping with childlike helplessness, dependent individuals tend to ally themselves with individuals they perceive as all-powerful and protective while avoiding conflict and smoothing over difficulties using denial.

Clinical disorders comorbidity with dependent personality includes disorders of mood and anxiety which include phobic, obsessive-compulsive, somatic symptom, factitious, dissociative, schizophrenic-schizoaffective and adjustment disorders; and four personality disorders--borderline, histrionic, masochistic and avoidant disorders. Differential diagnosis difficulties overlap with dysthymic disorder and agoraphobia.

Treatments:

The treatment of an individual with a dependent personality disorder (DPD) targets affective, behavioral-interpersonal and cognitive systems (Cloninger, 1986). The DPD cognitive style is to avoid upsetting thoughts and anxiety because of a limited ability to be assertive and solve problems or live independently. The long-range goal of therapy is to improve the excessively dependent individual's ability to function independently while being able to ask for and accept help to do so effectively. A goal is to encourage a desire and willingness to make decisions, take responsibility for his or her behaviors, feel comfortable with being alone, and seek to learn new skills and become increasingly competent. Treatment strategies include teaching assertiveness and challenging dysfunctional beliefs about being inadequate. Individuals with this disorder are more likely to respond to treatment than those with borderline or narcissistic patterns and to learn from skills training such as exposure strategies, anxiety management, assertive training, and problem-solving. Therapeutic techniques also must include confronting resistance and refusal to take responsibility for change as well as addressing

transference issues such as excessive compliance, clinging helplessness, and fear of challenging authority; and counter-transference issues around power, unwillingness to confront, and being over-protective. The dependent individual will make progress if he or she can take responsibility for change, follow through with medication requests, display evidence of improved assertiveness, and make decisions on his or her behalf.

Many different therapeutic approaches can be used, sometimes together, to bring about personal growth and move from dependency to increasing individuation. Some psychodynamic psychotherapeutic approaches have been recommended to facilitate personality change and corrective emotional experiences, particularly when the client reveals past experiences of trauma and abandonment. In addition to individual therapy, group therapy can enhance interpersonal communication, assertiveness, and the verbal capacity to establish self-identity with others. Family or couple's therapy is also known to be helpful to maintain the goals worked on during treatment. Finally, the use of psychopharmacological treatment for modification of target symptoms such as depression and anxiety can facilitate the therapeutic process.

Termination is a critical aspect of the treatment since the client with DPD has experienced difficulty with separation and loss in the past and faces distressing emotions and a fear of being alone once again. The therapeutic task is to support the client's emotions of loss such as anger, depression, and grief as well as to interpret the client's defenses that may emerge to avoid these emotions such as avoidance, missing therapy sessions, new somatic symptoms, and rationalization. Specific techniques can also be used to help clients with termination. These include spacing sessions, developing a self-plan for continuing psychological growth, and planning how to deal with the possibility of recurring symptoms after therapy has been completed.

Psychodynamic psychotherapy can be effective when the focus is on solutions to specific life problems. Achieving a personality change would take a lengthy therapeutic process, something that is not recommended since it reinforces a dependent relationship with the therapist. Assertiveness training and other behavioral approaches have been shown to be most effective in helping individuals who have difficulty with boundary setting, saying 'no' and determining self-determination goals. Challenging unhealthy dependent relationships should be avoided at the onset of therapy but, when done carefully, are important as treatment progresses. Restraint must be used if the individual is not ready to give up these unhealthy relationships. After the goals of the treatment have been reached, the therapist should take the initiative to terminate therapy since DPD clients often don't know "how much is enough." As the end of the therapeutic work approaches, the client is likely to re-experience feelings of insecurity, lack of self-confidence, increased anxiety and perhaps even depression - issues which should be confronted at the time in therapy.

Narcissistic Personality Disorder:

Psychotherapy can be effective, particularly when psychotherapists treat symptoms related to crises associated with the client's diagnosis rather than to treat the personality disorder per se. Developing a positive transference and therapeutic alliance should not be relied upon with narcissistic patients when long-term therapy is attempted since the transference is unstable with a tendency to devalue the therapist. Goals for psychotherapy should be modest and may best be achieved when

combined in a supportive way with group therapy since a group can be more confrontational than an individual therapist and the transference issues are less significant.

Monitoring:

Monitoring improvement can be through instruments such as the Narcissistic Personality Disorder Scale, Narcissistic Personality Inventory, and the three events noted previously (corrective achievements, corrective disillusionments, and corrective relationships). If the client has a significant other participating in the therapy or couple's therapy, reports by the significant other would be recommended.

Paraphilic Disorders

Paraphilic disorders include voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, sexual masochism disorder, sexual sadism disorder, pedophilic disorder, fetishistic disorder, and transvestic disorder.

Definition and Interview:

Paraphilic disorders of sexual deviation vary in severity. The basic structure of the diagnostic criteria is essentially the same from the DSM-IV-TR and for the DSM-5. The DSM-5 created a distinction between paraphilias and paraphilic disorder. These disorders are divided into courtship disorders (voyeuristic, exhibitionistic, frotteuristic) and algolagnic disorders (sexual masochism, sexual sadism). Courtship disorders involve distorted view and behaviors of courtship, and algolagnic disorders include pain and suffering.

A paraphilia, alone, does not necessitate a clinical intervention. Paraphilia is an "intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with normal, physically normal mature, consenting human partners" (APA, 2013, p. 685). A paraphilia involves "another person's psychological distress, injury or death, or it involves a desire for sexual behaviors with unwilling persons or persons unable to give legal consent" (King, 2014a,).

A paraphilic disorder is a paraphilia that is causing distress or impairment in someone else or causing harm or a risk of harm to another individual. A client is to meet Criteria A and B to have a paraphilic disorder, and in Criterion B the client is acting on an urge with a nonconsenting individual or exhibits the urge to cause distress or impairment. If only Criterion A but not Criterion B is met, then it is a paraphilia but not a paraphilic disorder (APA, 2013).

Individuals with paraphilic disorders do not usually seek treatment. The APA (2013) described paraphilias as individuals with recurrent, intense, sexually arousing fantasies, urges, or behaviors involving inappropriate objects that last longer than six months and cause clinically significant distress and impaired daily functioning. Also, the DSM-5 described eight specific paraphilic disorders: (1) voyeuristic disorder, (2) exhibitionistic disorder, (3) frotteurism disorder, (4) sexual masochism disorder, (5) sexual sadism disorder, (6) pedophilic disorder, (7) fetishistic disorder, and (8) transvestic disorder.

Sexual desire and arousal disorder have been combined with one disorder (sexual interest/arousal disorder). Vaginismus and dyspareunia have been combined to create genito-pelvic pain/penetration disorder, and sexual aversion has been removed. According to Morrison (1993, 1995), pedophilia is the one disorder most commonly diagnosed, followed by exhibitionism, voyeurism, and frotteurism, although it is not uncommon for a client to be diagnosed with more than one type of paraphilia.

The DSM-5 arranges these disorders according to a common classification scheme, that is, anomalous activity preferences (courtship disorders and algolagnic disorders). The second group is based on anomalous target preferences (directed at other humans and two directed elsewhere).

An essential component of the interview process is a risk assessment (Maletzsky, 1998). Paraphiliacs tend to minimize and refuse full disclosure; therefore, the evaluation should include a mental status examination to include superego functioning, self-reports, psychological tests, and corroborating information from previously involved professionals, friends, and family members. The interview should be comprehensive.

According to Perry and Orchard (1992), the interview may have four goals: the diagnosis, treatment, providing information to legal and social agencies, and providing information to the client and families. In addition to interviewing for the disorder, a thorough assessment should include the client's background and present functioning. The counselor should take the time to explain to the client the purpose of the interview, counselor's role, and the limits of confidentiality (Seligman & Hardenberg, 2000, p. 109).

All sexual dysfunctions have a minimum time frame of six months, except for substance/ medication-induced sexual dysfunction.

The interviewer can formalize the interview by obtaining information on nature, time of onset, duration, frequency, and progression of the symptoms. Paraphilias, as disorders, usually progress from single acts of masturbation with paraphilic fantasies—exhibitionism and voyeurism (without physical contact with others) to physical, sexual behaviors (Perry & Orchard, 1992). The interviewer can sequentially structure the interview to obtain information (Seligman & Hardenburg, 2000) as follows:

1. assess for fantasies, urges, and behaviors. The interviewer may listen to determine if there is a linkage between the client's action and a sense of self, feelings of power, and a derived meaning in his/her life (Goodman, 1993).
2. also, determine the average amount of time the client devotes to sexual thoughts, activities, the frequency of and stimuli for his/her orgasms
3. assess for impulse control and his/her symptoms, which continue the repetitive cycle of increasing tension, release, and regret
4. determine if the client's involvement in sexual aggression is planned, indicating he or she has more control
5. assess for the triggers for the symptoms, choice, and nature of the contact with victims
6. inquire into what the client may say to a victim

The interviewer needs to understand the client's thoughts, motives, and defenses used in the disorder. The paraphilic client usually desires intimacy and closeness but fears rejection and engulfment, avoids normal expressions of emotion, both affection and anger, and acts out behaviorally instead (Levine, Risen, & Althof, 1990). Perry and Orchard (1992) indicated that this client often uses the defenses of rationalization, denial, projection, and cognitive distortions. An individual with a diagnosis of paraphilia disorder may be described as being vulnerable, has impaired self-esteem, is unable to exhibit empathy, has a reduced capacity for insight, has poor social skills, and has poorly developed attachment behavior to his/her parents. Perry and Orchard described the client with a paraphilic disorder as one who is well defended, assumes very little responsibility, and has a tendency not to be remorseful.

The interviewer must be knowledgeable of comorbid disorders. Frequently found in conjunction with paraphilia disorders are impulse-control disorders, obsessive-compulsive disorders, personality disorders (Bradford, 1996), substance use disorders, mood disorders, and anxiety disorders (Kafka & Prentky, 1994).

In summary, the interviewer should understand that a paraphilic may exhibit feelings and behaviors of anger, loneliness, impaired self-esteem, reduced capacity for empathy, vulnerability, poor insight, poor social skills, inadequate attachments and self-centeredness, absence of impulse control, emotional guardedness, and defense mechanisms of rationalization, denial, projection, and cognitive distortions.

Incidence:

Specific prevalence percentages are not presented in the DSM-5 except for voyeuristic disorder reported to be approximately 12 % (APA, 2013). Maletzsky (1998) reported astonishingly high incident rates in some populations. However, the prevalence rates for offenders are more difficult to determine because so many cases go unreported. Based on victim reports, Herman (1980) estimated that between 4% and 17% had molested children of one or both genders. Undeniably, offenders are significantly more likely to be males than females (Priest & Smith, 1992).

Treatment:

The first treatment step, according to Roundy and Horton (1990), is for the counselor to examine his/her willingness to treat a client with this diagnosis, personal biases that may affect treatment, and belief in the treatment process. Secondly, the counselor must ensure that the abusive behaviors are discontinued (Salter, 1988). Additional recommendations include removal of the perpetrator from environments where behaviors may potentially occur (Salter; e.g., accessibility to children for a pedophile) and the integration of polygraph or plethysmograph (Priest & Smith, 1992) into the treatment process. Interventions that may reduce clients' sexually deviant behaviors include the following: covert sensitization, role-playing, modified aversive behavior rehearsal, cognitive restructuring, and group counseling (Priest & Smith). Many persons with compulsive sexual behaviors may benefit from 12-step type group treatments in organizations such as SAA (Sex Addicts Anonymous). The group process is essentially a peer-moderated cognitive-behavioral approach.

Instrumentation:

Seligman and Hardenburg (2000) in defining the assessment and treatment procedures for paraphilias also list some inventories that are useful for sexual assessment. Some of these are:

1. Millon Clinical Multiaxial Inventory (MCMI; Millon et al., 1997)
2. Minnesota Multiphasic Personality Inventory (MMPI)
3. The Abel Assessment for Sexual Interest-3 (AASI-3; Abel Screening Inc., 2017)
4. Aggressive Sexual Behavior Inventory (Mosher & Anderson, 1986)
5. The Index of Sexual Satisfaction (Hudson, 1998; Hudson, Harrison, & Crosscup, 1981)
6. The Derogatis Sexual Functioning Inventory (DSFI; Derogatis, 1975)
7. The Sexual Self-Efficacy Scale-Erectile Functioning (SSES-E; Libman, Rothenberg, Fichten, & Amsel, 1985)
8. The Brief Sexual Symptom Checklist (Reynolds et al., 1988)
9. Brief Sexual Functioning for Women (Taylor, Rosen, & Leiblum, 1994)

Other Mental Disorders

Other Specified Mental Disorder Due to Another Medical Condition

Historically in this country, 60% of all patients with diagnosable psychiatric disorders, mixed medical and psychiatric problems, primary medical problems associated with psychiatric symptoms, and medical problems causing psychiatric illnesses are treated by primary care physicians (Shepherd, Cooper, Brown, & Kalton, 1966). This high percentage reflects the tendency of many individuals to choose their family doctors rather than mental health professionals, either because of preference or inadequate insurance coverage.

The connection between "psyche" and "soma" is so significant that physical symptoms nearly always are experienced emotionally and vice versa, as Lipp (1977) stated: "There is no fundamental difference between mind and body … The brain itself is the most sensitive indicator of body physiology. Subtle symptoms of brain dysfunction, occasioned by systemic disease, may precede signs of dysfunction in other parts of the body, often by a considerable lead time. In pernicious anemia psychological symptoms may precede hematological evidence of disease by many months" (Lipp, pp. 37-38).

It is important for the mental health professional to understand the mind-body relationship and to be sensitive to the possibility that a physical illness might be at the root of the client's mental or emotional problem (Goldberg, 1987; Peterson & Martin, 1973). It has been known for a long time that a variety of physical and organic symptoms can cause mental illness, including hyperthyroidism and

hyperparathyroidism (Gatewood, Organ, & Mead, 1975; Taylor, 1975), brain tumors causing mental changes (Keschner, Bender, & Strauss, 1938), endocrine and metabolic diseases such as Addison's disease and pernicious anemia (Lipp, 1977; O'Shanick, Gardner, & Kornstein, 1987) and other organic maladies (Peterson & Martin).

Anxiety

Anxiety may be associated with autonomic epilepsy, multiple sclerosis, delirium, uremia, hypoglycemia, thyrotoxicosis, hypoparathyroidism, porphyria, toxic reactions to poisons (e.g., mushrooms and heavy metals), withdrawal from sedatives, tranquilizers or other psychoactive agents, and excessive use of stimulants, caffeine, and some sympathomimetic agents found in decongestants and anti-asthma drugs.

Depression

Depression may be associated with Parkinson's disease, multiple sclerosis, myasthenia, chronic infections, uremia, diabetes mellitus (Dinner, 2004), lung and pancreatic cancers, pernicious anemia, hypopituitarism, thyroid abnormalities, Cushing's or Addison's disease, menopause, pregnancy, steroid use, Reserpine use (for treating hypertension), Interferon (used to treat Hepatitis B), some birth control pills, and chronic heavy metal poisonings. Although there is no correlation between depression and epilepsy variables Lamber and Robertson (1999) reported that two-thirds of patients experience depression or depressive symptoms with epilepsy.

Psychosis and Behavioral Abnormalities

Psychosis and behavioral abnormalities may be associated with psychomotor seizures, multiple sclerosis, Cushing's disease, systemic lupus erythematosus, hypothyroidism, heavy metal poisoning, sudden withdrawal /from some psychoactive medications such as benzodiazepines, reactions to medications such as steroids, INH, alkaloids, thyroid supplements, amphetamines, furosemide, and reactions to drugs such as hallucinogens, mushrooms, cocaine, PCP, and other illicit substances.

Instrumentation:

Primary Care Evaluation of Mental Disorders (PRIME-MD) is a two-stage screening and interview procedure used by primary care physicians to diagnose 18 specific mental disorders in 5 major groups: mood, anxiety, somatic symptom, alcohol, and eating disorders (Spitzer et al., 1995).

Unit 3. REFERENCES

The following references are cited for the content of this supplement. Those with double asterisks preceding the reference were cited within the 37 on-line scenarios and within the supplement. The second set of references is article sources for a study that include selected disorders for assessment, instrumentation, treatment, and monitoring.

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REFERENCE II

The following reference is a list of selected classifications and disorders related to assessment/ diagnosis, treatment, instrumentation, and monitoring.

NEURODEVELOPMENTAL DISORDERS

Assessment:

King, J. H. (2014). Assessment and diagnosis of neurodevelopment disorders. *Counseling Today,* 57(6), 12-15.

Pollak, J., Levy, S., & Breitholt, T. (1999). Screening for medical and neurodevelopmental disorders for the professional counselor. *Journal of Counseling & Development*, 77, 350-358.

Autism Spectrum Disorder

Lord, C., Risi, S., DiLavore, P. S., Shulman, C. S., Thurm, A., & Pickles, A. (2006). Autism from 2 to 9 years of age. *Archives of General Psychiatry,* 63, 695-701.

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Schopp, L., Johnstone, B., & Merrell, D. (2000). Telehealth and neuropsychological assessment: New opportunities for psychologists. *Professional Psychology: Research and Practice*, 31, 179-183.

Weissman, M. M., Markowitz, J. C., Klerman, G. L., & King, J. K. (2013). Assessment and diagnosis of autism spectrum disorder. *Counseling Today*, 56(3), 18- 20.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treatment of mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Attention-Deficit/Hyperactivity Disorder

Assessment:

Brown, M. B., (2000). Diagnosis and treatment of children and adolescents with attention-deficit/hyperactivity disorder. *Journal of Counseling & Development,* 78, 195-203.

Greenhill, L. L. (1998). Diagnosing attention-deficit/hyperactivity disorder in children. *Journal of Clinical* Psychiatry, 59, 31-41.

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Treatment:

Author. (2005). What is the most effective treatment for ADHD in children? *The Journal of Family Practice,* 54(2), 166-168.

Sinzig, J., Dopfner, M., & Lehmkuhl, G. (2007). Long-acting methylphenidate has an effect on aggressive behavior in children with attention-deficit/hyperactivity disorder. *Journal of Child and Adolescent Psychopharmacology,* 17(4), 421-432.

Tourette's Disorder

Assessment:

Himle, M. B., Caprioretti, M. R., Hayes, L. P., Ramanujam, K., Scahill, L., Sukhodolsky, D. G., … & Piacentini, J. (2014). Variables associated with tic exacerbation in children with chronic tic disorders. *Behavior Modification,* 38(2), 163-183.

Kenny, C., Kuo, S., & Shahed, J. J. (2008). Tourette's syndrome. *American Family Physician*, 77(5), 651-658.

Treatment:

Verdellen, C. W. J., Hoogduin, C. A. L., Kto, B. S., Keijers, G. P. J., Cath, D. C., & Hoijtink, H. B. (2008). Habituation of premonitory sensations during exposure and response prevention treatment in Tourette's syndrome. *Behavior Modification*, 32(2), 215-227.

Rhythmic Movement Disorder

Treatment:

Hoban, T. (2003). Rhythmic movement disorder in children. *CNS Spectrum,* 8(2), 135-138

SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

Schizophrenia

Assessment:

Carpenter, W. T. (2014). Porous diagnostic boundaries: A new emphasis for the bulletin. *Schizophrenia Bulletin,* 30(1), 1-2. doi:a0.1093/schbul/sbt14

Fenton, W. S., Mosher, L. R., & Matthews, S. M. (1981). Diagnosis of schizophrenia: A critical review of current diagnostic systems. *Schizophrenia Bulletin,* 7(3), 452-456.

Treatment:

Tandon, R., & Jibson, M. D. (2001). Pharmacologic treatment of schizophrenia: What the future holds. *CNS Spectrum,* 6(2), 980-986.

Schizophrenia Spectrum Disorders

Assessment:

King, J. H. (2014). Assessment and diagnosis of schizophrenia spectrum disorders. *Counseling Today*, 56(9). 12-14.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

BIPOLAR AND RELATED DISORDERS

Bipolar Disorders

Assessment:

Baldassano, C. F. (2005). Assessment tools for screening and monitoring bipolar disorder. *Bipolar Disorders,* 7(Suppl. 1), 8-15.

Chung, H., Culpepper, L., DeWester, J. N., Grieco, R., Kaye, S., Lipkin, … & Ross, R. (2007). Recognizing and understanding bipolar disorder. *Journal of Family Practice*, 56. S5.

Chung, H., Culpepper, L., DeWester, J. N., Grieco, R., Kaye, S., Lipkin, M., … & Ross, R. (2007). Recognizing and understanding bipolar disorder at the interface of primary care and psychiatric medicine. Part 4: Treatment by phase: Pharmacologic management of bipolar disorder. *The Journal of Family Practice,* 56(11SUPPL), S19-S27.

Das, A. K., Olfson, M., Gameroff, M.J., Pilowsky, D. J., Blanco, C., Feder, A., … & Weissman, M. M. (2005). Screening for bipolar disorder in a primary care practice. *JAMA,* 293(8), 956-963.

King, J. H. (2014). Assessment and diagnosis of psychotic and bipolar-related disorders. *Counseling Today*, 56(11), 12-15.

Wilkinson, G. B., Taylor, P., & Holt, J. R. (2002). Bipolar disorder in adolescence: Diagnosis and treatment. *Journal of Mental Health Counseling*, 24(4), 348-357.

Zimmerman, M. (2014). Screening for bipolar disorder: Confusion between case-findings and screening. *Psychotherapy and Psychosomatics*, 4, 259-262.

Treatment:

Basco, M. R., Merlock, M., & McDonald, N. (2003). Cognitive-behavioral strategies for the management of bipolar disorder. *Primary Psychiatry,* 10(5), 65-71.

Bordnick, P. S. (1997). Trichotillomania: A social worker's guide to practice. *Research on Social Work Practice*, 7, 216-228.

Chung, H., Culpepper, L., DeWester, J. N., Grieco, R. L., Kaye, N. S., Lipkin, M., Rosen, S. J., & Ross, R. (2007). Treatment by phase: Pharmacologic management of bipolar disorder. *The Journal of Family Practice*, 56(11), S19-S27.

Coryell, W. (2005). Rapid cycling bipolar disorder: Clinical characteristics and treatment options. *CNS Drugs*, 19(7), 557-569.

Fountoulaksi, K. N., Grunze, H., Panagiotidis, P., & Kaprinis, G. (2008). Treatment of bipolar depression: An update. *Journal of Affective Disorders*, 109, 21-34.

Rea, M. M., Thompson, M. C., Miklowitz, D., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family-focused treatment versus individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 71(3), 482-492.

Sylvia, L. G., Peters, A. T., Deckersbach, T., & Nierenberg, A. (2013). Nutrient-based therapies for bipolar disorder: A systematic review. *Psychotherapy and Psychosomatics,* 82(10), 10-19.

Wilkinson, G. B., Taylor, P., & Holt, J. R. (2002). Bipolar disorder in adolescence: Diagnosis and treatment. *Journal of Mental Health Counseling*, 24(4), 348-357.

Monitoring:

Baldassano, C. F. (2005). Assessment tools for screening and monitoring bipolar disorder. *Bipolar Disorders,* 7(Suppl. 1), 8-15.

DEPRESSIVE DISORDERS

Disruptive Mood Dysregulation Disorder

Diagnosis:

Axelson, D., Birmaher, B., Findling, R. L., Fristad, M. A., Kowatch, R. A., Youngstrom, E. A., …Diler, R. S. (2011). Concerns regarding the inclusion of temper dysregulation disorder with dysphoria *in the diagnostic and statistical* manual of mental disorders, fifth edition. *Journal of Clinical Psychiatry*, 72(9), 1257-1262.

Copeland, W. E., Angold, A., Costello, E. J., & Egger, H. (2013). Prevalence, comorbidity, and correlates of DSM-5 proposed disruptive mood dysregulation disorder. *American Journal of Psychiatry,* 170, 173-179.

Seligman, L., & Moore, B.M. (1995). Diagnosis of mood disorders. *Journal of Counseling and* Development, 74, 65-69.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive* systematic *guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Instruments:

Berking, M., & Znoj. H. (2008). Entwicklung und vali die rung eines fragebogens zur standdisierten selbsteinschatzung emotionaler kompetenzen (SEK-27) [Development and validation of the Emotion-Regulation Sills Questionnaire (ERSQ-277]. *Zeitschrift fur Psychiatrie, Psychologie und Psychotherapie*, 56, 141-153. doi: 10.1024/1661-4747.56.2.141

Radkovsk, A., McArdle, J. J., Bockting, C. L. H., & Berking, M. (2014). Successful emotion regulation skill application predicts subsequent reduction of symptom severity during treatment of major depressive disorder. *Journal of Consulting and Clinical Psychology*, 82(2), 248-262. (Emotions Regulations Skills Questionnaire) [Berking & Zoj, 2008].

Treatment:

Barrett, J. E., Williams, J. W., Oxman, T. E., Frank, E., Katon, W., Sullivan, M. …Sengupta, A. S. (2001). Treatment of dysthymia and minor depression in primary care. *The Journal of Family Practice,* 50(5), 405-412.

Major Depressive Persistent Disorder And Cyclothymic Disorder

Assessment:

Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus*, 8(1), 32-42. (EFT manualized effectiveness)

King, J. K. (*2014).* Assessment and diagnosis of psychotic and bipolar-related disorders. *Counseling Today,* 56(11), 12-15.

King, J. K. (2014). Assessment and diagnosis of depressive disorders and bereavement reactions. *Counseling Today*, 57(2), 12-15. Seligman, L., & Moore, B. M. (1995). Diagnosis of mood disorders. *Journal of Counseling &* Development, 74, 65-69.

Instruments:

Hakstian, A. R., & McLean, P. D. (1989). Brief screen for depression. *Journal of Consulting and Clinical* Psychology, 1(2), 139-141.

Kurlowicz, L. & Greenberg, S. A. (2007). The Geriatric Depression Scale (GDS). *Geriatric Nursing,* 4. www.hartfordign.org, retrieved 8-21-2014.

Muller, B.E., & Erford, B.T. (2012). Choosing assessment instruments for depression outcome research with school-aged youth. *Journal of Counseling & Development,* 90(2), 208-220.

Radkovsk, A., McArdle, J. J., Bockting, C. L. H., & Berking, M. (2014). Successful emotion regulation skills application predicts subsequent reduction of symptom severity during treatment of major depressive disorder. *Journal of Consulting and Clinical Psychology*, 82(2), 248-262. (Emotions Regulations Skills Questionnaire) [Berking & Zoj, 2008].

Voelz, Z., & Joiner, T. E., Jr. (2002). The tripartite model of anxiety and depression: Implications for the assessment and treatment of depressed adults and adolescents. *Primary Psychiatry*, 9(6), 59-62.

Wilkinson, G. B., Taylor, P., & Holt, J. R. (2002). Bipolar disorder in adolescence: Diagnosis and treatment. *Journal of Mental Health Counseling,* 24(4), 348-357.

Treatment:

Barrett, J. E., Williams, J. W., Oxman, T. E., Frank, E., Katon, W., Sullivan, J., …& Sengupta, A. S. (2001). Treatment of dysthymia and minor depression in primary care. *The Journal of* Family Practice, 50(5), 405-412.

Carney, C. E. (2013). Sleep therapy is expected to gain a wider role in depression treatment. *New York Times,* November 24, 2013; http: nytimes.com/ 2013 /11/24/

DeLima, M. S. & Hotopf, M. (2003). Benefits and risks of pharmacotherapy for dysthymia. *Drug Safety,* 26(1), 55-64. (Result: effective outcome evidence)

Gilliam, C. M., & Cottone, R. R. (2005). Couple or individual therapy for the treatment of depression: An update of the empirical literature. *The American Journal of Family Therapy*, 33, 265-272.

Gintner, G. G. (1995). Differential diagnosis in older adults: Dementia, depression, and delirium. *Journal* of Counseling *& Development,* 73, 346-351.

Goldman, R. N., Greenberg, L.S., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research*, 16, 536-546. (effectiveness study for EFT)

Greenberg, L. & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research,* 8, 210-224. (*effectiveness study for EFT)

Harpin, R. E., Lieberman, R. P., Marks, I., Stern, R., & Bohanon, W. E. (1982). Cognitive-behavior therapy for chronically depressed patients: A controlled pilot study. *Journal of Nervous Mental Disorders*, 170, 295-301.

Hollon, S. D. (1999). The prevention of depression and anxiety. *Prevention & Treatment*, 2, 274-291.

Hollon, S. D., Thase, M. E., & Markowitz, J. C. (2002). Treatment of prevention of depression. *Psychological Science in the Public Interest*, 3: 39-77

Kanter, J. W., Kohlenberg, R. J. & Loftus, E. F. (2002). Demand characteristics, treatment rationales, and cognitive therapy for depression. *Prevention and Treatment,* 5, Article 41.

Kanter, J. W., Rusch, L. C., Landes, S. L., Holman, G. I., Whiteside, U., & Sedivy, S. K. (2009). The use and nature of present-focused interventions in cognitive and behavioral therapies for depression. *Psychotherapy: Research, Theory, Practice, Training,* 46, 220-232.

Markowitz, J. C. (1966). Psychotherapy for dysthymic disorder. In M. B. Keller & W. B. Sanders (Eds), *The psychiatric clinic of North America: Mood disorder,* 9(1). 133-147. (*clinical trials for effectiveness for CBT & Interpersonal therapy).

Paradise, L., & Kirby, P. (2005). The treatment and prevention of depression: Implications for counseling and counselor training. *Journal of Counseling & Development*, 83, 116-119.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Watson, J. C., Gordon, L.B., Stermac, L., Kalogerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting Clinical Psychology*, 71, 773-781.

Wilkinson, G. B., Taylor, P., & Holt, J. R. (2002). Bipolar disorder in adolescence: Diagnosis and treatment. *Journal of Mental Health* Counseling, 24(4), 348-357.

Monitoring:

Achenbach, T. M., & Rescoria, L. A. (2001). *Manual for the ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families**.**

Berking, M., & Znoj. H. (2008). Enwicklung und validierung eines fragebogens zur standdisierten selbsteinschatzung emotionaler kompetenzen (SEK-27) [Development and validation of the Emotion-Regulation Skills Questionnaire (ERSQ-277]. *Zeitschrift fur Psychiatrie, Psychologie und Psychotherapie*, 56, 141-153. doi: 10.1024/1661-4747.56.2.141

McHugh, K., & Behar, E. (2009). Readability of self-report measures of depression and anxiety. *Journal of Consulting and Clinical Psychology*, 77(6), 1100-1112.

ANXIETY DISORDERS

Anxiety Disorders

Assessment:

Eack, S. M., Singer, J. B., & Greeno, C. G. (2006). Screening for anxiety and depression in community mental health: The Beck Anxiety and Depression Inventories. *Community Mental Health*, 44, 465-474.

Fong, M. L., & Silien, K. A. (1999). Assessment and diagnosis of DSM-IV anxiety disorders. *Journal of Counseling & Development,* 77, 209-217.

Frick, P. J., Silverthorn, P., & Evans, C. (1994). Assessment of childhood anxiety using structured interviews: Patterns of agreement among informants and association with maternal anxiety. *Psychological Assessment*, 6(4), 372-379.

King, J. K, (2014). Assessment and diagnosis of anxiety, somatic symptom and related disorders. *Counseling Today*, 56(12), 12-15.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Instruments:

Eack, S. M., Singer, J. B., & Greeno, C. G. (2006). Screening for anxiety and depression in community mental health: The Beck Anxiety and Depression Inventories. *Community Mental Health*, 44, 465- 474.

Jones, K. D. (2012). Dimensional and cross-cutting assessment in the DSM-5. *Journal of Counseling and* Development, 90(4), 481-487.

Treatment:

Ayers, C. R., Sorrell, J. T., Thorp, S. R., & Wetherell, J. L. (2007). Evidence-based psychological treatments for late-life anxiety. *Psychology and Aging,* 22(1), 8-17.

Clark, D. M., Ehlers, A., Hackman, A., McManus, F., Fennell, M., Grey, N., … & Wild, J. (2006). Cognitive therapy versus and applied relaxation in social phobia: A randomized controlled trial. *Journal of Counseling and Clinical Psychology*, 74(3), 568-578.

Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus,* 8(1), 32-42. (*EFT shows promise as a treatment for anxiety)

Gryczkowski, M. R., Tiede, M. S., Dammann, J. E., Jacobsen, A. B., Hale, L. R., & Whiteside, S. P. H. (2013). The timing of exposure in clinic-based treatment for childhood anxiety disorders. *Behavior Modification,* 37(1), 113-127.

Herbert, J. D., Gaudiano, B. A., Moitra, E., Myers, V. H., Dalrymple, K., & Brandsma, L. L. (2009). Cognitive behavior therapy for generalized social anxiety disorder in adolescents: A randomized controlled trial. *Journal of Anxiety Disorders,* 23, 167-177.

Miller, L. D., Short, C., Garland, E. J., & Clark, S. (2010). The ABCs of CBT (Cognitive Behavior Therapy): Evidence-based approaches to child anxiety in public school settings. *Journal of Counseling and Development*, 88, 432-439.

Persons, J. B**.** (2001). Understanding the exposure principle and using it to treat anxiety. *Psychiatric Annals,* 31(8), 473, 475-476.

Thompson, J. M. (2002). Psychodynamic insight-oriented treatment of anxiety. *Primary Psychiatry,* 9(7), 43-46.

Ward, H. E., Shapira, N. A., & Goodman, W. K. (2002). Nonpharmacological somatic treatments of anxiety disorder. *Primary Psychiatry,* 9(7), 55-58.

Zimand, E., Anderson, P., Gershon, J., Graap, K., Hodges, L. & Rothbaum, B. (2002). Virtual reality therapy: Innovative treatment for anxiety disorders. *Primary Psychiatry,* 9(7), 51-54.

Separation Anxiety Disorder

Treatment:

Cheer, S., & Figgitt, D. P. (2001). Spotlight on Fluvoxamine in anxiety disorders in children and adolescents. *Pediatric Drugs,* 3(10), 762-781.

Choates, M. L., Pincus, D. B., Eybert, S. M. & Barlow, D. H. (2005). Parent-child interaction therapy for treatment of separation anxiety disorder in young children: A pilot study. *Cognitive and Behavioral Practice,* 12(1), 126-135.

Dia, D. A. (2001). Cognitive-behavioral therapy with a six-year-old boy with separation anxiety disorder: A case study. *Health and Social Work*, 26(2), 125-128.

Schneider, S., Blatter-Meunier, J., Herren, C., In-Albon, T., Adornetto, C., Meyer, A., & Lavallec, K. (2013). The efficacy of a family-based cognitive-behavioral treatment for separation anxiety disorder in children aged -13: A randomized comparison with a general anxiety program. *Journal of Consulting* and Clinical Psychology, 81(5), 932-940.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Social Anxiety Disorder

Treatment:

Albano, A. M. (2003). Treatment of social anxiety disorder. In R. Reinecke, F. Datillo, & A. Freeman (Eds.), *Casebook of cognitive behavioral therapy with children and adolescents* (2nd ed., pp. 128-161.

Beidel, D. D., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology*, 68, 1072-1080.

Cheer, S., & Figgitt, D. P. (2001). Spotlight on Fluvoxamine in anxiety disorders in children and adolescents. *Pediatric Drugs,* 3(10), 762-781.

Curtis, R. C., Kimball, A., & Stroup, E. I. (2004). Understanding and treating social phobia. *Journal of Counseling & Development,* 82, 3-9.

Herbeert, J. D., Gaudiano, B. A., Moitra, E., Myers, V. H., Dalrymple, K., & Brandsma, L. L. (2009). Cognitive behavior therapy for generalized social anxiety disorder in adolescents: A randomized controlled trial. *Journal of Anxiety Disorders,* 23, 167-177.

Huppen, J. D., Strunk, D. R., Ledley, D. R., Davidson, J. R. T., & Foa, E. B. (2008). Generalized social anxiety disorder and avoidant personality disorder: Structural analysis and treatment outcome. Depression and Anxiety, 25, 441-448.

Rowa, K., & Anthony, M. M. (2005). Psychological treatments for social phobia. *Canadian Journal of Psychiatry,* 50(6), 308-316.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Monitoring:

Mezo, P. G., McCabe, R. E., Antony, M. M., & Burns, K. (2005). Psychometric validation of a monitoring-blunting measure for social anxiety disorder: The Coping Styles Questionnaire for Social Situations (CSQSS). *Depression and Anxiety*, 22(1), 20-27.

Synder, M. (1974). Self-monitoring of expressive behavior. *Journal of Personality and Social Psychology* (Vol. 12). New York: Academic Press.

Panic Disorder

Treatment:

Addis, M. E., Hatgis, C., Cardemil, E., Jacob, K., Krasnow, A., & Mansfield, A. (2006). Effectiveness of cognitive-behavioral treatment for panic disorder versus treatment as usual in a manage care setting: 2-year follow-up. *Journal of Counseling and Clinical Psychology,* 74(2), 377-385.

Beamish, P. M., Granello, P. F., Granello, D. H., McSteen, P. B., Bender, B. A., & Hermon, D. (1996). Outcome studies in the treatment of panic disorder: A review. *Journal of Counseling & Development,* 74, 460-467. [Outcome studies for diagnosis/assessment and treatment)

Clark, D. M., Salkovskis, P. M., Hackmann, A., Wells, A., Ludgate, J., & Gelder, M. (1999). Brief cognitive therapy for panic disorder: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 67(4), 583-589.

Gould, R. A., Otto, M. W., & Pollack, M. H. (1995). A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review*, *15*, 819-844.

Leavitt, L.T., Hoffman, E. C., Grisham, J. R., & Barlow, D. H. (2010). Empirically supported treatments for panic disorder. *Psychiatric Annals,* 31(8), 478-487.

Marchland, L., Marchland, A., Pierre Landry, P., Legate, A., & Labrecque, J. (2013). Efficacy of two cognitive-behavioral treatment modalities for panic disorder with nocturnal panic attacks. *Behavior Modification*, 35(7), 680-704.

Generalized Anxiety Disorder

Treatment:

Brown, A. P., Marquis, A., & Guiffrida, D. A. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling & Development*, 91(1), 96-104.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685-716 dol:10.1146/annurev. psch.52.1.685. (several clinical trials effectiveness for CBT)

Grover, R. L., Hughes, A. A., Bergman, R. L., & Kingery, J. N. (2006). Treatment modifications based on childhood anxiety diagnosis: Demonstrating the flexibility in manualized treatment. *Journal of* Cognitive Psychotherapy: An International Quarterly, 20(3), 275-285.

Newman, M.G., Castonguay, L. G., Borkovec, T.D., Fisher, A.J., Boswell, J. F., Szkodny, L.E., & Nordbert, S. S. (2011). A randomized controlled trial of cognitive-behavioral therapy for generalized anxiety disorder with integrated techniques from emotion-focused interpersonal therapies. *Journal of Consulting and Clinical Psychology*, 79(2), 171-181.

Roemer, L., Orsillo, S. M., & Salters-Pedneault, K. (2008). Efficacy of an acceptance-based behavior therapy for generalized anxiety disorder: Evaluation in a randomized trial. *Journal of Consulting and Clinical Psychology,* 76(6), 1083-1089. (ACT shows promise for GAD).

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Siqueland, L., Rynn, M. & Diamond, G. S. (2005). Cognitive behavioral and attachment based family therapy for anxious adolescents: Phase I and II studies. *Journal of Anxiety Disorders*, 19, 361-381.

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

Treatment:

Cheer, S., & Figgitt, D. P. (2001). Spotlight on Fluvoxamine in anxiety disorders in children and adolescents. *Pediatric Drugs,* 3(10), 762-781.

Hill, N. R., & Beamish, P. M. (2007). Treatment outcomes for obsessive-compulsive disorder: A critical review. *Journal of Counseling & Development*, 85, 504-510.

King, J. K. (2014). Assessment and diagnosis of obsessive-compulsive and related disorders. *Counseling Today*, 57(4), 12-15.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Twohig, M. P., Abramowitz, J. S., Bluett, E. J., Fabricant, L. E., Jacoby, R. J., Morrison, K. L., … & Smith, B. M. (2015). Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework. *Journal of Obsessive-Compulsive and Related Disorders,* 6, 167-173.

Monitoring

Simpson, H. B., Maher, M. J., Wang, Y., Bao, Y., Foa, E. B., & Franklin, M. (2011). Patient adherence predicts outcome from cognitive behavior therapy in obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology*, 79(2), 247-252.

Body Dysmorphic Disorder

Assessment:

King, J. K. (2014). Assessment and diagnosis of obsessive-compulsive and related disorders. *Counseling Today*, 57(4), 12-15.

Knobloch, P. (2013). Body dysmorphic disorder and teens. *Counseling Today*, (56), 6, 12-13.

Phillips, K. A. (2000). Body dysmorphic disorder: Diagnostic controversies and treatment challenges. *Bulletin of the Menninger Clinic*, 64(11), 18-35.

Treatment:

Delinsky, S. S., & Wilson, G. T. (2006). Mirror exposure for the treatment of body image disturbance. *International Journal of Eating Disorders*, 39(2), 108-116.

Phillips, K. A. (2004). Treating body dysmorphic disorder using medication. *Psychiatric Annals,* 34(12), 945-953.

Phillips, K. A., & Dufresne, R. (2000). Body dysmorphic disorder: A guide for dermatologists and cosmetic surgeons. *American Journal of Clinical Dermatologist,* 1(4), 235-242.

Seligman, L., & Reichenberg, L. W. (2012*). Selecting effective treatment: A comprehensive* systematic *guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Hoarding Disorder

Assessment:

King, J. K. (2014). Assessment and diagnosis of obsessive-compulsive and related disorders. *Counseling Today*, 57(4), 12-15.

Kress, V. E., Stargell, N. A., Zoldan, C. A., & Paylo, M. J. (2016). Hoarding disorder: Diagnosis, assessment, and treatment. *Journal of Counseling & Development,* 94, 83-90.

Treatment:

Kress, V. E., Stargell, N. A., Zoldan, C. A., & Paylo, M. J. (2016). Hoarding disorder: Diagnosis, assessment, and treatment. *Journal of Counseling & Development,* 94, 83-90.

Trichotillomania

Assessment:

White Kress, V. E., Kelly, B. L., & McCormick, L. J. (2004). Trichotillomania: Diagnosis and treatment, *Journal* of *Counseling & Development,* 82(2), 185-190.

Diefenbach, G. J., Reitman, D., & Williamson, D. A. (2000). Trichotillomania: A challenge to research and practice. *Clinical Psychology Review, 20*, 289-309.

Diefenbach, G. J., Tolin, D. F., Crocetto, J., Maltby, N., & Hannan, S. (2005). Assessment of Trichotillomania: A psychometric evaluation of hair-pulling scales. *Journal of Psychopathology and Behavioral Assessment, 27*, 169-178.

Stein, D. J., Hollander, E., Trungold, S., Cohen, L., DeCaria, C. M., Mullen, L., & Islam, M. (1995). Compulsive and impulsive symptoms in trichotillomania. *Psychopathology,* 28, 208-213.

Instruments:

The two most common instruments are the:

1. Massachusetts General Hospital Hairpulling Symptom Severity Scale (MGH-HS; Keuthen., et al., 1995)
2. National Institute of Mental Health Trichotillomania Severity Scale (NIMHLl-TSS: Swedo et al., 1989).

Treatment:

McDonald, K. E. (2013). Trichotillomania: Identification and treatment. *Journal of Counseling & Development*, 90(4), 421-426.

White Kress, V. E., Kelly, B. L., & McCormick, L. J. (2004). Trichotillomania: Diagnosis and treatment. *Journal of Counseling & Development,* 82(2), 185-190

Monitoring:

Azrin, N. H., Nunn, R. G., & Franz, F. E. (1980) research with trichotillomania clients had a 97% reduction in hair pulling for 4 weeks following the training and 87% after 22 months of therapy.)

Azrin, N. H., Nunn, R. G., & France, F. E. (1980). Treatment of hair pulling (trichotillomania): A comparative study of habit reversal and negative practice training. *Journal of Behavior Therapy and Experimental Psychiatry,* 11, 13-20.

Diefenbach, G. J., Reitman, D., & Williamson, D. S. (2000). Trichotillomania: A challenge to research and practice. *Clinical Psychology Review*, 20, 289-309

Enos, S., & Plante, T. (2001). Trichotillomania: An overview and guide to understanding. *Journal of Psychosocial Nursing & Mental Health Services*, 39, 10-16. (Habit reversal technique-HRT.

Excoriation Disorder (Skin-Picking Disorder)

Assessment:

King, J. K. (2013). Assessment and diagnosis of PTSD and skin-picking disorder. *Counseling Today*, (56)4, 20-22.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

TRAUMA-AND STRESSOR-RELATED DISORDERS

Posttraumatic Stress Disorder

Assessment:

Arlinghause, K. A., Shoaib, A. M., & Price, T. R. P. (2005). Neuropsychiatric assessment. In J. M. Silver, T. W. McAlister, & S. C. Yudofsy, *Textbook of traumatic brain injury* (pp, 63-65), Washington, DC: American Psychiatric Association.

Beck, J. G., & Coffey, S. F. (2007). Assessment and treatment of posttraumatic stress disorder after a motor vehicle collision: Empirical findings and clinical observations. *Professional Psychology: Research and Practice,* 38(6), 629-639.

Blake, D. D. (1993). Psychological assessment and PTSD: Not just for researchers. *NCP Clinical Quarterly*, 3(1), 15-17.

Jorge, R. E. (2005). Neuropsychiatric consequences of traumatic brain injury: A review of recent findings. *Current Opinion in Psychiatry*, 18 (3), 289-99.

King, J. K. (2013). Assessment and diagnosis of PTSD and skin-picking disorder. *Counseling Today*, (56)4, 20-22.

Instruments:

Bardhoshi, G., Erford, B. T., Duncan, K., Dummett, B., Falco, M., Deferio, K., & Kraft, J. (2016). Choosing Assessment instruments for posttraumatic stress disorder screening and outcome research. *Journal of Counseling & Development,* 94, 184-194.

Treatment:

Block, C. K., & West, S. E. (2013). Psychotherapeutic treatment of survivors of traumatic brain injury: Review of the literature and special considerations. *Brain Injury,* 27(7-8), 775-788. doi: 10.3109/02699052.2013.775487

Chaill, S. P., Foa, E. B., Hembree, E. A., Marshall, R. D., & Nacash, N. (2006). Dissemination of exposure therapy in the treatment of posttraumatic stress disorder. *Journal of Traumatic Stress,* 19(5), 597-610.

Elhai, J. D., Gray, M. J., Kashdan, T. B., & Franklin, C. L. (2005). Which instruments are most commonly used to assess traumatic exposure and posttraumatic effects: A survey of traumatic stress professionals? *Journal of Traumatic Stress,* 18(5), 541-545.

Falsetti, S. A. (2003). Cognitive-behavioral therapy in the treatment of posttraumatic stress disorder. *Primary Psychiatry*, 10(5), 78-82.

Korn, D. L. (2009). EMDR and the treatment of complex PTSD: A review. *Journal of EMDR Practice and Research*, 3(4), 264-278.

Makinson, R., & Young, J. S. (2012). Cognitive behavioral therapy and the treatment of posttraumatic stress disorder: Where counseling and neuroscience meet. *Journal of Counseling & Development*, 90(2), 131-140.

Ponniah, K., & Hollon, S. D. (2009). Empirically supported psychological treatment for adult acute stress disorder and posttraumatic stress disorder: A review. *Depression and Anxiety*, 26, 1086-1109.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Van Etten, M. L., & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. *Clinical Psychology & Psychotherapy,* 5, 126-144.

Acute Stress Disorder

Treatment:

Bryant, R. A., Moulds, M. L., Guthrie, R. M., & Nixon, R. D. V. (2005). The additive benefit of hypnosis and cognitive-behavioral therapy in treating acute stress disorder. Journal of *Counseling and Clinical Psychology,* 73(2), 334-340 [controlled study-CBT-hypnosis results reflected a greater reduction in re-experiencing symptoms of posttreatment than CBT]

Buydens, S., Wilensky, M., & Hensley, B. J. (2014). Effects of the EMDR Protocol for recent traumatic events on acute stress disorder: A case series. *Journal of EMDR Practice and Research*, 8(1), 2-12. http://dx.doi.org/10.1891/1933-3196.8.1.2

Ponniah, K., & Hollon, S. D. (2009). Empirically supported psychological treatment for adult acute stress disorder and posttraumatic stress disorder: A review. *Depression and Anxiety*, 26, 1086-1109.

Adjustment Disorder

Assessment:

Carta, M. G., Balestrieri, M., Murru, A., & Hardoy, N. C. (2009). Adjustment Disorder: Epidemiology, diagnosis and treatment. *Clinical Practice Epidemiology Mental Health*, 5(1), 15. doi:10086/1745-0179-5-15.

Greenberg, W. M., Rosenfeld, D. N., & Ortega, E. A. (1995). Adjustment disorder as an admission diagnosis. *American Journal of Psychiatry,* 152(3), 459-461.

Strain, J. J., & Diefenbacher, A. (2008). The adjustment disorder: The conundrums of the diagnoses. *Science Digest,* 49, 121-130. doi: 10.1016/j.comppsych.2007.10002

Treatment:

Bachem, R., & Maercker, A. (2016). Self-help interventions for adjustment disorder problems: A randomized waiting-list controlled study in a sample of burglary victims. *Cognitive Behavioral Therapy,* 45(5), 397-413. doi:10.1080/16506073.2016.1191083

Skruibis, P., Eimontas, J., Dovydaitiene, M., Mazulyte, E., Zelvience, P., & Kaziauskas, E. (2016). Internet-based modular program BADI for adjustment disorder: Protocol of a randomized controlled trial. *BMC Psychiatry*, 16, 264-270. doi:10.1186/s12888-016-0980-9

Strain, J. J. (1995). Adjustment disorders. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders* (2nd ed., pp. 1655-1665). Washington, DC: American Psychiatric Association Press

DISSOCIATIVE DISORDERS

Dissociative Identity Disorder

Assessment:

Steinberg, M., Rounsaville, B., & Cicchetti, D. (1991). Detection of dissociative disorders in psychiatric patients by a screening instrument and a structured diagnostic interview. *American Journal of Psychiatry*, 148, 1050-1054.

Instrument:

Bauerband, L. A., & Galupo, P. (2014). The Gender Identity Reflection and Rumination Scale: Development and psychometric evaluation. *Journal of Counseling & Development*, 92(1), 219-231.

Ellison, J. W., & Ross, C. A. (1997). Two-year follow-up of inpatients with dissociative identity disorder. *American Journal of Psychiatry*, 154(832-839.

SOMATIC SYMPTOM AND RELATED DISORDERS

Somatic Symptom Disorder

Assessment:

Burket-Smith, M. (2001). Somatization and chronic pain. *Acta Anaesthesiologica Scandinavica*, 45(9), 114-1120.

King, J. K, (2014). Assessment and diagnosis of anxiety, somatic symptom and related disorders. *Counseling Today*, 56(12), 12-15.

Treatment:

Looper, K. J., & Kirmayer, J. (2002). Behavioral medicine approaches to somatoform disorders. *Journal of Counseling and Clinical Psychology,* 70(3), 810-827. * [efficacy studies for CBT support for hypochondriasis, body dysmorphic disorder, chronic fatigue syndrome, and group treatment for BDD.]

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

FEEDING AND EATING DISORDERS

Assessment:

Anderson, D. A., Lundgren, J.D., Shapiro, J. R., & Paulosky, C. A. (2004). Assessment of eating disorders: Review and recommendations for clinical use. *Behavior Modification,* 28, 763-782.

Berg, K. C., Peterson, C. B., & Frazier, P. (2012). Assessment and diagnosis of eating disorders: A guide for professionals. *Journal of Counseling & Development,* 90(3), 262-269.

King, M. B. (1989). Eating disorders in a general practice: Prevalence, characteristics and follow-up at 12 to 15 months. *Psychological Medicine*, (Monograph Supplement), 14.

Mitchell, J. E., & Peterson, C. B. (2005). Assessment of eating disorders. *New York, NY: Guilford Press.*

Pica Disorder

Assessment:

Rapp, J. T., Dozier, C. L., & Carr, J. E. (2001). Functional assessment and treatment of pica: A single-case experiment. *Behavioral Interventions,* 16, 111-125.

Instruments:

Eberly, C. C., & Eberly, B. W. (1985). A review of the Eating Disorder Inventory. *Journal of Counseling and Development*, 64, 285-288.

Reas, D. L., Whisenhunt, B. L., Netemeyer, R., Williamson, D. A. (2002). Development of the body checking questionnaire: A self-report measure of body checking behaviors. *International Journal of Eating Disorders*, 31(3), 324-333.

Treatment:

Bell, K. E., & Stein, D. M. (1992). Behavioral treatment of pica: A review of empirical studies. *International Journal of Eating Disorders*, 11, 377-389.

Burke, L., & Smith, S. L. (1999). Treatment of pica: Considering least intrusive options when working with individuals who have a developmental handicap and live in a community setting. *Developmental Disabilities Bulletin,* 27, 30-46.

Federici, A., Wisniewski, L., & Ben-Porath, D. (2012). Description of an intense dialectical behavior therapy program for multidiagnostic clients with eating disorders. *Journal of Counseling & Development,* 90, 330-338.

Binge Eating Disorder

Assessment:

Tanofsky-Kraft, M., Goosens, L., Eddy, K.T., Ringham, R., Goldschmidt, A., Yanovski, S.Z., …& Olsen, C. (2007). A multisite investigation of binge eating behaviors in children and adolescents. *Journal of Consulting and Clinical Psychology*, 75(6), 901-913. (relationship between negative emotions and loss of control in eating, sensitive to negative feedback)

Instruments:

Lydecker, J. A., White, M. A., & Grilo, C. M. (2016). Black patients with binge-eating disorder: Comparison of different assessment methods. *Psychological Assessment,* 28(10), 1319-1324. http://dx.doi.org/10.1037/pas0000246

Treatment:

Grilo, C. M., Crosby, R. D., Wilson, G. T., & Masheb, R. M. (2012). 12-month follow-up of fluoxetine and 1108-1113.cognitive behavioral therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology*, 80(6), 1108-1113.

Grilo, C. M., & Masheb, R. M. (2012). Predictors and moderators of response to cognitive behavioral therapy and medication for the treatment of binge eating disorder. *Journal of Consulting and Clinical Psychology*, 80(5), 897-906.

Lenz, A. S., Taylor, R., Fleming, M., & Serman, N. (2014). Effectiveness of dialectical behavior therapy for treating eating disorders. *Journal of Counseling & Development,* 92(1), 26-35.

McLean, S. A., Paxton, S. J., & Wertheim, E. H. (2011). A body image and disordered eating intervention for women in midlife: A randomized controlled trial. *Journal of Consulting and Clinical Psychology,* 79(6), 751-758.

Safer, D. L., Lock, J., & Couturier, J.L. (2007). Dialectical behavior therapy modified for adolescent binge eating disorder: A case report. *Cognitive and Behavioral Practice,* 14, 157-167.

Tanofsky-Fraff, M., Goossens, L., Eddy, K. T., Ringham, R., Goldschmidt, A., Yanovski, S. Z., … & Yanovski, J. A. (2007). A multisite investigation of binge eating behaviors in children and adolescents. *Journal of Consulting and Clinical Psychology*, 75(6), 901-913.

Telch, C., Agras, W., & Linehan, M. (2001). Dialectical behavior therapy for binge eating disorder. *Journal* of Counseling and Clinical Psychology, 61, 1051-1065.

Monitoring:

Allen, H. N., & Craighead, L. W. (1999). Appetite monitoring in the treating of binge eating disorder. *Behavior Therapy,* 30(2), 253-272.

Latner, J. D., & Wilson, G.T. (2002). Self-monitoring and the assessment of binge eating. *Behavior Therapy*, 33(3), 465-477

Bulimia Nervosa, Anoxrea Nervosa

Assessment:

Anderson, D. A., Lundgren, J. D., Shapiro, J. R., & Paulosky, C. A. (2004). Assessment of eating disorders: Review and recommendations for clinical use. *Behavior Modification*, 28, 763-782.

Berg, K. C., Peterson, C. B., & Frazier, P. (2012). Assessment and diagnosis of eating disorders: A guide for professional counselors. *Journal of Counseling & Development,* 90(3), 263-269.

King, J. K. (2014). Assessment and diagnosis of feeding, eating and elimination disorders. *Counseling Today,* 56(10), 12-15.

Miller, J. E., & Peterson, C. B. (2005). *Assessment of eating disorders.* New York, NY: Guilford Press.

Shekter-Wolfson, L., Woodside, L. F., & Lackstrom, J. (1997). Social work treatment of anorexia and bulimia: Guidelines for practice. *Research on Social Work Practice*, 7(1), 5-31.

Wonderlich, S. A., & Mitchell, J. E. (1997). Eating disorders and comorbidity: Empirical, conceptual, and clinical implications. *Psychopharmacology Bulletin*, 33, 381-390.

Instruments:

Erford, B. T., Richards, T., Peacock, E., Voith, K., McGair, H., Muller, B., …Chang, C. (2013). Counseling and guided self-help outcomes for clients with bulimia nervosa: A meta-analysis of clinical trials from 1980-2010. *Journal of Counseling & Development,* 91, 152-157.

Fairburn, C. G., & Cooper, Z. (1993). The Eating Disorder Examination. In C. G. Fairburn & G. T. Wilson (Eds*.), Binge eating: Nature, assessment, and treatment* (pp. 317-360). New York, NY: Guilford Press**.**

Sandford, K., & Erford, B. T. (2013). Choosing assessment instruments for bulimia practice and outcome research. *Journal of Counseling & Development,* 91, 367-379.

Treatment:

Appolinario, J. C., & McElroy, S. (2004). Pharmacological approaches in the treatment of binge eating disorder. *Current Drug Targets*, 5, 301-307.

Berekowitz, M., & Eisler, I. (2007). A randomized controlled trail of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry*, 164, 591-598.

Delinsky, S. S., & Wilson, G. T. (2006). Mirror exposure for the treatment of body image disturbance. *International Journal of Eating Disorders*, 39(2), 108-116.

Gowers, S. G. (2006). Evidence-based research in CBT with adolescent eating disorders. *Child and* Adolescent Mental Health, 11(1), 9-12.

Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus,* 8(1), 32-42. *(EFT shows promise as a treatment for eating disorders)

Hurst, K., Read, S., & Wallis, A. (2012). Anorexia nervosa in adolescents and Maudsley-family based treatment. *Journal of Counseling & Development*, 90, 339-345. *(Maudsley family was manualized in 2001 and 5 randomized clinical controlled efficacy studies have been conducted and several uncontrolled studies)

Johnson, W. G., Tsoh, J. Y., & Varnado, P. J. (1996). Eating disorders: Efficacy of pharmacological and psychological interventions. *Clinical Psychology Review,* 16(6), 457-478.

Lenz, A. S., Taylor, R., Fleming, M., & Serman, N. (2014). Effectiveness of dialectical behavior therapy for treating eating disorders. *Journal of Counseling & Development,* 92(1), 26-35.

Mischoulo, D., Eddy, K., Keshaviah, A., Dinescu, D., Ross, S., Kass, A., …Herzog, D. (2011. Depression and eating disorders: Treatment and course. *Journal of Affective Disorders*, 130, 470-477.

Sandberg, K., & Erford, B. T. (2013). Choosing assessment instruments for Bulimia practice and outcome research. *Journal of Counseling & Development,* 91(3), 367-379.

Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., …& Dodge, L., (CBT guided self-care had slight advantage over family therapy)

Schwitzer, A. M. (2012). Diagnosing, conceptualizing, and treating eating disorders not otherwise specified: A compromise practice model. *Journal of Counseling & Development,* 90, 281-289.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Shallcross, L. (2013). Body language. *Counseling Today*, 56(1), 28-40.

Wilson, G. T., Grilo, C.M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist*, 67(3), 199-216.

ELIMINATION DISORDERS

Enuresis Disorder

Assessment:

Shapira, B. E., & Dahlen, P. (210). Therapeutic treatment protocol for enuresis using an enuresis alarm. *Journal of Counseling & Development*, 89, 246-252. (Shapira and Dalen recommended the diagnostic interview for assessment attending to family genetic data, medical causes (bladder), followed by the client's willingness to participate in the treatment-alarm)

Treatment:

Shapira, B. E., & Dahlen, P. (210). Therapeutic treatment protocol for enuresis using an enuresis alarm. *Journal of Counseling & Development*, 89, 246-252.

SLEEP-WAKE DISORDERS

Assessment:

King, J. H. (2014). Assessment and diagnosis of sleep-wake disorders. *Counseling Today*, 56(7). 12-15.

Mastin, D. F., Bryson, J., & Corwyn, R. (2006). Assessment of sleep hygiene using the Sleep Hygiene Index. Journal *of Behavioral Medicine*, 29(3), 223-227.

Milner, C. E., & Belicki, K. (2010). Assessment and treatment of insomnia in adults: A guide for clinicians. *Journal of Counseling and Development*, 88(2), 236-244.

Seligman, L., & Hardenburg, S. A. (2000). Assessment and treatment of paraphilia. Journal of Counseling & Development, 78, 113.107-

Voinescu, B. I., Szentagotai, A., & David, D. (2012). Sleep disturbance, circadian preference *an*d symptoms of adult attention deficit hyperactivity disorder (ADHD). *Journal of Neural Trasm*, 119, 1195-1204.

Instruments:

Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegal, A. & Horwitz, R. (1990). Clarifying confusion: The Confusion Assessment Method. *Annals of Internal Medicine*, 113(12), 941-948.

Johns, M. W. (1991). A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep,* 14, 540-545.

Treatment:

Carney, B. (2013). Sleep therapy is expected to gain a wider role in depression treatment. *New Times,* November 24, 2013; http: nytimes.com/ 2013 /11/24/

Elliott, A. C. (2001). Primary care assessment and management of sleep disorders. *Journal of the* American Academy of Nurse Practitioners, 13(9), 409-417.

McCurry, S. M., Logsdon, R. G., Teri, L., & Vitiello, M. V. (2007). Evidence—based psychological treatments for insomnia in older adults. *Psychology and Aging,* 22(1), 18-27.

Rowe, S. L., Jordan, J., McIntosh, V. V. W., Carter, F. A., Frampton, C., Bulik, C. M., … & Franz, F. (2010). Does avoidant personality disorder impact on the outcome of treatment for bulimia nervosa*? International Journal of Eating Disorder,* 43, 420-427.

Seligman, L., & Reichenberg, L. W. (2012). Selecting effective treatment: A comprehensive systematic *guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Insomnia Disorder

Assessment:

Carney, C. E., Ulmer, C., Edinger, J. D., Krystal, A.D. & Knauss, F. (2009). Assessing depression symptoms in those with insomnia: An examination of the Beck Depression II Second Edition (BDI-II). *Journal of Psychiatric Research,* 43(5), 576-582.

Milner, C.E., & Belicki, K. (2010). Assessment and treatment for insomnia in adults: A guide for clinicians. *Journal of Counseling and Development*, 88, 236-244.

Riemann, D., Fischer, J., Mayer, G., & Peter, H. J. (2003). The guidelines for 'non-restorative sleep': Relevance for the diagnosis and therapy of insomnia. *Somnologie, 7(2), 66-76.*

Treatment:

Edinger, J. D., & Carney, C. E. (2013). *Overcoming insomnia: A cognitive-behavioral approach, therapist guide (2nd ed.).* New York, NY: Oxford University Press.

Garland, S. N., Carlson, L. E., Stephens, A. J., Antle, M. C., Samuels, C., & Campbell, T. S. (2014). Mindfulness-based stress reduction compared to cognitive behavioral therapy for the treatment of insomnia. *Journal of Clinical Psychology*, 32(5), 449-459.

Harvey, A. G., Belanger, L., Talbot, L., Eidelman, P., Beaulieu-Bonneau, S., Fortier-Brochu, E. F., …& Morin, C. M. (2014). Comparative efficacy of behavior therapy, cognitive therapy, and cognitive behavior therapy for chronic insomnia: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 82(4), 670-683.

Morin, C. M., Hauri, P. J., Espie, C. A., Spielman, A. J., Buysse, D. J., & Bootzin, P. R. (1999). Nonpharmacological treatment of chronic insomnia. *An American Academy of Sleep Medicine Review*. 22(8), 1134-1156.

Vincent, N. L., & Samatha-Finnegan, H. (2008). Barriers to engagement in sleep restriction and stimulus control in chronic insomnia. *Journal of Consulting and Clinical Psychology,* 76(5), 820-828.

Instrumentation:

Duke Structured Interview for Sleep Disorders (DSISD), Structured Interview for Psychiatric Disorders, Patient Version (SCID-P), Insomnia Symptom Questionnaire (ISQ; Spielman, Saskin, & Thorpy, 1987), *Sleep Hygiene Index* (Mastin, Bryson, & Corwyn, 2006)

Mastin, D. F., Bryson, J., & Corwyn, R. (2006). Assessment of sleep hygiene using the Sleep Hygiene Index. *Journal of Behavioral Medicine,* 29(3), 223-227.

Monitoring:

Carney, C. E., Buysse, D. J., Ancoli-Israel, E. Edinger, J. D., Krystal, A. D., Lichstein, K. L., & Morin, C. M. (2012). The consensus sleep diary: Standardizing prospective sleep-monitoring. *Sleep*, 35(2), 287-302.

SEXUAL DYSFUNCTIONS

Sexual Disorders

Assessment:

Frank, J. E., Mistretta, P., & Will, J. (2008). Diagnosis and treatment of female sexual dysfunction. *American Family Physician*, 77(5), 636-645.

Goodman, A. (1993). Diagnosis and treatment of sexual addiction. *Journal of Sex & Marital Therapy,* 19(3), 225-251.

Greiner, K. A., & Weigel, J. W. (1996). Erectile dysfunction. *American Family Physician,* 54(5), 1675-1682. [Article includes: physiology, assessment, and treatment]

King, J. H. (2014). Assessment and diagnosis of sexual and gender-related disorders. *Counseling Today*, 56(8), 12-15.

Seligman, L., & Hardenburg, (2000). Assessment and treatment of paraphilias. *Journal of Counseling* Development, 78, 107-113.

Instruments:

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

Chambless, D., & Lifshitz, J. (1984). Self-reported sexual anxiety and arousal: The expanded Sexual Arousability Inventory. *Journal of Sex Research,* 20, 241-254.

Treatment:

Moulden, H. M., & Marshall, W. L. (2005). Hope in the treatment of sexual offenders: The potential application of hope theory. *Psychology, Crime, & Law,* 11(3), 329-342.

Priest, R., & Smith, A. (1992). Counseling adult sex offenders: Unique challenges and treatment paradigms. *Journal of Counseling & Development*, 71, 27-32.

Schneider, S., Blatter-Meunier, J., Herren, C., In-Albon, T., Adornetto, C., Meyer, A., & Lavalle, K. L. (2008). The efficacy of a family-based cognitive-behavioral treatment for separation anxiety disorder in children aged 8—12: A randomized comparison with a general anxiety program. *Journal of Consulting and Clinical Psychology*, 81(5), 932-940.

Segraves, R. T., & Althof, S. (1998). Psychotherapy of sexual dysfunctions. In P. Nathan & J. Gorman (Eds.), *A guide to treatments that work* (pp. 447-471). New York: Oxford University Press.

Seligman, L., & Reichenberg, L. W. (2012). Selecting effective treatment: A comprehensive systematic *guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

GENDER DYSPHORIA

Gender Dysphoria Disorder

Assessment:

Grant, J., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force**.**

King, J. H. (2014). Assessment and diagnosis of sexual and gender-related disorders. *Counseling Today*, 56(8), 12-15.

Instruments:

1. The Age-Universal Intrinsic/Extrinsic Scale-Revised (Maltby & Lewis, 1996)

   (19-items measure of religious orientation is applicable for both religious and nonreligious respondents. Two scales intrinsic and extrinsic religiosity)
2. The Age Universal Quest Scale-Revised (Maltby & Lewis, 1998)

   (12 items and the scale measures "an open-ended, responsive dialogue with existential questions raised by the contradictions and tragedies of life."
3. The Lesbian Identity Scale (LIS) (McCarn & Fassinger, 1996) and the Gay Identity Scale (GIS) (Fassinger & Miller, 1996)

   (40 items measuring eight phases in development.)
4. Internalized Homonegativity (Mohr & Fassinger, 2000)

   (5 items measuring degree of gay, lesbian, or bisexual individuals have internalized antigay beliefs and values.
5. Propensity to Seek Conversion Therapy (PSCT)

   (9 item to measure propensity to seek conversion therapy.
6. Klein Sexual Orientation Grid (KSOG) (Klein, Sepekoff, & Wolf, 1985)

   (Classifies in terms of sexual orientation. Seven components of sexual orientation include sexual attraction, sexual behavior, sexual fantasies, emotional preference, sexual preference, self-identification, and hetero/gay lifestyle.
7. Social Desirability (Reynolds, 1982)

   (Assesses the degree the participant responds in a socially desirable manner)
8. Rosenberg Self-Esteem Scale (Rosenberg, 1965)

   (Scale measures self-perceived worth
9. Lesbian Internalized Homophobia Scale (LIHS) (Szymanski & Chung, 2001)
10. Lubben Social Networks Scale (Lubben et al., 2006)

    (Scales include support from relatives and support from friends)
11. Cohen's Perceived Stress Scale (Cohen, Kamarck, & Mermelsteing, 1983)

    (Most widely used sure of perceived stress over the previous month)

12. Gender Identity/Gender Dysphoria Questionnaire-Adolescent-Adult (GIGDQ-AA) (Deogracias, 2004; Deogacias, et al., 2007; Singh et al., 2010) (both adolescent and adult-with male and female pole,
13. The Depression, Anxiety, and Stress Scale (DASS) (Lovibond & Lovibond, 1995)
14. The Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988).

Treatment:

1. Narrative theory (internalizing of problems)

Flentje, A., Heck, N. C., & Cochran, B. N. (2013). Sexual reorientation therapy interventions: Perspectives of ex-ex-gay individuals. Journal of Gay & Lesbian Mental Health, 17, 256-277.

Lasser, J. S., & Gottlieb, M. C. (2004). Treating patients distressed regarding their sexual orientation: Clinical and ethical Alternatives. *Professional Psychology: Research and Practice,* 35(2), 194-200.

Menvielle, E., & Hill, D. B. (2011). An affirmative intervention for families with gender-variant children: A process evaluation. *Journal of Gay & Lesbian Mental Health,* 15, 94-123.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Techniques/Interventions:

2. Metaphor imagery for externalizing, transforming, and shifting of underlying maladaptive emotional schemas (McGuinty, Armstrong, & Carrrière, 2014)

DISRUPTIVE IMPULSE-CONTROL AND CONDUCT DISORDER

Assessment:

King, J. H. (2014). Assessment and diagnosis of disruptive, impulse-control and conduct disorder. *Counseling Today*, 57(30), 12-15.

Oppositional Defiant Disorder

Assessment:

Harvey, E.A., Metcalfe, L.A., Herbert, S.D., & Fanton, J.H. (2011). The role of family experiences and ADHD in the early development of oppositional defiant disorder. *Journal of Consulting and Clinical Psychology*, 79(6), 784-795.

Instruments:

Erford, B. T., Paul, L. E., Oncken, C., Kress, V. E., & Erford, R. (2014). Counseling outcomes for youth with oppositional behavior: A meta-analysis. *Journal of Counseling & Development,* 92, 13-24.

Treatment:

Erford, B. T., Paul, L. E., Oncken, C., Kress, V. E. & Erford, M. R. (2014). Counseling outcomes for youth with oppositional behavior: A meta-analysis. *Journal of Counseling & Development,* 92(1), 13-24.

Lockman, J. E., & Lenhart, L. A. (1993). Anger coping intervention for aggressive children-conceptual models and outcome effects. Clinical Psychology Review, 13, 785-805. doi: 10.1111/j.1469-7610.2008.020.x

Intermittent Explosive Disorder

Assessment:

King, J. H. (2014). Assessment and diagnosis of disruptive, impulse-control and conduct disorder. *Counseling Today,* 57(3), 13-17**.**

Olvera, R. L. (2002). Intermittent explosive disorder: Epidemiology, diagnosis, and management. *CN Drugs*, 16(8), 517-526.

Treatment:

McCloskey, M. S., Noblett, K. L., Deffenbacher, J. L., Gollan, J. K., & Coccaro, E. F. (2008). Cognitive-behavioral therapy for intermittent explosive disorder: A pilot randomized trial. *Journal of Consulting and Clinical Psychology*, 76(5), 876-886.

Conduct Disorder

Assessment:

Searight, H. R., Rottnek, F., & Abby, S. L., (2001). Conduct disorder: Diagnosis and treatment in primary care. *American Family Physician*, 63(8), 1579-1588.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1998). Assessment and diagnosis of conduct disorder. *Journal of Counseling & Development*, 76, 1899-197.

Treatment:

Lockman, J. E., & Lenhart, L. A. (1993). Anger coping intervention for aggressive children-conceptual models and outcome effects. Clinical Psychology Review, 13, 785-805. doi: 10.1111/j.1469-7610.2008.020.x

Mpofu, E. (2002). Psychopharmacology in the treatment of conduct disorder children and adolescents: Rationale, prospects, and ethics. *South African Journal of Psychology*, 32(4), 9-21.

Kleptomania

Treatment:

Dannon, P. N. (2002). Kleptomania: An impulse control disorder. *International Journal of Psychiatry in Clinical Practice*, 6, 3-7**.**

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

Assessment:

Evans, W. (1998). Assessing and diagnosis of the substance use disorders (SUDS). *Journal of Counseling & Development,* 76(3), 325-334.

Weigel, D. J., Donovan, K. A., Krug, K. S., & Dixon, W. A. (2007). Prescription opioid abuse and dependence: Assessment strategies for counselors. *Journal of Counseling & Development*, 85, 211-215.

Treatment:

Kleber, H. D. (2003). Pharmacologic treatments for heroin and cocaine dependence. *The American Journal of Addictions*, 12, S5-S18.

Maxwell, S., & Shinderman, M. S. (2000). Use of naltrexone in the treatment of alcohol use disorders in patients with concomitant major mental illness. *Journal of Addictive Diseases*, 19(3), 61-69.

Rivto, P., Lewis, M. D., Irvine, J., Brown, L., Matthew, A., & Shaw, B. F. (2003). The application of cognitive-behavioral therapy in the treatment of substance abuse. *Primary Psychiatry,* 10(5), 72-77.

Schulz, J. E. & Parran, T., Jr. (1988). Principles of identification and intervention (screening, assessment, intervention, monitoring, and follow-up care). *American Society of Addiction Medicine* (chapter 1). 249-304.

Sofuoglu, M., & Kosten, T. (2005). Novel approaches to the treatment of cocaine addiction. *CNS Drugs*, 19(1), 13-25.

Stein, D. J. (1995). Cognitive therapy of substance abuse. *Journal of Cognitive Psychotherapy*, 9(2), 120-135.

Instrument:

McLellan, A. T., Luborsky, L., Woody, G. E., & O'Brien, C. P. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. *The Journal of Nervous and* Mental Diseases, 16, 26-33.

Monitoring:

Leibert, T. W. (2006). Making change visible: The possibilities in assessing mental health counseling outcomes. *Journal of Counseling & Development,* 84 (2), 108-113.

NEUROCOGNITIVE DISORDERS

Neurocognitive Disorders

Assessment:

King, J. K. (2013). Assessment and diagnosis of neurocognitive disorders. *Counseling Today,* 56(6), 20-22.

Treatment:

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatment: A comprehensive systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: John Wiley & Sons.

DEMENTIA DISORDER

Assessment:

Gintner, G. G. (1995). Differential diagnosis in older adults: Dementia, depression, and delirium. Journal of Counseling & Development, 73, 346-351.

Instruments:

Alexopoulos, G., Abrams, R. C., Young, R. C., & Shamoian, C. A. (1988). Cornell Scale for depression in dementia. *Biological Psychiatry,* 23, 271-284.

Bland, R. C., & Newman, C. (2001). Mild dementia or cognitive impairment: The Modified Mini-Mental Examination (3MS) as a screen for dementia. *Canadian Journal of Psychiatry,* 46(6), 506-510.

Logsdon, R. G., McCurry, S. M., & Teri, L. (2007). Evidence-based psychological treatments for disruptive behaviors in individuals with dementia. *Psychology and Aging*, 22(1), 28-36.

Yesavage, J. A., Brink, T. L., Rose, T. L., Lum, O., Huang, V., Adey, M., & Leirer, V. O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Psychiatric Research,* 17(1), 37-49.

Treatment:

Logsdon, R. G., McCurry, S. M., & Teri, L. (2007). Evidence-based psychological treatments for disruptive behaviors in individuals with dementia. *Psychology and Aging,* 22(1), 28-36.

MAJOR OR MILD NEUROCOGNITIVE DISORDER DUE TO ALZHEIMER'S DISEASE

Alzheimer's

Assessment:

Villareal, D., & Morris, J. (1999). The diagnosis of Alzheimer's disease. *Journal of Alzheimer's disease,* 2, 249-263.

Instruments:

Bland, R. C., & Newman, S. C. (2001). Mild dementia or cognitive impairment: The Modified Mini-Mental State Examination (3MS) as a screen for dementia. *Canadian Journal of Psychiatry*, 46, 506-510.

PERSONALITY DISORDERS

Assessment:

Fong, M. (1995). Assessment and DSM-IV diagnosis of personality disorders: A primer for counselors. *Journal of Counseling & Development,* 73, 35-639.

Glickauf-Hughes, C., & Mehlman, E. (1995). Narcissistic issues in therapists: Diagnostic and treatment considerations. *Psychotherapy*, 32(2), 213-221.

Graham, J. R. (2006). MMPI-2: *Assessing personality and psychopathology* (4th ed.). NY: Oxford University Press.

Hope, D. A., Herbert, J. D., & White, C. (1995). Diagnostic subtype, avoidant personality disorder, and efficacy of cognitive-behavioral group therapy for social phobia. *Cognitive Therapy and Research,* 19(4), 399- 417.

Perry, J. C., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy personality disorders. American Journal of Psychiatry, 156(9), 1312-13221.

Ward, R. (2004). Assessment and management of personality disorders. *American Family Physician,* 70(8), 1505-1513.

Instruments:

Leising, D., Rehbein, D., & Eckardt, J. (2009). The Inventory of Interpersonal Problems (IIP-64) as screening measure for avoidant personality disorder. *European Journal of Psychological Assessment*, 25(1), 16-22.

Treatment:

Hofmann, S. G. (2007). Treating avoidant personality disorder: The case of Paul. Journal of Cognitive Psychotherapy: An International Quarterly, 21(4), 346-352.

Huppen, J. D., Strunk, D. R., Ledley, D. R., Davidson, J. R. T., & Foa, E. B. (2008). Generalized social anxiety disorder and avoidant personality disorder: Structural analysis and Treatment outcome. *Depression and Anxiety*, 25, 441-448.

Kiehn, B., & Swales, M. (2010). *An overview of dialectical behavior therapy in the treatment of borderline personality disorder*. http://priory.com/dbt.htm.

Kliem, S., Kroger, C., & Kosflder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects models. *Journal of Consulting and Clinical Psychology*, 78(6), 931- 951.

Links, P. S. (2002). The role of couple therapy in the treatment of narcissistic personality disorder. *American Journal of Psychotherapy*, 56(4), 522-539.

Livesley, W. J. (2005). Principles and strategies for treating personality disorder. *Canadian Journal of Psychiatry*, 50(8), 442-450.

Rowe, S. L., Jordan, J., McIntosh, V. V. W., Carter, F. A., Frampton, C., Bulik, C. M., …& Frsnz, F (2010). Does avoidant personality disorder impact on the outcome of treatment for bulimia nervosa*? International Journal of Eating Disorder,* 43, 420-427.

Borderline Personality Disorder

Treatment:

Brown, A. P., Marquis, A., & Guiffrida, D. A. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling & Development,* 91(1), 96-104.

Kliem, S., Droger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting* and *Clinical Psychology*, 78(6), 936-951.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *Lancet*, 34, 453-461.

Oldham, J. M. (2006). Borderline personality and suicidality. *American Journal of Psychiatry,* 63, 20-26.

Ost, L. G. (2008). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy,* 46, 296-321.

Putnam, F. W., & Lowenstein, P. J. (1993). Treatment of multiple personality disorders: A survey of current practices. *The American Journal of Psychiatry*, 150(7), 1048-1952.

PARAPHILIC DISORDERS

Relational Clinical Attention

Treatment:

Elliott, R., Greenberg, L., & Leiter, G. (2004). Research on experiential psychotherapy, in Begin and Garfield, *Handbook of psychotherapy and behavior change*. New York, John Wiley & Sons.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schlinder, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Science Practice,* 6, 67-79. [effectiveness study for relational-individual]

COUPLES COUNSELING

Treatment:

Angus, L. (2012). Toward an integrative understanding of narrative and emotion processes in emotion-focused therapy of depression: Implications for theory, research and practice. *Psychotherapy Research,* 22(4), 367-380.

Crapuchettes, B., & Beauvoir, F. C. (2011). Relational meditation. *Psychotherapy Networker,* 35, 44-52.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schlinder, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Science Practice,* 6, 67-79. [effectiveness study)

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Assessment:

Fox, J., & Jones, K. D. (2013). DSM-5 and bereavement: The loss of normal grief. *Journal of Counseling &* Development, 91(1), 113-119.

King, J. K. (2014). Assessment and diagnosis of depressive disorders and bereavement reactions. *Counseling Today*, 57(2), 12-15.

SUICIDE AND SELF-INJURIOUS THOUGHTS AND BEHAVIORS (SITB)

Batterham, P., Calear, A., & Christensen, H. (2013). The Stigma of Suicide Scale: Psychometric properties and correlates of the stigma of suicide. *Crisis,* 34(1)13-21. doi:10.1027/0227-5910/a00156

Bender, T. W., Gordon, K. H., Bresin, K., & Joiner, LT. (2011). Impulsivity and suicidality: The mediating role of painful and provocative experiences. *Journal of Affective Disorders*, 129, 301-307. doi:10.1016/j.jS.2010.07.023

Britt, T. W., Greene-Shortridge, T. M., Brink, S., Nguyen, Q. B., Rath, J., Cox, A. L., …Castro, C. A. (2008). Perceived barriers to care for psychological treatment: Implications for reactions to stressors in different contexts. *Journal of Social and Clinical Psychology,* 27, 317-335. doi:10.1521/jscp.2008.27.4.317

Bush, K., Kivlahan, D. R., McDonnell, M. B., Fihn, S. D., & Bradley, K. A. (1998). The AUDIT alcohol consumption questions (AUDIT-C): An effective brief screening test for problem drinking. *Archives of Internal Medicine,* 158, 1589-1795. doi:10.1001/EXHINRW.158.16.1789

Centers for Disease Control and Prevention. (2012). Youth, risk behavior surveillance--- United States, 2011. *MMWR Surveillance Summaries,* 61, SS-4. Available from www.cdc.gov/mmwr/pdf/ss/ss6104.pdf

Craigen, L. M., Healey, A. C., Walley, C. T., Byrd, R., & Schuaster, J. (2010). Assessment and self-injury: Implications for counselors. *Measurement and Evaluation in Counseling and Development,* 43(1), 3-15

Glenn, C. R., Franklin, J. C., & Nock, M. K. (2015). Evidence-based psychosocial treatments for self-injurious thoughts and behaviors in youth. *Journal of Clinical Child & Adolescent Psychology*, 44(1), 1-29.

Gratz, K. (2001). Measurement of deliberate self-harm: Preliminary data on the Deliberate Self-Harm Inventory. *Journal of Psychopathology and Behavioral Assessment*, 23, 253-263. doi:10.1023/A:1012779403943

Gratz, K., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment,* 26(1), 41-54. doi:10.1023/B: JOBA.0000007455.08539.94

Joiner, T. E., Pfaff, J. J., & Acres, J. G. (2002). A brief screening tool for suicidal symptoms in adolescents and young adults in general health settings: Reliability and validity data from the Australian National General Practice Youth Suicide Prevention Project. *Behaviour Research and Therapy*, 40, 471-481. doi:10.1016/s0005-7967(01)00017-1

Kirkwood, A., & Bennett, L. (2014). The shift from "No harm contracts" to safety plans" for suicide prevention and treatment: A review of the literature. Idaho State University Institute of Rural Health. Retrieved http:// wwwo.isu.edu/irh/projects/better)today/B2T2Virtual Packet/Suicide Prevention/Safety, 4-26-214.

Lam, R. W., Tam, E. M., Shiah, I. S., Yatham, L. M., & Zis, A. P. (2000). Effects of light therapy on suicidal patients with winter depression. *Journal of Clinical Psychiatry*, 61, 30-32.

Lewinsohn, P. M., Seeley, J. R., Roberts, R. E., & Allen, N. B. (1997). Center for Epidemiologic Studies Depression Scale (CES-D) as a screening instrument for depression among community-residing older adults. *Psychology and Aging,* 12, 277-287.

Malin, T. (2012). The top 10 reasons against the use of no-suicide contracts. *Genesee Health Systems*. retrieved 8-26-2014 www.geNCMHCE.org/News/Qaulity matters/tabid/315 Article 129

McMyler, C., & Pryjmachuk, S. (2008). Do 'no suicide' contracts work? Journal of *Psychiatric Mental Health Nursing*, 15(6), 512-522. (lack of quantitative evidence and ethical issues regarding coercion on the part of therapist and service user's issues with 'control')

Nock, M. K., Green, J. G., Hwang, I., McLaughlin, K. A., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (23013). Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: Results from the National Comorbidity Survey Replication adolescent supplement lifetime suicidal behavior among adolescents. JAMA Psychiatry, 70, 300-310.

Nock, M. K., Holmberg, E. B., Photos, V.I., & Michel, B. D. (2007). Self-Injurious Thoughts and Behaviors Interview: Development, reliability, and validity in an adolescent sample. *Psychological. Assessment.* 19, 309–317. doi:10.1037/1040-3590.19.3.309

Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kipper, B. A., & Barrios, F. X. (2001). The Suicidal Behaviors Questionnaire-Revised (SBQ-R): Validation with clinical and nonclinical samples. *Assessment*, 8, 443-454. doi:10.1177/107319110100800409

Ribeiro, J. D., White, T. K., Van Orden, K.A., Selby, E. A., Gordon, K. H., Bender, T. W., & Joiner, T. E. (2014). Fearlessness about death: The psychometric properties and construct validity of the revision to the Acquired Capability for Suicide Scale. *Psychological Assessment,* 26(1), 115-126. doi:10.1037/10037/a0034858

Rom, M. A., Stanley, I. H., & Thomas, T. E., Jr. (2016). The web-based assessment of suicide and suicide-related symptoms: Factors associated with disclosing identifying information to receive study compensation. Journal of Personality Assessment, 98(6), 616-619. doi:10.1080/00223891.2016.1180528

Sansone, R. A., Wiederman, W. W., & Sansone, L. A. (1998). The Self-Harm Inventory (SHI): Development of a scale for identifying self-destructive behaviors and borderline personality disorder. *Journal of Clinical Psychology*, 54, 973-983.

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate risk. *Cognitive and Behavioral Practice,* 19, 256-264.

Steidel, A. G. L., & Contreras, J. M. (2003). A new familism scale for use with Latino populations. Hispanic J*ournal of Behavioral Science,* 25, 312-330.

Van Order, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner, T. E. (2010). Thwarted belongingness and perceived burdensomeness: Construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment*, 24, 197-215. doi:10.1037/a0025358

OUTCOME RESEARCH ARTICLES

Author. (2006). Evidence-based practice in psychology. *American Psychologist,* 61(4), 271-285.

Baker, S. (2012). A new view of evidence-based practice. *Counseling Today*, 42-43.

Clancy, C. M., & Eisenberg, J. M. (1998). Outcomes research: Measuring the end results of health care. *Science Compass,* 282, 245-246.

Deacon, B. J., & Abramowitz, J. S. (2004). A pilot study of two-day cognitive-behavioral therapy for panic disorder. *Behaviour Research and Therapy*, 44, 807-817.

Drake, R. E., Goldman, H. H., Leff, S., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W. C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services,* 52(2), 179-182. 1176-1179.

Glenn, C. R., Franklin, J. C., & Nock, M. K. (2015). Evidence-based psychosocial treatments for self-injurious thoughts and behaviors in youth. *Journal of Clinical Child & Adolescent Psychology*, 44(1), 1-29.

Goldman, R. N., Greenberg, L.S., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of Depression. *Psychotherapy Research*, 16, 536-546. (effectiveness study for EFT)

Greenberg, L. & Watson, J. (1998). Experiential therapy of depression: Differential effects of client centered relationship conditions and process experiential interventions. *Psychotherapy Research,* 8, 210-224. (effectiveness study)

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z. & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist,* 51(10), 1059-1064.

Johnson, W. G., Tsoh, J. Y., & Varnado, P. J. (1996). Eating disorders: Efficacy of pharmacological and psychological interventions. *Clinical Psychology Review,* 16(6), 457-478.

Krumboltz, H. M. (2009). Cardiovascular quality and outcomes: Outcomes research. *AHA Journals,* 2, 1-3. http:// ciroutcomes, ahajournals.org/contennt2/1/1.

Lambert, M. J., & Cattani-Thompson, K. (1996). Current findings regarding the effectiveness of counseling: Implications for practice. *Journal of Counseling & Development,* 74, 601-607.

Lambert, M. J., & Shimokawa, J. (2011). Collecting client feedback. *Psychotherapy,* 48(1), 72-70.

Leibert, T. W. (2006). Making change visible: The possibilities in assessing mental health counseling outcomes. *Journal of Counseling & Development,* 84, 108-113.

Meyers, J. E., & Harper, M. C. (2004). Evidence-based practice with older adults. *Journal of Counseling & Development*, 82(2), 202-218. (Interventions for sleep disturbances, anxiety disorders, depression dementia, and substance abuse,)

Roysircar, G. (2009). Evidence-based practice and its implications for culturally sensitive treatment. *Multicultural Counseling and Development*, 37, 66-81.

Sexton, T. L. (1999). Evidence-based counseling: Implications for counseling practice, preparation, and professionalism. *Eric Digest,* EDO-CG-99-9.

Spinnazola, J., Blaustein, M., & van der Kolk, B. A. (2005). Posttraumatic stress disorder treatment outcome research: The study of unrepresentative samples. *Journal of Traumatic Stress,* 18, 425- 436.

Stewart, R. E., & Chambless, D. L. (2009). Cognitive-Behavioral therapy for adult anxiety disorders in clinical practice: A meta-analysis of effectiveness studies. *Journal of Consulting and Clinical Psychology,* 77(4), 595-606. (CBT effective for: panic disorder, social anxiety, obsessive-compulsive generalized anxiety, and Posttraumatic stress disorders (Deacon & Abramowitz, 2004)

Uppgaard, R. O. (1996). Outcome- based research has an important place I the scientific community. *British Medical Journal*, 312, 71-72.

VandenBos, G. R. (1996). Outcome assessment of psychotherapy. *American Psychologist,* 51(10), 1005-1006.

Watson, J. C., Gordon, L. B., Stermac, L., Kalogerakos, F., & Steckley, P. (1998). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting Clinical Psychology,* 71, 773-781. (effectiveness study)

Weisz, J. R., & Hawley, K. M. (2001). *Procedural and coding manual for identification of evidence-based treatments*. Los Angeles: University of California.

Whiston, S. C., & Sexton, T. L. (1993). An overview of psychotherapy outcome research: Implication for practice. *Professional Psychology: Research and Practice*, 24(1), 43-51.

Unit 4. APPENDICES

Evidence-Based Treatments for Children & Adolescents (Selected Disorders)

Two different treatment classifications may be noted in the following efficacious treatment criteria for respective disorders. These descriptions are modified to provide an overview of the specific requirements to be met for three efficacious ratings.

1. Chambless Classification

Well-established interventions (WE) include:

(a) Superior to pill placebo or alternative treatment, or

(b) equivalent to an already-established treatment. Two good research group designs in two independent research settings by an independent investigatory team and is statistically superior to a pill or psychological placebo or another treatment. The intervention is to use a manualized treatment, conducted with a group treated for a specific problem, employ a valid and reliable assessment measure with appropriate data analyses (Chambless & Hollon, 1998; Chambless et al., 1996).

Probably efficacious (PE) interventions demonstrate either:

(a) more effective than no treatment control group in at least two well-conducted group design studies or

(b) is superior to pill placebo or alternative treatment in two group-design studies and is statistically superior to a wait-list group.

Possibly efficacious interventions include:

(a) are superior to no treatment and waitlist control group in at least one study, and

(b) possibly conducted by one team thus pending replication (Chambless & Ollendick, 2001).

2. Nathan and Gorman (2002) Classification

Type 1 studies: (most rigorous scientific evaluations using randomized design, clinical trials, comparison groups, blind assessment, inclusion and exclusion criteria, state-of-the-art diagnosis, adequate sample sizes to power the analyses, clearly described statistical methods

Type 2 studies: Clinical trials, comparison groups to test intervention, some flaws because some aspect of Type I criteria is omitted or missing. A Type 2 example might be the lack of randomization

Type 3 studies: Studies have significant methodological flaws, these may include pre-post uncontrolled studies and retrospective designs. The studies may be open trials and considered pilot studies

Type 4: Secondary analysis articles or reviews (meta-analysis)

Type 5: Do not include secondary data analysis

Type 6 studies: Case studies, essays, and opinion papers

In the following disorders, Chambless et al. (1996) and Nathan and Gorman (2002) classifications were a part of each efficacious article summary.

Autism

Evidence-based treatment:

Rogers and Vismara (2008) conducted an evidence-based review of autism treatments. Twenty-two randomized controlled design studies were evaluated and classified according to efficacious levels (Chambless et al., 1996; Nathan and Gorman, 2002). There were 4 Type I, 6 Type 2, 11 Type 3 and 1 Type six studies published during the years 1998 through 2006. The treatments that met criteria for efficacious programs include:

Well-established:

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

Possibly efficacious:

None

Probable efficacious:

Focused Parent Training (FPT): FPT is a caregiver-based intervention (a special child care worker is assigned, and a shorter version consists of 15 hours over 12-weeks focusing on communication development). The focus is compliance, mutual enjoyment, joint attention and language (Jocelyn et al., 1998). FPT is a 2-year intervention program. The aim of the program is three-fold. The first stage is to promote the child's engagement (compliance and willingness to join in mutual activities). The second stage is to elicit early precursors of social communication (joint pleasure and joint attention

behaviors, imitation, and functional play). The final stage is to stimulate language development (Oosterling et al., 2010).

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

Parent-implemented Training (PIT): social communication intervention including community care, speech and social skills training, a manualized parent-delivered program language intervention (Aldred et al., 2004)

Tellegen and Sanders (2014) conducted a single randomized control trial efficacy treatment study. The authors reported efficacious outcome for Primary Care Stepping Stones Triple P. Triple P is a brief four-session treatment devoted to reduce child problems and improve parent styles, parenting satisfaction, and parental adjustment.

Instruments:

Instrument measures in the 22 efficacious treatments included:

1. Autism Diagnostic Interview (ADI; Lord et al., 1994)
2. Autism Observation Schedule (ADOS; Lord et al., 2000)
3. The Vineland Adaptive Behavior Scales (Sparrow et al., 1984)
4. The MacArthur Communicative Developmental Inventory (Fenson et al., 1993)

Attention Deficit/Hyperactivity Disorder (Child & Adolescent)

Pelham and Fabiano (2008) conducted an evidence-based ADHD study using published empirical studies for the years 1997 to 2006. The authors reported that Behavioral Parent Training (BPT) and Behavioral Classroom Management (BCM) met well-established criteria. Of the 46 studies under review, 2 were BPT (mainly group-based treatments), 22 BCM studies that utilized contingency management procedures, and 22 were peer interventions and relationships (BPI). Behavioral Peer Interventions (BPI) focused on peer interactions and relationships such as social skills training, group-based, and office-based approaches had minimal effects. In summary, the results of this efficacious study included:

Well-established:

1. Behavioral Parent Training (BPT)
2. Behavioral Classroom Management (BCM)
3. Intensive Program-based Peer Intervention (BPI)

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

Phobic and Anxiety Disorder

Evidence-based analysis regarding anxiety treatment for children and adolescents was conducted by Silverman, Pina, and Viswesvaran (2008). Thirty-two peer-reviewed anxiety studies were analyzed to determine if efficacious criteria were met for one of the six types (well-established, probably-efficacious treatments, possibly-efficacious treatments, and experimental treatments). Most of the 32 studies were classified as Type 1. Eight studies met Type 2 criteria, and three studies met criteria for Type 3. Findings indicated that none of the 32 studies met criteria for well-established. Individual Cognitive Behavior Therapy (ICBT), Group Cognitive Behavior Therapy (GCBT), ICBT, GCBT, GCBT with Parents, GCBT for social phobia (SOP), and Social Effectiveness Training for Children (SET-C) for SOP met criteria for probably efficacious (Silverman et al., 2008).

Well established (WE):

None

Possibly efficacious:

Individual Cognitive Behavior Therapy (ICBT), Group Cognitive Behavior Therapy (GCBT), GCBT with Parents, GCBT for social phobia (SOP)

Probably efficacious:

Social Effectiveness Training (SET-C) for SOP met probably efficacious

Instruments:

Silverman et al. (2008) reported the most widely used youth self-rating scales for children and parents include:

1. Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1987)
2. Children's Depression Inventory (CDI; Kovacs, 2003, 27-items) or the Children's Depression Inventory-Short Version (CDI-S; Ahlen & Ghaderi, 2017), a 10-item measure of depressive symptoms widely used for screening purposes. A newer although not used as of yet CDI-2S is a 12-item inventory.
3. Fear Survey Schedule for Children-Revised (FSSC-R; Ollendick, 2006)
4. Child Behavior Checklist (CBCL; Achenbach, 1991a), most widely used

Obsessive-Compulsive Disorders

Treatment:

Evidence-based treatment for OCD regarding children was evaluated for effectiveness by Barrett et al. (2008). The authors analyzed 50 peer-reviewed OCD empirical studies. Of the 21 studies 2 met criteria for Type 1 effectiveness, 4 met criteria for Type 2 and the remaining were classified as Type 3, uncontrolled. Findings indicated that none of the 21 studies met criteria for well-established, exposure-based ICBT was probably efficacious and possibly efficacious for family-focused GCBT and family-focused ICBT (Lewin & Placentini, 2010).

Well-established (WE):

None

Probably efficacious (PE):

Individual Exposure-based ICBT plus medication

Possibly efficacious:

Family-focused individual ICBT or family-focused GCBT

Instruments:
(used in studies-most frequent)

1. Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS; Scahill et al., 1997)

Feeding and Eating Disorders

Efficacious Treatment (child & adolescents):

Keel and Haedt (2008) conducted an eating problem and eating disorder efficacious study for the years 1985-2006. The efficacious study included 2 Type I, 10 Type II for young adolescents (ages 11-20) and 49 empirical studies for adults aged 17-65. The majority of the studies related to bulimia nervosa (BN). In the adult studies, CBT is the treatment of choice for older adolescents. CBT is the treatment of choice for adolescents (ages 18 to 21). The Maudsley Model of Family Therapy is the most widely used treatment for children and adolescents emphasizing family organization and interaction, facilitating eating and weight gain (parables, paradoxes, personal authority, rationalizations, and psychodynamic interpretation), and homework

Well established (WE):

Family therapy

Probably efficacious:

None

Possibly efficacious:

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

Instruments:

The efficacious studies did not identify the accompanying instruments within the studies to be the best instruments, however, were chosen for the particular studies.

1. Eating Attitudes Test (Garner & Garfinkel, 1979; Garner et al., 1982)
2. Eating Disorder Inventory
3. Restraint Scale

4. Bulimic Investigatory Test Edinburgh

Conduct and Oppositional Disorders

Efficacious Treatment:

Eyberg et al. (2008) conducted an evidenced-based study for the years 1996 to 2007 regarding psychosocial treatment for children and adolescents with disruptive behavior (conduct and oppositional defiant disorders). The review included 20 Type I studies and 14 type II studies in addition to specific information regarding sample type, child race, sex, and age.

Well-established efficacious (WE):

Parent Management Training Oregon Mode PMTO).

Probably efficacious (PE):

Anger Control Training, Assertive Group 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 (enhanced) Treatment, Problem-solving Skills Training (PSST), PSST + practice, PSST + Parent (PSST + PMT, Rational-emotive Mental Health Program (REMH)

Instruments (used in research studies):

1. Parent report was used in 22 studies
    a. Child Behavior Checklist (Achenbach, 1991a)
    b. Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999)
    c. Revised Behavior Problem Checklist (Quay & Peterson, 1987)
2. Teacher report was used in 13 studies
    a. Teacher Report Form (Achenbach, 1991b)
    b. Conners Teaching Rating Scale (Conners, et al., 1998)

Depression

Efficacious Treatment (children & adolescents):

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

Well-established:

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

Probably efficacious:

CBT Penn State Program, Self-control Therapy, Coping with the Depressant Adolescent, and Interpersonal Therapy-adolescent met probably efficacious.

Adolescents (13 and older)

Well-established (WE):

Cognitive Behavioral Treatment (10 studies), Group, Child Only (6 studies), Child Group plus Parent component (2 studies),

Probably Efficacious (PE):

Behavior Therapy

Penn Prevention Control Enhancement (4 studies), Self-control Therapy (2 studies), Behavior Therapy (2 studies)

Experimental (interventions): Individual Video Self-monitoring (1 study), Parent-child (1 study), Primary and Secondary Control Enhancement Training (1 study), Stress-Busters (1 study), Family Systems (1 study), Child Group plus Parent Intervention (1 study), Systems Integrative Family Therapy (1 study), Group, Child Only, Relaxation Training (1 study), Child Group plus Parent/Teacher Consultation, Social Skills Training (1 study)

Possibly Efficacious:

None

Instruments:

1. Children's Depression Inventory (CDI; Kovacs, 2003)-most often used
2. Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991)
3. Schedule for Affective Disorders and Schizophrenia for Children (K-SADS; Chambers et al., 1996) most often used diagnostic tool

Trauma (PTSD)

Evidence-based treatment for children and adolescents exposed to trauma were evaluated by Silverman, Ortiz, and Viswesvaran (2008) for effectiveness. The study analyzed published randomized controlled research for the years 1992-2006. The authors analyzed 23 peer-reviewed studies regarding sexual abuse (11 studies), physical abuse (3), community violence (1), major hurricane (1), marital violence (1), and vehicle accident (1). Seven of the studies were classified as Type 2 and 16 Type 1.

Well-established (WE):

Trauma-focused Behavioral Therapy (TF-CBT)

Probably efficacious (PE):

School-based Group Cognitive-behavioral, and Cognitive-behavioral Intervention in Schools

Possibly efficacious:

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

Substance (adolescent)

Efficacious Treatment (adolescents):

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

Well-established (WE):

Multidimensional family (MDFT), Functional Family Therapy (FFT), and group CBT

Probably efficacious (PE):

Multisystemic Therapy (MST), Brief Strategic Family Therapy (BSFT), and Behavior Family Therapy (BFT)

Suicide and Self-Injurious Thoughts and Behaviors (SITBs)

Glenn, Franklin, and Nock (2015) evaluated 29 random control trial (RCT) SITB effectiveness studies. The research evaluation 5-level research methodology developed by Chambless and Holon was used to determine the level of effectiveness (1998). Treatments reviewed for effectiveness include CBT, CBT-Individual plus BCT-family, CBT-Individual plus CBT-Family plus Parent Training, CBT skills Group, DBT, DBT-Group only, Family-Based Therapy, FBT Suicide-Attachment, FBT-Parent training, FBT-Ecological, FBT Problem focused, FBT-Emergency only, Interpersonal Psychotherapy (IPT-Individual), Psychodynamic therapy- Individual plus family, and Combined skills Group Intervention.

Results: CBT, FBT, IPT, and Psychodynamic Therapy appeared to offer effective treatment. None of the treatment modalities met criteria for Level 1: Well-established.

Level 2, probably efficacious include CBT-Individual + CBT-Family +Parent Training, FBT-Parent Training only for SITB, FBT-Attachment for Suicide Ideation (SI,) IPT-Individual for SI, and Psychodynamic Therapy-Individual + Family for Deliberate Self-harm, Self-harm, or Parasuicide (DSH)

Level 3, possibly efficacious include FBT-Ecological for Suicide Attempts (SA)

In summary, CBT, FBT, IPT, and Psychodynamic Therapy had common elements of a relationship involving the interpersonal functioning, emotion regulation, problem-solving, and interpersonal effectiveness skills. A safety plan is recommended to aid the client in identifying warning signs of distress, coping skills, social supports, clinical resources, and ways to restrict access to lethal means.

Adult Efficacious Treatments

DeRubeis and Crits-Christoph (1998) conducted a review of effective treatments for ten adult psychological disorders as defined by Chambless and Hollon's (1998) efficacy criteria. Studies published in 15 professional journals during the years 1993 to 1998 were included in the review. Even though there have been numerous effectiveness replication studies for many of these disorders several of the studies were published during the 1980s with the majority in the 1990s to 1996. Also, caution is to be exercised as each of the disorder evaluations was conducted with a limited number of randomized trials. This list is work-in-progress, and current meta-analysis reports will be included as they appear in the literature.

This review conducted during 1998 was based on the criteria including:

Efficacious:

Treatment has been found to be efficacious in at least two studies by two independent research teams

Possible efficacious:

Treatment in one study that is efficacious or if all of the research has been conducted by one team as possibly efficacious pending replication (Chambless & Hollon, 1998).

Major Depressive Disorder

Well-efficacious:

1. Cognitive Therapy,
2. Cognitive-behavior Therapy is effective for relapse prevention,
3. Cognitive-behavioral Therapy with Medication, and Behavior Therapy
4. Interpersonal Therapy
5. Psychodynamic Interpersonal Psychotherapy

Possibly efficacious:

Problem-solving Therapy

Generalized Anxiety Disorder (GAD)

Nine clinical trial studies were reviewed for efficacious treatment for GAD, and all but one study reported that cognitive therapy was more effective than pill placebo, wait-list, and nondirective therapy.

Well-efficacious:

1. Cognitive Therapy
2. Applied Relaxation
3. Cognitive-behavioral Therapy is a 'specific' treatment

Agoraphobic Disorder

Well-efficacious:

Exposure Therapy

Social Phobia Disorder

Well-efficacious:

Exposure Therapy alone, Exposure plus Cognitive Restructuring (CBT)

Panic Disorder

Eleven clinical trial studies conducted during the years 1993 to 1998 were utilized for evaluating treatment efficacy. The 11 cognitive therapy trial studies were compared to different treatments. Some of these comparison treatments included a wait list, applied relaxation, brief supportive psychotherapy, exposure-based treatment, and no treatment.

Well-efficacious:

1. Cognitive Therapy
2. Panic Control Therapy (PCT)
3. Exposure Therapy
4. Applied Relaxation

Obsessive-Compulsive Disorder

Well-efficacious:

Exposure and Response Prevention (ERP)

Possibly efficacious:

Cognitive Therapy, Family-assisted Exposure, Partner Assisted Exposuer (PAE)

Posttraumatic Stress Disorder

Well-efficacious:

Exposure (behavior therapy)

Possible efficacious:

Stress Inoculation Therapy, Eye Movement Desensitization Response (EMDR)

Schizophrenia Disorder

Well-efficacious:

None

Possibly Efficacious:

Social Skills Training

Alcohol Abuse-Dependence

Well-efficacious:

None

Possibly efficacious:

Social Skills Training, Cue Exposure and "urge coping skills" Therapy plus Coping Skills Training and Social Skills Training

Substance 'Use' (Abuse-Dependence)

Well-efficacious:

None

Possibly efficacious:

Supportive-expressive Therapy for Opiate Dependence and Cognitive Therapy for Opiate Dependence, Supportive-expressive (SE) plus Drug Counseling (DC), and Cognitive Therapy plus Drug Counseling.

Insomnia

Smith and Perlis (2006) reported that the American Sleep Disorders Association (1997) reported that CBT-I was the first line treatment for primary sleep insomnia. Also, Irwin et al. (2006) in a meta-

analysis of 51 studies reported that for sleep quality, sleep latency, and wakening after sleep onset that behavioral interventions such as:

1. progression relaxation
2. sleep restriction
3. stimulus control
4. imagery training
5. paradoxical intention and biofeedback were efficacious for all except total sleep time

Two studies were located in the literature for effectiveness outcome for insomnia (sleep restriction and sleep compression therapy and multicomponent cognitive-behavioral therapy).

Multicomponent cognitive-therapy included sleep hygiene education, stimulus control, sleep restriction, and relaxation training. These efficacy studies were conducted by Morin, Cuthbert, and Schwartz (1994) and Murtagh and Greenwood (1995). The treatments were stimulus control and sleep restriction when compared to a placebo.

Cognitive-behavioral was found to be mildly effective as an intervention for sleep maintenance (Montgomery & Dennis, 2003). Irwin et al. (2006) conducted a randomized clinical trial (RCT) efficacious study involving 23 of 51 intervention studies meeting criteria for at least one of five sleep outcomes, sleep quality, sleep latency, total sleep time (TST-less so), sleep efficiency, and awakenings after sleep onset (WASO). The outcome data included (McCurry et al., 2007):

Well-efficacious:

1. Behavioral interventions (sleep quality, sleep latency, sleep efficiency, WASO)

Probably efficacious:

CBT, Relaxation Training (sleep efficiency), behavioral

Eating Disorders

Waller, Stringer, and Meyer (2012) conducted a study of the most commonly used techniques for eating disorders. The techniques were based on similar criteria as efficacious studies. The techniques and criteria include:

Widely supported:

1. routine weighing
2. food diaries
3. cognitive restructuring
4. exposure
5. structured eating

Partially supported:

Behavioral experiments, surveys

Unsupported:

Schema therapy, mindfulness

Marital or Couples

Distress and with adult mental health problems

Baucom, Shoham, Mueser, Dakuto, and Stickle (1998) conducted an intervention effectiveness study for marital distress and adult diagnosable mental problems when accompanied by the spouse (one or the other spouse) in marital therapy. Twenty-two behavioral marital therapy (BMT) outcome studies were conducted.

Efficacious with special treatment:

1. Behavioral Marital Therapy (BMT),
2. Emotion-focused Therapy (EFT)

Possibly efficacious:

Cognitive therapy, Cognitive-behavioral Therapy, Insight-oriented Therapy, Systemic Therapy, Cognitive Marital Therapy (CMT), Insight-oriented Marital Therapy (IOMT), Cognitive Therapy (CT) for Couples, and Couples Systemic Therapy

Marital counseling with a partner with a diagnosable disorder:

The following treatments meeting efficacious criteria include partner-assisted or couples-based intervention when one partner has diagnosable mental problems. These studies focused on the effectiveness of partner assisted or family-assisted.

Agoraphobia

Efficacious:

None

Possibly efficacious:

CBT, partner assisted (PAE) plus couple communication, partner assisted

Depression

Efficacious:

None

Possibly efficacious:

Behavioral marital therapy (BMT)

Sexual Dysfunctions

Efficacious:

None

Possibly efficacious:

Sexual Skills Training (SST; female orgasmic disorder), Masters and Johnson's Program (M & J; female orgasmic disorders), BMT plus M & J (mixed female sexual dysfunctions), Marital plus OCT for hypoactive sexual desire)

Alcohol 'Use' (Abuse & Dependence)

Included 30 studies in which two studies met criteria for the evaluation.

Well Efficacious:

None

Possibly efficacious:

Community Reinforcement Approach (CRA), Behavioral Marital Therapy (BMT)

Schizophrenia

Well Efficacious:

Behavioral Family Therapy, Supportive Family Therapy

Possible efficacious:

Family Systems Therapy

Technique Definitions

Techniques

PART 1: Techniques and Application

Acting As IF

Application: (shyness, social skills)

To improve social interest Adlerian therapy might suggest the use of the 'acting as if' technique. This technique might be used to decrease symptoms, increase functioning, increase client's sense of humor and to change client perspective-taking (Erford, Eaves, Bryant, & Young, 2010). This technique is used to gauge if the client has the skills to act as if he/she could manage the interaction of counseling focus (goal). The client is to learn to 'catch oneself' (another Adlerian technique) repeating a dysfunctional behavior.

Attention Technique Training (ATT)

Intrusive thoughts, rumination, and worry serve to maintain emotional distress. The goal of ATT is to interrupt the sustained and excessive processing of thoughts, threats, and emotional components of the cognitive attentional syndrome (CAS). The outcome of the training is attentional control. Psychoeducation is the first component of the training (rational). The next step is to practice attending to auditory stimuli with a clinician, followed by inside and outside the therapy hour. A device with an automated voice delivers stimuli (Fergus & Bardeen, 2016).

Aversion Therapy

This classical conditioning therapy is used to reduce the frequency of the undesirable behavior. It is based on the removal of a positive.

Behavioral Activation Treatment (BAT)

BAT is a frontline evidence-based intervention for depression. When a client engages in enjoyable activities and develops or enhances problem-solving skills, that client exemplifies behavioral activation that can offset negative emotions, ruminations, and avoidant behaviors. The focus is on behavior activation without cognitive change, problem-solving, change, completion of goals, and from the urge to engage in avoidance behaviors.

Behavioral activation is an outgrowth of cognitive-behavioral therapy. It is considered a brief (9 sessions) short-term focus on assisting the client in overcoming the urge to escape or engage in avoidance behaviors such as drinking (alcohol). Intervention components include an introduction, psychoeducation, treatment rationale, life values assessment, activity hierarchy, goal setting, review

and modify goals, and session closure (Read et al., 2016). This technique has support as an adjunct for depression and to enhance well-being.

Behavioral Rehearsal

Application: (clients experiencing anger, frustration, anxiety, phobias, panic attacks, and depression)

Behavioral rehearsal is a form of role play. The client plays the role of him/herself, and the counselor plays the role of the person with whom the anxiety is present or experienced. The client is encouraged to communicate his/her feelings about the anxiety-producing person or event/ circumstances. The client continues to repeat the exercise until the communication is effectively managed.

Bibliotherapy

Application: illness, death, self-destructive behaviors, family relationships, identity, violence and abuse, race and prejudice, sex and sexuality, gender-specific anxieties, depression, gender, insight into self, attitudes

Bibliotherapy was coined by Samuel Crothers for the use of books in counseling (Erford et al., 2010). Glaser encouraged clients to read, and that reading was an important component of reality therapy. The client will gain insight into a problem, learn new information, and increase self-esteem. There are four stages in the use of bibliotherapy; identification, selection, presentation, and follow-up.

Blow up (Lazarus)

Blow up is another form of paradoxical intention (Frankl). Lazarus encouraged clients to exaggerate and elaborate their symptoms. The technique is helpful for those clients with obsessive thoughts. The client will dwell on the typical symptom and take it to the most disastrous conclusion (similar to implosive therapy). The purpose of blow up is to make a disconnect between the problematic behavior and the discriminate stimulus.

Cognitive Restructuring

Application: Problematic disorders and symptoms include polarized thinking, extreme emotional reactions, anxiety disorders, panic disorder, self-esteem, stress, and social phobia, OCD, and substance disorders.

Cognitive restructuring involves identifying inaccurate negative thoughts that contribute to the development of and continuation of self-defeating behaviors and is often an important part of the treatment for depression. Cognitive restructuring is a technique used during Albert Ellis, Aaron Beck, and Don Meichenbaum's behavioral and cognitive-behavioral therapies.

Decoupling (DC)

Decoupling is a self-administered approach for nail biting. Nail biting was classified as an impulse control disorder not otherwise specified in the DSM-IV-TR. The DSM-5 does not list nail-biting, but the literature indicates there are some specific behaviors that are impulse related which have comorbidity such as trichotillomania. Decoupling is one of three approaches to treat nail-biting: habit reversal (awareness training and competing for response training), mild aversion therapy (bitter substance), and decoupling. DC strategy is to shift the nail-biting and to mimic and eventually "sabotage" the behavior thus to shape and deviate the original movement rather than to freeze it (Moritz et al., 2011).

Deep Breathing

Application: An intervention to treat anxiety disorders, anxiety, managing stress, GAD, panic attacks, agoraphobia, depression, irritability, muscle tension, headaches, fatigue, breath holding, shallow breathing, cold hands and feet, child birthing, sleep, pain, smokers quit, and anger.

This technique is used to calm the body through breathing awareness and diaphragmatic breathing. There are several breathing techniques that focus on control of the physiological response of the body (pulse, blood pressure, and lung usage/oxygen/carbon dioxide interchange).

Defusion

Defusion (defuse) is a technique of acceptance and commitment therapy. The client is assisted in how to change to inner experiences. The inner experience is to be viewed as to what they are, rather than what they present themselves to be (Twohig et al., 2015). Cognitive fusion is the degree one's internal experiences are perceived as trustworthy regarding reality and acting upon those perceptions rather than as a transitory and subjective mental state (Ferreira et al., 2015; Gillanders et al., 2014). Cognitive confusion leads to avoidance behaviors and consequences.

Empty Chair (Gestalt)

Application: (interpersonal and intrapersonal issues, body image issues although empty chair is not recommended for clients with severe emotional distress-psychotic disorders)

The client plays different roles and establishes a voice dialogue with one or more imagined individual sitting in an empty chair. It is as though someone is sitting in the chair and the client talks to the chair. The intervention helps individuals move from talking about something toward experiencing the fullness of an immediate interaction and 'here-and-now' experience with an individual symbolized by an empty chair that includes sensation, affect, cognition, and movement. Implementation of this technique is a six-step process leading to a deepening of the expression of an interactive experience which can promote pathways to action.

Exception Technique

Application: (identifying strengths, resources the client is using, behavioral problems)

The exception technique is used to observe an instance when the problem is not occurring and then was improving, even if only slightly. The stated exception is unused or unnoticed, and the client does not recognize their exceptions (Presbury, Echterling, & McKee, 2002). The counselor and client search for the action or behavior that was different than the constant or always occurred instance.

Exposure

Exposure therapy is effective behavioral intervention to treat anxiety disorders using in vivo or habituation (repeated). Specific phobias are the most common disorder treated with exposure as well as OCD. Systematic desensitization is a gradual exposure to a feared object, specific situation and phobias. Exposure can be conducted using imagery, virtual reality, role play, and in vivo.

Extinction

Application: (perhaps tantrums)

Extinction is based on punishment, withholding reinforcement to reduce the frequency of a specific behavior. It is most effective when combined with counterconditioning (positive reinforcement).

Family Constellation

Alfred Adler's concept of family constellation involves the number of individuals and birth order, to include the personality characteristics of the members, to help determine the lifestyle of the client within the context of the family. Bert Hellinger founded the family constellation to discover the client's unconscious connections with family ancestors and determine his or her entanglements with hidden family dynamics. The counselor, using this approach, interviews the client to learn of significant family members and their roles, the presence of non-verbal communications, and the nature of the family fears and prohibitions to shed light on family dysfunctions.

Family Mapping

Family mapping is a visual representation of a minimum three generations including adjectives descriptive of each member. The map is a view of relationships although additional data can be requested as to marriages, deaths, and occupations dependent upon the presenting client distress.

Flagging the Minefield

This technique may be similar to a substance term 'triggers' in which all members are aware of and encounter challenging symptoms for the diagnosis. The purpose of flagging the minefield is to reinforce what the client learned that provokes, or triggers the symptoms during the counseling hour and to implement alterations or changes in the natural setting (home, work, social, etc.). Flagging is a problem-solving process in which the client learns or anticipates vulnerable times, behaviors, and situations for the problem. The client's adherence (compliance/noncompliance) to the strategy for change (goals/homework) may be a method to monitor for improvement and the counseling commitment to change.

Flooding

Application: Phobias

A respondent conditioning technique in which extinction is achieved by confronting the anxiety-producing stimulus. The flooding technique is often used in phobia reduction or elimination.

Guided Imagery/Visual

Application: phobias, training in relaxation, social skills, and stress management, anxiety, facilitate relaxation, sense of control, improve problem-solving and decision-making, alleviate pain, and develop new perspectives

This technique is used for many theories as an adjunct of change (cognitive, behavioral, transpersonal, Gestalt, and psychodynamic). Visual imagery includes mental, positive imagery, and goal-rehearsal imagery or coping. Guided imagery is a subtype of visual imagery that assists the client to put emotional or interpersonal issues into words, development of goals, rehearse new behaviors, and exert control over emotions or stressors. The counselor leads the client through a series of steps (visual) directed at the stimulus words.

Habit Reversal Training

Habit reversal training technique is used to help a client identify the nail-biting situations, stresses, and other factors that trigger a bad habit such as excoriation disorder or skin picking. The therapist will help find other things for the client to do instead of skin picking, such as squeezing a rubber ball. The alternate activities will help ease the stress and occupy the client's hands.

Habituation

Application: (agoraphobic disorder)

The client is to remain in the exposure situation long enough and should repeat the exposure frequently enough for the anxiety to diminish.

Head-on-Collision (Intensive)

When a therapist identifies a defense, the defense is immediately confronted.

Hunger Illusion

Application: addiction

Dr. George Weinberg developed a three-step counseling method to help clients identify the moment an automatic thought takes place as in need to drink. The client often does not analyze why he/she is about to enter a drinking establishment. The client might be thinking a friend is in there or enter because a friend is about to enter. The second step is to stop and don't act, and the third step is to recognize or become aware of what thoughts and feelings come up (Weinberg, 1996).

Hypnosis

Hypnosis is an altered state of human consciousness characterized by reduced peripheral awareness, enhanced capacity for suggestibility, and increased access to the hypnotized individual's memories and unconscious thoughts and emotions. Hypnotherapy utilizes this modality to access memories, unconscious thoughts and emotions and facilitate the client's ability to form new responses, thoughts, behaviors, attitudes, or feelings. Several different forms of hypnotherapy include the following three types: traditional, Ericksonian, and cognitive/behavioral.

Imagery therapy

Application: (Treating anxiety, PTSD)

Imagery therapy is a time-limited visual behavioral technique or therapy that is often used to reduce the frequency and intensity of specific fears. The therapy is commonly referred to as imagery rehearsal therapy (IRT). The rehearsal aspect, which is a component of imagery therapy, uses a fear evoked from nightmares and rescripts to alter the ending conducted while the client is awake. Guided imagery is useful for stress reduction and stress management. The technique may include meditation, diaphragm deep breathing, muscle relaxation, or self-hypnosis.

Imago Dialogue

Imago dialogue is effective for marital fighting when emotions escalate, anger is expressed, and fear is present. The process is to help the couple prevent escalation, and the couple can feel safer and less reactive when together during times of conflict. The three dialogue components include mirroring (accurately repeat the speaker's statement), validating (let the speaker know what was shared is clear, content is valuable, and makes sense), and empathizing (taking the position of the other person). The goal is shift from anger to a calm, accepting listening stance (Crapuchettes & Beauvoir, 2011)

In Vivo

Therapeutic procedures that take place in the environment, often practiced in the office to later be practiced or acted out in the environment (natural setting).

Interoceptive Exposure (IE)

Application: (panic disorder, PTSD)

Interoceptive exposure exercises are behavioral treatments designed to surface feelings that are evoked by bodily symptoms during a panic attack (somatic sensations). Common steps for treating panic attacks with interoceptive exposure is to provide tasks that are similar to physical symptoms when experiencing a panic attack include hyperventilation, breathing through a straw, exercising, running in place, spinning around in a chair, and breath-holding. Bodily symptoms and resulting maladaptive beliefs that are distressing for the person are corrected through direct exposure to internal and external cues for different body sensations perceived as dangerous (Craske et al., 2014; Deacon et al., 2013; Deacon et al., 2012).

Meditation or Yoga

Meditation. Three forms of meditation are focused attention, mindfulness, and compassion. Focused attention is to concentrate on the in-and-out cycles of breathing. The mind tends to wander so focused attention is used to regain the focus. Mindfulness (open-monitoring) is observing sights, sounds, and other sensations including internal bodily sensations and thoughts. Compassion is having feelings of benevolence toward other people whether friend or enemy (Ricard et al., 2014a, b). The goal of meditation is to achieve a clear mind, emotional balance, a sense of mindfulness, and compassionate caring. Neuroscientists who are proponents of meditation believe that meditation facilitates a rewiring of the brain circuits, stimulate the growth of the brain, and center the mind.

Mental Imagery

A relaxation method whereby the client imagines a safe pace through the use of imagery.

Mindfulness-Based Stress Reduction (MBSR)

MBSR developed by Jon Kabat-Zinn is a technique or strategy that, when combined with meditation, is used to teach clients how to quiet the mind and to become aware of the present moment. During 2012, there were 477 scientific journal articles published on mindfulness practices (Pickert, 2014). This training of the brain to focus is a way to cope emotionally and behaviorally with the stressors encountered on a daily basis. Jon Kabat-Zinn (1990) believed the mind could be rewired to allow the client to pause and reset and has been recommended for anxiety issues. The typical program is once a week for eight weeks of two-and-half hour meetings. The concept is based on the fact that the mind can adapt and rewire (neuroplasticity). The strategy is to reduce distress through meditation and mindfulness practice. Research tends to support that mindfulness practice does lower cortisol levels and blood pressure, and increases immune response. Mindfulness-based stress reduction and cognitive behavioral therapy have been found to be useful for insomnia (Garland et al., 2014). Mindfulness-based stress reduction bibliotherapy is a self-help bibliotherapy format and is an evidence-based intervention (Hazlett-Stevens & Oren, 2017). The intervention is eight, 2.5-hour to 3-hour weekly sessions and one all-day practice session.

Miracle Question

Application: (couples, teenagers at risk)

Miracle question is a solution-focused technique for a problem-free image. The client is encouraged to express 'how the problem' might be different. Counselor and client may then strategize how to work from an idealized outcome back to the present. The contrast between what is and what the client wants provides clarity to the task at hand (goal establishment).

Modeling

Application: (personal and social skills, cognitive problems, autism, intellectual disabilities, socially disturbed children, self-confidence)

Modeling is a social learning technique (imitation, identification, observational learning) composed of overt, symbolic, and covert types. Cognitive modeling helps the client eliminate negative, self-defeating thoughts and behaviors by substituting them with positive statements or behaviors. Models or specific techniques utilized, independent of a theory or in conjunction with a theory may be social skills training and communication skills training.

Paradoxical Intention

Application: (agoraphobia, insomnia, problems blushing)

This technique consists of deliberately practicing an undesirable habit or thought to identify and remove it. The counselor will prescribe disturbing and undesirable behaviors or symptoms from which the client wants to experience resolution or freedom (involuntary fear, pain, depression)-and encourage him or her to exaggerate those symptoms or behaviors. The technique may be symptom prescription, symptom scheduling, symptom restraining or symptom reframing. This technique, first described by Victor Frankl, is utilized in individual counseling (Erickson) and family therapy (Jay Haley). The premise of using this technique is the disbelief that most problems are driven by emotional rather than logical thinking (DeBord, 1989).

Premack Principle

Application: (management situations such as classroom, eating disorders, food refusal)

This operant conditioning technique is based on the concept of positive reinforcement (higher probabilities behaviors will act as reinforcers for lower probability behaviors). An undesirable behavior will likely increase if followed by a high probability behavior (reward). The two probability behaviors are to be paired in time and space.

Primal Therapy

Application: (depression, phobias, panic and anxiety attacks)

The primary emphasis of primal therapy is based on the recognition that within each person's life experiences there are various kinds and levels of emotional and physical pain which are imprinted and carried forward in the form of memories which tend to be repressed in individuals with physical or emotional symptoms. The therapy attempts to access those repressed memories (unconscious) and enable the client to re-experience them in the present. Primal therapy became very influential during the early 1970s after the publication of The Primal Scream, by Arthur Janov. Although it achieved a period of popularity and inspired many popular cultural icons, primal therapy has declined in popularity, partly because the outcomes haven't been successful enough to convince research-oriented psychotherapists of its effectiveness. However, Janov and many advocates continue to practice this therapy.

Progressive Muscle Relaxation Training

Application: (anxiety, stress, high blood pressure, headaches, asthma, insomnia)

Progressive muscle relaxation, developed by Dr. Edmund Jacobson in the early 1920s (Jacobson, 1938), is a technique for controlling anxiety induced muscular tension using tensing and then relaxing a muscle or muscle groups. Jacobson's research found that there is a connection between excessive muscular tension and disorders of mind and body and that relaxation can oppose states of stress and provide resolution for or prevention of psychosomatic disorders. The client can sense the difference when a muscle is tensed and then relaxed. This resulting relaxation provides the client the feedback of being able to control the neuro-musculature via brain activity. In training sessions, the client reclines with eyes closed and follows instructions to relax and release all distracting thoughts or behaviors.

Pushing the Button

Pushing the button is to move back and forth with negative to pleasant thought (Mosak-Adlerian). The client learns to create whatever feeling he or she wants by thinking about it. The client is encouraged to first initiate a pleasant memory with its attached positive emotions, then change to an unpleasant image and attached negative feelings, then back to the positive memory and emotion.

Reframing

Application: (understanding, accepting, or solving a problem, couples in conflict, client attitudes toward counseling, family therapy, reducing negative emotions, mild to moderate depression)

Reframing gives a new definition to a situation, so a new and different constructive change takes place. The purpose is to alter or change the context of a dysfunctional conceptual or emotional viewpoint of a situation. The client is encouraged to see a new point of view different from the original point of view and to consider the alternative. The technique is a paradoxical strategy. Reframing involves six steps: (1) explanation of the treatment rationale (overview of procedure), (2) identification of client perceptions and feelings in situations of the issue, (3) deliberate enactment of selected perceptual features, (4) identification of alternative perceptions, (5) modification of perceptions in situations of the issue, and (6) homework and follow-up (Cormier, Nurius, & Osborn, 2009, p. 348). The authors provided stubbornness as a client issue that may be reframed as independence.

Relaxation

Muscle relaxation (Edmund Jacobson)-relaxes muscle groups systematically and in a fixed order, small muscle group of the feet and working to the head or vice versa.

Restructuring

Restructuring is a technique used in cognitive therapies such as CBT and ACT. When a client experiences stress in overt or covert behavior consistent with excessive intensity or socially inappropriate context that is annoying is to practice restructuring. The goal of restructuring is to create a response rather than to decrease a response (level of change). Cormier et al. (2009) recommended using restructuring when developing client goals.

Role Playing

Application: (typically used with adolescents using reality, rational-emotive, cognitive, and social learning theories or treatments)

Role-playing is acting the part of someone else under different conditions. The technique is taught in seven stages and the client practices switching roles in a safe environment.

Role Reversal

Application: (conflict, split in the self)

Role reversal is a Gestalt technique introduced, at times, when the counselor suspects the client is displaying behavior that is a reversal of some underlying feeling. The client takes on a role of another person, or position of another, during which the anxiety is present to make contact (get in touch) with the feelings and thoughts associated with the interaction. When this technique is used by a counselor to resolve an interpersonal conflict or help a client better understand or empathize with another individual, the client can be asked to imagine having that individual's thoughts and feelings and take on the role of that person.

Scaling (Solution-focused technique)

Application: (motivation, hurting self or others, self-esteem)

Scaling, a behavioral approach, is used to clarify or bring specificity to abstract concepts to achieve concreteness. It is also used as a self-report monitoring technique. Scaling uses a representative linear rating of 1-5 or 1-10 defined from least to most of a concept such as improvement or feeling at the time. Variations in scaling may be utilized throughout the counseling process to assess a point-in-time for concepts such as catastrophic thinking, motivation to change, relationships, personal reactions, suicide ideation/attempt, and improvement.

Script Analysis

Eric Berne (interpersonal therapy) suggested that there were three unhealthy life scripts: depression (no love scripts), madness (no mind script), and addiction (no joy script). From early childhood, an individual's life script began to be formed based on transactions that took place between a parent and child. According to Berne's transactional analysis (TA) theory, life scripts were established either using strokes (rewards) or injunctions (should/oughts, etc.) Unhealthy transactions led to the formation of unhealthy life scripts and negative symptoms and behaviors. According to TA theory individuals suffering from adverse symptoms and behavioral difficulties because of unhealthy life scripts can learn to rescript their lives. A counselor utilizing TA theory can analyze a client's life script by assessing for one of the four basic 'OK' positions established by transactions based on mother-father-child-interactions. Of significance, according to TA theory, is that only one of these four 'OK positions' is positive: 'I'm OK and you're OK. The other three positions are all negative: 'I'm not OK, you're OK', 'I'm not OK, you're not OK', 'I'm OK, you're not OK'. The purpose of conducting a script analysis is to assist the client in recognizing that his or her present life script has been adversely affecting interpersonal relationships and has not been achieving the autonomy desired. The redesign

is to modify or change a therapeutic plan in which the client can decide against the present script and rewrite one to achieve autonomy.

Sculpturing

Virginia Satir, a family theorist, believed family members were physically molded and displayed particular characteristic roles that portrayed their view of the family constellation. The family is in a physical arrangement of its members (in space and time), and each member represents a person's symbolic view of the actual relationship with other family members. These relationships are known to the members of the family.

Sensate focusing

Application: (sexual disorder)

Sensate focusing techniques allow a couple to experience closeness and intimacy without intercourse. A sex therapist will guide the timing and technique for sensate focusing to develop an increasing awareness of the texture and qualities of the partner.

Short-term Dynamic Psychotherapy

Application: (somatic symptom, anxiety, mood disorders and interpersonal difficulties and medical symptoms such as a headache, shortness of breath, diarrhea, or sudden weakness)

Habib Davanioo (2005) was the founder of short-term dynamic psychotherapy (ISTDP). ISTDP is designed to be conducted as quickly as possible maintaining the core principles of psychodynamic psychotherapy (defense mechanisms, unconscious, and transference) and to hone in on the sequence of feelings. The therapist attempts to overcome resistance as quickly as possible and to focus on the impulse-laden feelings outside of consciousness or awareness. Davanioo's techniques include pressure challenge and head-on-collusions (the reality of defense mechanisms).

Sleep Restriction

Application: (sleep disorders)

Sleep restriction is recommended to re-establish a destabilized or irregular sleep-wake rhythm for insomnia. The goal is to increase 'sleep pressure' starting with a specified number of hours considered to be the needed sleep time for a client. If that number is 7 hours, the client is instructed to go to bed only from 11:00 to 5:00 AM (6 hours). If the client complies, the bedtime will increase 30 minutes weekly 11:00 to 5:30, and to 11:00 to 6:00. Compliance is the major issue for this method especially for the elderly (Stepp et al., 2011).

Social Rhythm

Social rhythm therapy is often combined with interpersonal therapy (IPT) to form interpersonal and social rhythm therapy (IPSRT; Frank et al., 2007). Social rhythm is based on the factors of the circadian clock that is interrupted numerous times affecting sleep-wake, appetite, energy, and

alertness. Frank suggested that clients predisposed to circadian rhythm disruptions may likely be vulnerable to mood disorders, especially bipolar disorder I and II. The client has difficulty adjusting to the somatic and cognitive states of those disruptions. IPSRT is a four-phase treatment, and the goal is to stabilize the client's social routines and improve his or her interpersonal relationships. Improvements are to be noted regarding reducing denial and increasing acceptance, and in reducing the number and severity of stressors (Frank, 2007).

Social Skills Training (SST)

Social skills training was developed by Michel Hersen for depressed women (Hersen, Bellack, Himmelhoch, & Thase, 1984). The use of modeling, behavioral rehearsal, corrective feedback, social reinforcement, and homework assignments are introduced to teach effective social behavior. Social phobia may be represented as a deficiency in verbal (e.g., appropriate speech content) and nonverbal (e.g., eye contact, posture, and gestures; Heimberg & Juster, 1995).

Spitting in the Client's Soup (Adler)

Application: (no empirical evidence for effectiveness)

Spitting in the client's soup is a paradoxical technique whereby the counselor helps the client recognize that certain adverse behaviors about which he or she received secondary gain, are destructive. This Adlerian technique requires the counselor to assess the ways a client can benefit if he or she is willing to change rather than maintain the disturbing behavior. The technique of spitting in the client's soup points out the ways the client gains from the symptom by using a word or question that changes (reduces symptoms) the meaning of a dysfunctional behavior (change goal).

Storytelling (mutual)

Application: (children between ages of 5 and 11, ADHD)

Several treatment approaches utilize storytelling (broader definition of storytelling) such as emotion-focused family therapy, play therapy, and prolonged exposure therapies. The point of interest in using mutual storytelling is that clients have been unable to analyze their own life stories. Emotion-focused family therapy helps the client or family during counseling hours to recognize repetitive non-verbal and verbal reports of the same old stories, empty stories, broken stories, untold stories, unexpected outcome stories and healing stories. These stories had not been analyzed by the client until they present in therapy. If this technique is used with a child the first step is to have the child create a self-fictional story with a beginning, middle, and end with interesting characters. The counselor formulates his/her story variation. The analysis includes asking the child to name the story, provide a moral to the story, and a title to the story.

Stimulus Control

This therapy involves making changes to a client's environment to help curb skin picking (example). For example, he/she might try wearing gloves or Band-Aids to help prevent feeling the skin and getting the urge to pick. Or he/she might cover mirrors if seeing facial blemishes or pimples

brings on picking behavior. The level of denial, manipulation, and deception is to be taken into consideration when developing a treatment program for the factitious client who often has a personality disorder in conjunction with the factitious disorder. A treatment framework is recommended that includes avoiding unnecessary hospitalization. While no specific treatment is known, it is recommended that the therapist is empathic and gently confronting yet supportive, provide validation, and reduce or avoid regressive dependency. Individual therapy is recommended if the client is old enough and can have insight, while family therapy is helpful for some to regain some degree of autonomy (Eisendrath, 1995).

Stress Inoculation Training (SIT)

Application: (speech anxiety, test anxiety, phobias, anger, assertion training, social incompetence, depression, social withdrawal in children)

SIT is a combination of cognitive restructuring with training in verbal self-instruction and behavioral self-management techniques for mild stressors that will allow a client to handle larger stressors. The client is encouraged to apply these skills to a series of increasingly stressful situations as therapy progresses.

Systematic Desensitization

Application: (specific phobias; in vivo or imaginal, OCD, sexual disorders, anxiety disorders)

The client repeatedly recalls, imagines, or experiences anxiety to provoke events and will use a relaxation technique to suppress the anxiety. A client gradually overcomes maladaptive anxiety elicited by an approaching feared situation or object. Wolpe believed that two competing situations could not co-occur. One cannot fear and be calm at the same time. The process is to strengthen the desirable one. Reinforcing the desired behavior is accomplished through systematic desensitization using a relaxation technique that is paired with an increasing fear hierarchy. This technique may be known as reciprocal inhibition, counterconditioning, or classical conditioning (Head & Gross, 2008).

Time Out

Application: A client is unable to cope with the situation, tantrums, alcoholic consumption, thumb sucking, aggression, intellectual disability disorder, self-injurious behaviors, noncompliant children, self-control issues, low functioning children with Autistic Disorder

Timeout is an operant technique based on punishment of undesirable behavior. Assuming that the undesirable behavior has been 'learned' the counselor applies a format whereby it can be 'unlearned.' The counselor instructs the removal of the negative behavioral reinforcement for a period until corrective actions have been taken. These steps can be in successive approximations to the goal or for a full recovery. The three types of time out include seclusionary, exclusionary, and non-seclusionary.

Token Economy

Application: (changes group behaviors, disruptive behaviors, ADHD, severe emotional problems, increase participation, school phobia, tantrums, thumb-sucking, encopresis, fighting, autism, feeding and eating disorders, schizophrenia, addictions)

A token economy is an operant technique based on the consequences of behavior. This is a positive reinforcement situation where the client receives a token of desirable behaviors. Once a sufficient number of tokens is accumulated the client can trade them for a larger object reinforcement on the available or want list. The trade reinforces delayed gratification and a cost accounting. This form of reinforcement is best suited for residential centers or closed hospital wards.

Thought Stopping

Application: addiction, skin picking, alcohol or substance use disorders, gambling, OCD, phobias, hypochondriasis, failure, sexual inadequacy, common fears, negative thoughts, smoking, hallucinations

The process is to interrupt the unwanted thoughts or behaviors causing the distress. The introduction of the word 'stop' (distractor) is to serve as a punishment decreasing the likelihood of the thought to continue (incompatible to what the client wants) followed by a substitute thought or behavior. Several individuals are credited with the technique to include Alexander Bain, James Taylor, and Joseph Wolpe (Erford et al., 2013).

Voice Dialogue

Voice dialogue was developed by Hal and Sidra Stone (Stone & Stone, 2007). Junian and behaviorist respectively trained developed a method of communicating with the different psychology of selves (subpersonalities). A voice dialogue is between different 'selves' of the person who may be at odds with their inner way of behaving. Conflicts are confusing, split meanings, and create doubt and vulnerabilities. The caregiver is the facilitator.

Techniques (Interventions)

Acute Stress Disorder

Psychoeducation, breathing control, imaginal exposure, cognitive restructuring, anxiety management training, relaxation training, coping skills training, prolonged exposure, psychological first aid, in vivo

(Major theories: CBT, CBT w/prolonged exposure, supportive therapy, EMDR)

Adjustment Disorder

Coping skills training, crisis-intervention, behavioral activation intervention (Shruibis et al., 2016), psychoeducation, stress inoculation, problem-solving, relaxation, time management, behavioral activation, bibliotherapy, mindfulness, miracle question (solution-focused therapy), stress inoculation training, reframing (Casey, 2009)

(Major theories: supportive therapy, interpersonal psychological theory (IPT), ACT, solution-focused therapy, mindfulness group therapy)

Agoraphobia Disorder

Situational exposure (Umpfenbach & Alpers, 2014), homework, systematic desensitization, imaginal, mindfulness, bibliotherapy, behavioral activation, stress inoculation, thought stop, positive-self statements, habituation, restructuring, relaxation training

(Major theories: CBT, panic control therapy)

Alcohol Use/Related

Cognitive-behavioral, urge coping, self-control training, stress management, supportive-expressive therapy, exposure prevention, homework, cognitive restructuring, maladaptive thinking, relapse prevention, problem-solving, social skills training, (Tolin, Frost, & Steketee, 2007), self-control training, stress management, cue-exposure (for dependence), mindfulness

(Major theories: CBT, ACT, DBT, multidimensional family, functional family therapy, group 12-step, supportive therapy, behavior family therapy, medication, group CBT)

Alzheimer's (Major or Mild Neurocognitive)

(Major theories: structured treatment manuals for behavioral and social learning theory, peaceful mind manual)

Anorexia Nervosa

Family organization and interaction, facilitate eating and weight gain, parables, paradoxes, personal authority, rationalizations, psychodynamic interpretation, homework,

(Major theories: Family therapy, CBT, IPT, Cash's body Image therapy, Maudsley model, CBT guided self-care, DBT)

Antisocial Personality Disorder

Imagery, empathic confrontation, homework, mentalization, mindfulness

(Major therapies: CBT, IPT, DBT, schema therapy agitation therapy, psychopharmacology, social skills training, psychoeducation)

Attention Deficit/Hyperactivity

Behavior parent training, contingency management (teacher reward, point systems, time-out), family therapy, social skills training, anger management, communication skills, recognition of nonverbal, time management, behavior classroom management (BCM), summer-based treatment programs, self-regulation (Fabiano et al., 2009), impulse control measures, interactive rehearsal, modeling, in vivo, replacing negative messages with positive self-talk, contingency management (Grover, Huges, Bergman, & Kingery, 2006), Emotional self-regulation (Jarrett, 2016), training in self-regulation of emotion and self-organization/problem-solving (Fabiano, 2009), parent management of organization (Sibley et al., 2016), interactive rehearsal and parent management therapy (PMT)

(Major theories: Behavioral parent training, behavioral parent management training, family counseling, structured DBT, behavioral classroom management training)

Autism Spectrum

Social development, focusing skills, sensitivity to cues, modeling communicative skills, predictable play (some techniques may not be appropriate for one of the four disorders combined with autism spectrum disorder)

Binge Eating Disorder (BED)

Psychoeducation, relaxation training (Kocovski, Fleming, Hawley, Huta, & Anthony, 2013; Wong & Moulds, 2010), mindfulness (focus is internal experiences, self-accepting attitudes, interrupting conditioned patterns, and decreasing reactive automatic responses to negative affect (Kabat-Zinn, 1993), body image exercises, relapse prevention

(Major theories: CBT, DBT, IPT, ACT, family therapy, exposure response therapy (ERP)

Bipolar I Disorder

Family psychoeducation, IPSRT with social rhythm, circadian rhythm, psychosocial intervention, bibliotherapy, communication skills training, relapse prevention

(Major theories: Pharmacotherapy, CBT, interpersonal and social rhythm theory, family-focused therapy, family-focused with CBT, psychoeducation)

Bipolar II Disorder

Sleep dysregulation, sleep chart, psychoeducation, problem-solving skills, nutrient-based therapies (poor eating)

(Major theories: Pharmacotherapy, interpersonal social rhythm therapy, behavioral activation system (BAS), family-focused psychoeducation, CBT)

Body Dysmorphic Disorder

Verbal expression, stress management

Borderline Personality Disorder

Mindfulness, attention regulation, body awareness

(Major therapies: DBT, CBT, schema therapy)

Brief Psychotic Disorder

Psychoeducation, medication (if delusions are prominent), social skills training, imagery

(Major theories: ACT, group and family therapy, supportive therapy, brief compassion-focused imagery intervention (Ascone, Sundag, Schlier, & Lincoln, 2017)

Bulimia Nervosa

Routine eating, structured eating, monitoring food intake, exposed-based methods, routine weighing, food diaries, homework, self-monitoring, cognitive restructuring (Waller, et al., 2007; Waller, Stringer, & Meyer, 2012), psychoeducation

(Major theories: CBT, DBT, exposure and response prevention (ERP), IPT, ACT)

Central Sleep Apnea

Psychoeducation, sleep restriction

(Major theories: Weight reduction, continuous positive airway pressure (CPAP)

Conduct Disorder

Social skills training, relaxation exercises, impulse control, negative talk, family involvement, active attention skills, active ignoring skills, parent training (setting limits, physical affecting, attention, planned ignoring), problem-solving skills training, emotion dysregulation, impulsivity social skills, anger management, parent management

(Major theories: Parent management training, multidimensional treatment, multisystemic therapy)

Delirium

Support groups, relaxation, coping skills

(Major therapies: Prevention, medication, supportive therapy)

Depression

Bibliotherapy, cognitive therapy in group format, interpersonal psychological therapy, problem-solving

Disruptive Mood Dysregulation Disorder

Social skills training, parent training, parent training, multisystemic (Eresund, 2007; Gilea & O'Neill, 2015)

(Major therapies are lacking in the literature): Medication, psychoeducation) treatment targets projection, denial, oppositional and defiant behaviors.

Eating Disorders

Mindfulness and acceptance, cognitive-behavioral, routine weighing, food diaries, exposure, structured eating, behavioral experiments

Excoriation Disorder

Cognitive restructuring, psychoeducation, habit reversal training (HRT), intervention awareness, relaxation training, competing response training, social support, generalization training (Gelinas & Gagnon, 2013).

(Major therapies: ACT, CBT)

Factitious Disorder

Reduction in self-injurious behaviors, coping skills, psychoeducation

(Major therapies)

Female Orgasmic Disorder

Bibliotherapy

(Major theories: CBT, systematic desensitization)

Generalized Anxiety (GAD)

Cognitive restructuring, relaxation training, emotion regulation, exposure techniques, problem-solving, muscle relaxation, guided imagery, diaphragmatic breathing, expressive therapy, systematic desensitization, problem-solving, habituation, mindfulness (Reemer & Orsilla, 2002), psychoeducation, daily diaries, relapse prevention, regulate personal feelings, interoceptive exposure to bodily sensations (Velting, Setzer, & Albano, 2004)

(Major therapies: CBT, ACT, mindfulness-based stress reduction, acceptance-based behavior therapy)

Hoarding Disorder

Psychoeducation, skills training with reinforcement to shore up problem-solving, imagined or direct exposure to distressing stimuli, cognitive-restructuring of hoarding-related beliefs (Kress, Stargell, Zoldan, & Paylo, 2016; Steketee & Frost, 2007), and to gain insight into thoughts and their behaviors; cognitive-behavioral interventions are effective, exposure techniques are helpful to practice discarding items (Zoldan, Stargell, & Kress, 2015), decision-making skills, and organization, Imagined or direct exposure to distressing stimuli, thought monitoring and stop (Meyers, 2016), thought journaling (what they collect and why), homework (research indicates compliance to homework is an issue), relapse prevention

(Major therapies: CBT, cognitive behavioral group, family-based parent psychoeducation)

Insomnia

Sleep hygiene, sleep diary, relaxation exercises, muscle relaxation, autogenic training, sleep scheduling, paradoxical intention, thought-stop, problem-solving training, bibliotherapy, sleep education, sleep restriction (Irwin, Cole, & Nicassio, 2006), cognitive restructuring, relaxation exercises, sleep charting, CBT-I (stimulus control sleep restriction), psychoeducation, bright light therapy, mindfulness

(Major therapies: Psychopharmacology, CBT, cognitive therapy, behavior therapy)

Intermittent Explosive

Stress management, social skills training, cognitive restructuring, reframing, anger management, emotion regulations, impulse control, distraction, relaxation training, systematic desensitization, habit reversal, problem-solving, real-life conflict situations

(Major therapies: CBT, behavior therapy, family therapy, group therapy; one effectiveness study for trauma-focused cognitive behavioral therapy; Hewag et al., 2017)

Major Depressive

Mindfulness-based cognitive therapy, exercise therapy, light therapy, medication, relaxation, bibliotherapy, mindful-based stress reduction (MBSR; Williams, Teasdale, Segal, and Kabat-Zinn, 2007), emotion regulation (Radovsky, McArdle, Bockling, and Berking, 2014)

(Major therapies: CBT, behavioral activation, interpersonal psychological therapy, family-based psychoeducation)

Marital Distress

Problem-solving (BMT), contracting, communication training skills

Obsessive-Compulsive

Exposure, response prevention (ERT), acceptance, defusion, self as context, present moment awareness, committed action, habituation, parent intervention, relaxation training, behavioral activation and pharmacotherapy (Arco, 2015), diaphragmatic breathing (APA, 2008; Van Oppen et al., 1995), in vivo, muscle relaxation, cognitive restructuring (Ludvig & Boschen, 2015), mindfulness (Ludvig & Boschen, 2015; Twohig et al., 2015), reframing, response prevention (Chambless et al., 1998), psychoeducation, stress management (breathing retraining, progressive muscle relaxation, and structured problem-solving), stress inoculation training (SIT), relapse prevention, thought record, thought repression (Wilhem, 2001)

(Major therapies: CBT, CBT and ERP, prolonged exposure, medication, mindfulness-based cognitive therapy, ACT, acceptance-based behavioral therapy)

Oppositional Defiant

Social skills training, problem-solving, active attention skills, active ignoring skills, parent training (setting limits, physical affection, attention, planned to ignore)

(Major therapies: CBT, brief cognitive therapy, parent management training, anger control training, parent-child interaction therapy, family intervention)

Panic Disorder

Psychoeducation, relaxation training, cognitive restructuring, cognitive reappraisal, controlled breathing, diaphragmatic breathing skills, imaginal exposure (IE), symptom-induction exercises, exposure therapy, interoceptive exposure, mindfulness, brief supportive therapy, in vivo (removal of safety features (Deacon, Lickel, Farrell, Kemp, & Hipol, 2013; Levit, Hoffman, Grisham, & Barlow, 2001), self-monitoring (on-going changes in panic, anxiety, and avoidance improving in self-awareness, and increased accuracy in self-observations), attack record (cues, maximal distress symptoms, thoughts, and behaviors), mood chart (situations avoided), relapse prevention, anxiety management

(Major therapies: Pharmacotherapy panic control therapy, CBT-exposure based and relaxation, interoceptive exposure, ACT, sensation-focused intensive treatment)

Paranoid Personality Disorder

(Major therapies: Cognitive analytic therapy, schema therapy)

Paraphilia Disorder

Stress reduction, aversion therapy, covert sensitization, thought stopping, extinction, cognitive restructuring, contingency management, aversive conditioning

Persistent Depressive Disorder

Social skills, assertiveness, decision-making

(Major therapies: CBT, interpersonal psychological therapy, medication, cognitive behavioral analysis of psychotherapy)

Personality Disorder

Psychoeducation, cognitive-behavioral, DBT, schema therapy, attachment therapy, mentalization

Phobia & Anxiety

In-vivo, imaginal, behavioral exposure, bibliotherapy, ACT

Posttraumatic Stress Disorder

Psychoeducation, imaginal exposure, stress reduction, exposure therapy, adaptive coping, stress reduction, prolonged exposure (McLean & Foa, 2003), in vivo, exposure and response prevention (Resick, Monson, & Rizvi, 2008), stress inoculation (Gentry, Baranowsky, & Rhoton, 2017), anxiety management, deep muscle relaxation, controlled breathing, cognitive restructuring, emotional self-regulation, stress inoculation training

(Major therapies: Prolonged exposure therapy, behavior therapy, EMDR, mindfulness-based cognitive therapy, cognitive processing therapy)

Schizophrenia

Cognitive-behavioral social skills, problem-solving skills, social skills training, family psychoeducation, medication, psychosocial intervention, social support, sleep dysregulation, sleep chart

(Major therapies: Psychopharmacology, interpersonal social rhythm therapy, behavioral activation system, family education, family-focused psychoeducational, Miklowitz, 2008), CBT,

Separation Anxiety

Anger management, parent management, problem-solving, modeling, breathing techniques, relaxation, cognitive restructuring, contingency management, extinction methods such as active ignoring, social skills training (Grover, Hughes, Bergman, & Kingery, 2006; Schneider et al., 2008, 2013), TAFF techniques include psychoeducation, reframing, irrational beliefs, coping strategies and relapse prevention (Schneider, Unnewehr, & Margraf, 2009)

(Major therapies: CBT, cognitive behavioral therapy, acceptance-based therapy, social effectiveness training, coping cat, separation anxiety family therapy)

Sexual Disorders

Psychoeducation, couples counseling, progressive relaxation, sensate focusing, systematic desensitization, stimulus-control and scheduling, cognitive restructuring, communication skill training

Social Anxiety Disorder

Exposure alone, exposure combined with cognitive restructuring, social skills training, attentional focus training, homework, applied relaxation, anxiety management, mindfulness, flooding, in vivo, imaginal, psychoeducation, exposure to feared situations, anxiety coping skills, problem solving, cognitive-behavioral models (Grover, Huges, Bergman, & Kingery, 2006; Shikatani, Anthony, Kuo, & Cassin, 2014), mindfulness composed of acceptance, decreasing experiential avoidance, acting with awareness, decentering, and decreased rumination (Dannahy & Stopa, 2007), CBT self-focused attention (Shikatani, Anthony, Kuo, & Cassin, 2014), attention modification (attention control conduction (ACC) and attention modification condition (AMC; Grover, Huges, Bergman, & Kingery, 2006; Kosteer, Fox, & MacLeod, 2007), progressive muscle relaxation, deep breathing, empty chair (Shahar, Bar-Kalifa, & Alon, 2017; Shahar, 2014),

ACT techniques (acceptance, valued action, cognitive defusion, behavioral exercises such as interoceptive, in vivo, and imaginal,

CBT techniques (psychoeducation, self-monitoring, cognitive restructuring, breathing retraining, exposure to include in vivo, interoceptive

(Major therapies: CBT, CBT with exposure, acceptance-based group therapy, emotion-focused therapy, coping cat, interpersonal psychological therapy)

Somatic Symptom

Relaxation exercises, social skills, family psychoeducation, relaxation, stress-reduction, sleep hygiene, cognitive restructuring, distraction techniques,

(Major therapies: Affective-cognitive behavioral therapy, group and family therapy)

Trichotillomania Disorder

Habit reversal training, psychoeducation, stimuli control, relaxation training, relapse prevention, self-monitoring, decoupling

(Major therapies: CBT, CBT coupled with habit reversal, group therapy, pharmacotherapy)

Part II: Techniques Noted in Treatment Research

Acceptance and Commitment Therapy (ACT)

ACT, psychoeducation, mindfulness, cognitive defusion, cognitive distancing, self-talk, acceptance, self as context, present moment awareness, values, committed action

Attachment Therapy

Psychoeducation, family connections (FC), parent-infant relationship, scheduling (predictability in routine) and monitoring, emotion regulation, mindfulness-based parenting

Cognitive-Behavioral (CBT)

In vivo, cognitive restructuring, reframing, breathing-retraining, interoceptive exposure, muscle relaxation, thought stopping, behavior reversal, contingency management, paradoxical intention, reframing

Cognitive-Processing Therapy (CPT)

Written accounts, rewritten and rewritten with different concepts such as intimacy, trust, etc., restructuring

Coping Cat

Psychoeducation, cognitive restructuring, changing self-talk, homework, graduated exposure tasks and role-playing. Also, exposure to feared stimuli using the FEAR acronym: F-feeling frightened, E-expecting bad things to happen, A-actions and attitudes that can help and R-results and rewards. (Southam-Gerow et al., 2016).

Dialectical Behavior Therapy (DBT)

Mindfulness and acceptance, interpersonal effectiveness, distress tolerance, focusing, emotion regulation

Interpersonal Therapy (IPT)

Social skills training, assertiveness training, role-playing, decision analysis, contract setting, modeling

Social Effectiveness Therapy (SET)

Psychoeducation, exposure to feared situations, anxiety coping skills, relaxation techniques, cognitive restructuring, problem solving and homework

Therapy Terms

The following terms were recommended for select disorders in the supplement. The definitions of the different terms are brief and may require further research.

Acceptance and Commitment Therapy (ACT)—The ACT is a psychological intervention that uses acceptance and mindfulness strategies mixed with commitment and behavior-change approaches to increase psychological flexibility. ACT targets experiential avoidance, reduced experiential awareness, and lack of motivation, symptoms which are prominent in eating disordered clients as well as extreme ambivalence about their need for treatment (Fairburn, 2008). The goal of the ACT is to increase psychological flexibility through acceptance of unavoidable distress, creating a mindful outlook to counteract excessive confusion with cognitions and to clarify personal values linked to behavioral goals. Metaphors and stories are interventions or techniques utilized to increase flexibility and manage internal stress. ACT utilizes six core processes to address excessive reliance on experiential control and the belief that emotions are harmful by increasing psychological flexibility and openness with unwanted thoughts and feelings that are resistant and difficult to amend. These six core processes include: (1) acceptance, (2) defusion, (3) self as context, (4) present moment awareness, (5) values, and (6) committed action (Bluett, Homan, Morrison, Levin, & Twohig, 2014). Before therapy clients are to identify their values as guiding goals for the exposure. Preliminary research evidence has found ACT effective for a variety of problems including chronic pain, addictions, smoking cessation, depression, anxiety, psychosis, workplace stress, diabetes management, weight management, epilepsy control, self-harm, body dissatisfaction, eating disorders, burn out, and several other areas. ACT effectiveness treatment has been researched in excess of 100 randomized clinical trials and found to be effective for depression (Bluett et al., 2014; Zettle & Hayes, 1986; Zettle, Rains, & Hayes, 2011), mixed anxiety (Arch et al., 2012), OCD (Twohig, 2009; Twohig et al., 2010), psychosis (Gaudiano & Herbert, 2006), and adjustment disorder (Wiggs & Drake, 2016).

CBT is considered the first line treatment for anxiety disorders although ACT, a third wave behavior therapy, has literature support for GAD, PTSD, social phobia/anxiety, panic disorder, specific phobias, and OCD. Vallestad, Nielsen, and Nielsen (2012) reviewed 19 studies of combined treatments of mindfulness and ACT for anxiety disorders.

Acceptance-Based Depression and Psychosis Therapy (ADAPT)—ADAPT shows promise in treating depression with psychotic features. This intervention targets acceptance, mindfulness, and values and results with a limited sample that revealed significant improvements and in psychosocial functioning (Gaudiano, Nowlan, Brown, Epstein-Lubow, & Miller, 2012).

Acceptance Enhanced Behavior Therapy (AEBT)-identified as a treatment but considered a mindfulness technique.

Addison's disease–an endocrine disease caused by hypofunction of the thyroid gland.

Affective functioning–feelings and emotions such as happiness, anger, anxiety, sadness, and depression that are observed in a client during a mental status exam. Non-verbal examples include

tears, facial expression, voice tone, and bodily posture. Drummond and Jones (2006) indicated that this domain includes dimensions of personality such as attitudes, motives, and emotional behavior, temperament, and personality traits (p. 420).

Al-Anon–an organization similar to AA for spouses and family members of those with alcohol-related disorders. The purpose of the organization is to assist the spouse and family members to regain self-esteem, to discontinue feeling blame for the user's drinking disorder, and to restructure their lives.

Alateen–an organization similar to Al-Anon for children and adolescents to help them understand their parent's alcohol disorders.

Alogia–an impoverishment in thinking that is inferred from observing impoverished speech and language behavior.

Alzheimer's Type (Dementia)–the gradual and continuing cognitive decline consisting of progressive deficits in memory or cognition, not due to other central nervous system, substance effects, or other systemic conditions are known to cause dementia.

Amnesia–the partial or total forgetting of past experiences, which can be associated with organic brain syndromes or functional, non-organic disorders.

Anemia–a pathological deficiency in the oxygen-carrying capacity of the blood measured in unit volume concentrations of hemoglobin, red blood cell volume, and red blood cell number.

Anger Management Training-Anger management training is an intervention for those disorders that exhibit behavioral acting out with anger (negative) emotions, aggression, often a primary emotion in domestic violence. Anger management training is used to suppress anger emotion in domestic violence. Anger emotion has a restricted emotional range (activates fast/rapidly) and has reduced deactivation cognition during a refractory period. The client has difficulty in dissociating from the anger and engaging in regulating the emotion. Some techniques implemented include faulty thinking, relaxation training, relationship skills, and cognitive self-talk (Short, 2016). Recent research suggested that suppression of emotion (anger) is associated with an increase in negative emotions, greater stress, and increased problems with physical health. Anger management after treatment has been effective for approximately 2 to 3 weeks before an inevitable blow-up.

Lieberman et al. (2007) reported that using emotion to change emotion increases the emotional range and reduces regular anger and leads to a greater capacity for reasoned thought and responsible behavior. Ekman (2003) identified three emotions that occur in conjunction with anger. The three emotions of fear, disgust, and guilt require treatment to increase the emotional range. The client has greater self-governance at the time of increased emotion of anger. Treatment from this perspective recommends using opposing emotions with fear, disgust, and guilt. The concept is to oppose a failure emotion with a success emotion (Tausch & Becker, 2012). An example might be anger and pride as opposing emotions to provide new thoughts and duration of expanded emotional range for anger feelings.

Anorexia Nervosa–chronic failure to eat for fear of gaining weight; characterized by an extreme loss of appetite that results in severe malnutrition, semi-starvation, and sometimes death.

Antabuse–Antabuse (disulfiram) is a drug used as an adverse conditioning treatment for alcohol dependence by triggering a very distressing (and sometimes dangerous) reaction to alcohol. Therefore 'alcoholics' who agree to use Antabuse as a deterrent must be fully informed about its potential dangers and a physician should monitor its use.

Autonomic Arousal–physiological responses to emotion controlled by the autonomic nervous system (ANS) – that part of the nervous system that governs the smooth muscles, the heart muscle, the glands, the viscera, and the sensory system. The ANS is comprised of the parasympathetic and sympathetic nervous systems and maintains homeostasis in the body generally without conscious control. This system affects heart rate, digestion, respiration rate, salivation, and perspiration, the diameter of the pupils, micturition (urination), and sexual arousal. Emotional arousal such as fear or excitement, for example, increases heart and respiration rates, papillary dilation, perspiration, and reduces digestive activity.

Avolition–an inability to initiate and persist in goal-directed activities.

Behavioral Activation (BA)-is a frontline intervention for depression that targets a client's behavioral avoidance patterns through a functional analysis that examines antecedents and consequences of behavior and the development of a goal-oriented plan for changing behavioral deficits using a stepwise process. (Martell, Addis, & Jacobson, 2001).

Bipolar Disorder–a mood disorder involving both depressive and manic episodes. Manic (and sometimes depressive) episodes are typically bizarre and associated with delusions (fixed erroneous beliefs) that individuals within the person's culture would regard as totally implausible.

Bizarre–strikingly out of the ordinary, odd, extravagant, or eccentric in style or mode involving sensational contrasts or incongruities; can be associated with delusions that involve a phenomenon that the person's culture would regard as totally implausible.

Bizarre Delusions–fixed false beliefs of a pathological nature. Delusions typically occur in the context of neurological or mental illness, although they are not tied to any particular disease and have been found to occur in the context of many pathological states (both physical and mental). However, they are of particular diagnostic importance in psychotic disorders and particularly in schizophrenia. They typically involve a phenomenon that the person's culture would regard as totally implausible.

Brief Psychotic Disorder–a disturbance, lasting at least one day, which involves delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior.

Bulimia Nervosa–excessive overeating or uncontrolled binge eating followed by self-induced vomiting or use of laxatives.

Catatonia–a form of withdrawal in which the individual retreats into a completely immobile state, showing a total lack of responsiveness to stimulation.

Cognitive functioning–Cognition is the process of obtaining, organizing, and using intellectual knowledge. This domain reflects the understanding set for daily living. The individual performs acts that acquire information that is stored in memory only to be retrieved at a later time. The interviewer probes for the mental strategies or plans the client can access and utilize. This domain includes the activities of input, storage, and output of information. In summary, Drummond and Jones (2006) described the cognitive domain to include the various tasks and levels in perceiving, thinking, and remembering (p. 422). The levels refer to the cognitive domain of learning and include conscious intellectual activity, thought, the organization, capacity for reasoning, and memory. Speech behavior may reflect cognitive functioning such as fragmented, fluid, staccato, slow, etc.

Cognitive Processing Therapy (CPT)–CPT is six-weekly sessions of 90-minutes duration consisting of psychoeducation, presentation of a treatment rationale, and components of the treatment. Homework consisting of a written account of the trauma for treating acute stress disorder challenges unhelpful beliefs and thinking patterns (negative beliefs are not mentioned in the therapy). Safety and trust are integrated into the readings of the trauma providing for intimacy and relationships and competing with comparing early written accounts with those written in the final session (Nixon, 2012).

Coitus–the physical union of male and female sex organs.

Compulsivity–actions or behaviors that an individual may consider irrational but feels compelled to do.

Conversion Disorder–a psychiatric disorder characterized by the presence of a conversion symptom such as numbness, paralysis, loss of function, or seizures, but where no neurological explanation can be found. The disorder is presumably caused by an intrapsychic conflict and can emerge suddenly in response to stress in a person's life.

Comorbidity–referring to two or more interactive disease processes. Individuals with a substance use disorder, for example, often have depression or posttraumatic stress disorder or both as one or more comorbid disorders.

Copying Cat–a manualized approach that recommends 16 to 20 sessions, the first half of which focuses on psychoeducation, emotional awareness, relaxation and cognitive restructuring, whereas the latter half focuses on facing fears through exposures (Kendall, 2000). The child behavior therapy program (copying cat) was designed to target anxiety disorders in general among children but especially SAD (Flannery-Schroeder & Kendall, 2000). Strategies or techniques for the treatment include psychoeducation, exposure to feared stimuli or situations, anxiety coping skills, and homework assignments.

Decoupling (DC)-DC is a self-administered approach for nail-biting. Nail-biting was classified as an impulse control disorder not otherwise specified disorder in the DSM-IV-TR. The DSM-5 does not list nail-biting, but the literature indicated there are some specific behaviors that are impulse related which have comorbidity such as trichotillomania. Decoupling is one of three approaches to treat nail-biting; habit reversal (awareness training and competing for response training), mild aversion therapy

(bitter substance), and decoupling. DC strategy is to shift the nail-biting and to mimic and eventually "sabotage" the behavior thus to shape and deviate the original movement rather than to freeze it (Moritz et al., 2011).

Delusional Disorder–a psychotic disorder similar to schizophrenia in which the delusional system is the basic or even the only abnormality. Schizophrenia and delusional disorder are distinct disorders that often share certain features such as paranoia, suspiciousness, and unrealistic thinking. Schizophrenia, however, is associated with a loss of contact with reality and a decline in general functioning. In contrast, delusional disorder, a much less common disorder, preserves contact with reality except for the focused delusional thinking that comprises specific functioning while preserving most realistic activity.

Demand Characteristics–the total of cues that convey the counselor's wishes, expectations, and worldviews to clients and influences their behavior. According to Kanter, Kohlenberg, and Loftus (2002), demand characteristics sometimes plays a role in dissociative identity disorder, repressed memory controversy, and during treatment rationales.

Dementia–the development of multiple deficits in memory or cognition that are due to the direct physiological effects of a general medical condition, to the persisting effects of a substance, or to multiple etiologies including Alzheimer's disease.

Dependence (substance)–Substance dependence is about physical dependence, and refers to a state resulting from the habitual use of a drug so that negative physical withdrawal symptoms result from abrupt discontinuation; derived from a pattern of substance use that leads to clinically significant impairment indicated by increasingly larger amounts of a drug over a longer period than intended.

Dependence–non-substance dependence refers to the reliance on or needing of someone or something for aid and support.

Depersonalization–A feeling of estrangement or detachment from oneself.

Depersonalization Disorder–a disorder associated with alterations in the perception or experience of the self so that one feels detached from, and as if one is an outside observer of one's mental processes or body.

Differential Diagnosis–the consideration of more than one alternative diagnosis with similar features (comorbid). For example, a counselor interviewing someone with symptoms of depression must consider a variety of diagnoses such as major depression, adjustment disorder with depressed mood, persistent depressive disorder, prolonged grief disorder, substance-induced depression, and bipolar disorder, depressed type.

Dissociative Amnesia–Formerly referred to as psychogenic amnesia, dissociative amnesia is a pervasive loss of memory of significant personal information usually of a traumatic or stressful nature that is too extensive to be explained by ordinary forgetfulness.

Dissociative Fugue–an individual who experiences sudden, unexpected travel away from one's home with the loss of recall for one's past.

Dissociative Identity Disorder–the presence of two or more distinct personalities or identity states that control an individual combined with that individual's inability to recall significant personal information beyond ordinary forgetfulness.

Double Depression–chronic, minor or intermittent depression, as well as major depressive disorder. For example, an individual suffering from persistent depressive disorder may have one or more episodes of major depressive disorder as an additional diagnosis. This combination comprises double depression.

Dysfunction–abnormal functioning.

Dyspareunia–a kind of sexual dysfunction characterized by pain during intercourse. Men may suffer from this disorder, but it is more typically a female problem.

Emaciation–the loss of substantial amounts of needed fat and muscle tissue, often due to a lack of nutrients from starvation or disease. It may be present in fashion models who choose the emaciation look and as the result of eating disorders such as anorexia and bulimia. The bones of an emaciated person are distinguishable, shoulder blades are sharp, ribs and spine can be seen, and extremities are not significantly wider than the bones that support them. Although humans can acquire emaciation deliberately, it is also found in animals and peoples across the planet due to lack of food and starvation.

Endocrine Diseases–illnesses like hyper or hypothyroidism, acromegaly (gigantism), adrenal hyperplasia, and diabetes mellitus caused by abnormalities of "glands" such as the thyroid, pituitary, adrenal, and pancreas.

Episode-See APA, 2013, p. 820

Erotomania–a period of delusion in which the central theme is that another person is in love with the individual.

Etiological Factors–the factors that contribute to or cause disease.

Exhibitionism–Involves exposing one's genitals to a stranger. The onset is usually before age 18 (APA, 1994, p. 525).

Exposure Therapy – exposure to real-life situations as a component of effective fear reduction. Weiner and McKay (2013) reported the methods of exposure involve imaginal and in vivo procedures. In vivo is based on a procedure of sensations with real-world stimuli, and imaginal exposure uses guided imagery to evoke sensory realism in situations based on reality. Found throughout the literature are terms now referred to as exposure therapy such as implosion, implosive therapy, flooding, expose, graded exposure, and real-life exposure (Schare & Wyatt, 2013).

Factitious–the intentional production of physical or psychological signs or symptoms. Persistent problems related to illness perceptions and identity (APA, 2013, p. 310).

Fetishism–involves the use of non-living objects. The person usually masturbates while holding, rubbing, or smelling the object

Flooding–a respondent conditioning technique in which extinction is achieved by confronting the anxiety-producing stimulus.

Frotteurism–occurring most commonly between the ages of 15 and 25 and involving achieving arousal and orgasm by fantasizing about or touching or rubbing against a non-consenting person (APA, 1994, p. 527).

Gender Dysphoria–persistence and intense distress about his or her assigned sex.

Gender Identity–the basic sense of self as a male or female.

Gender Role–the public manifestation of gender identity.

Grandiose (Grandiosity)–an over-inflated appraisal of one's worth, power, knowledge, importance, or identity.

Group-Cognitive-Behavioral Therapy (G-CBT or CBGT)-Heimberg and Becker (2002) indicated that G-CBT involves the application of psychoeducation, breathing retraining, cognitive restructuring, simulated and in vivo exposure to social stimuli, and social skills training for social phobia. CBGT is one of two treatment cognitive-behavior programs for children and adolescents experiencing a social anxiety disorder (Herbert & Forman, 2011, 2012, 2013).

Habituation–non-associative learning in which there is a progressive diminution of behavioral response probability with repetition of a stimulus. As a treatment technique, it is a strategic application of exposure and response prevention (ER) for OCD and Tourette's clients. The client is prevented from performing the repetitive behavior (compulsion) after exposure to the feared stimuli, and anxiety levels are reduced.

Hallucination–a sensory perception that has the compelling sense of the reality of an actual perception but that occurs without external stimulation of the relevant sensory organ.

Hyper–excessive activity compared to the normal.

Hyperparathyroidism–overactive parathyroid gland activity causing abnormal levels of calcium in the body.

Hypersomnia–excessive sleepiness as evidenced by prolonged sleep or daytime sleep episodes that occur daily.

Hyperthyroidism–excessive production of thyroid hormones due to overactive thyroid gland activity that causes symptoms such as anxiety, agitation, perspiration, and rapid pulse.

Hypo–diminished activity compared to the normal.

Hypoactive Sexual Desires Disorder–a deficiency or absence of sexual fantasies and desire.

Hypochondriasis–recurrent complaints of physical problems or pain because of anxiety or an unrealistic fear of having a serious disease.

Hypoglycemia–abnormally low blood sugar often related to excessive insulin production by the pancreas, sometimes associated with stress.

Iatrogenic–a condition induced in a patient by a physician's words or actions.

Insomnia–a subjective complaint of difficulty falling or staying asleep or poor sleep quality.

Labelle Indifference–an individual's lack of anxiety or other emotional response to a symptom that would be considered distressing by most people.

Malingering–the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives (e.g., avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs). The malinger seeks medical care and presents symptoms deceitfully in a deliberate attempt to deceive for external purposes such as obtaining insurance benefits for a phony injury, getting lighter criminal sentences, avoiding prison, obtaining drugs, obtaining money, or simply to attract attention or sympathy.

Major Depressive Disorder–a type of major mood disorder characterized by a single or recurrent major depressive episode occurring without intervening manic episodes.

Mania–a severe medical condition characterized by extremely elevated mood, energy, and unusual thought patterns, most often associated with bipolar disorder, where episodes of mania may cyclically alternate with episodes of clinical depression. Although mania and hypomania have sometimes been associated with creativity and artistic talent, mania is undesirable and has the potential to be very destructive. Classic symptoms include rapid speech, racing thoughts, decreased the need for sleep, hypersexuality, euphoria, grandiosity, irritability, and increased interest in goal-directed activities. Mild forms of mania, known as hypomania, represent little or no impairment but can induce behavior such as spending sprees; more severe forms of mania do cause impairment and may even feature grandiose delusions or hallucinations.

Manic–a period of mania that usually begins and ends suddenly and causes a radical change in an individual's social functioning.

Meditation-research indicates the benefits of meditation may elicit positive emotion, minimize negative affect and rumination, and enable effective emotion regulation (Williams, 2010).

Mentalization- is a developmental process of self-control, and the capacity to direct attention is linked resulting in the opportunity to understand one's self and others' behavior regarding individual thoughts, feelings, and desires (Fonagy & Batemen, 2008,).

Metabolic Diseases–illnesses related to abnormal functioning of organs caused by genetic abnormalities, chronic disorders, and lifestyle-induced somatic changes, infectious processes, or inflammatory diseases. Organs that may be affected include the liver (hepatitis), kidneys (hypertensive

nephropathy), blood (thalassemia), pancreas (diabetes), cardiovascular (arteriosclerotic disease), and gastrointestinal system (celiac disease).

Metabolic Syndrome - a disorder diagnosed by the presence of three out of five of the following medical conditions: abdominal obesity, elevated blood pressure, elevated fasting blood sugar, high serum triglycerides, and abnormally low high-density cholesterol (HDL) levels. Certain psychoactive medications, primarily selected antipsychotics, have been found to trigger this disorder due to symptoms such as weight increase, insulin resistance, dyslipidemia, impaired glucose tolerance, Type II diabetes and hypertension. Dyslipidemia and increased insulin resistance can be collateral or a direct consequence of psychoactive drug actions. Studies have shown the prevalence in the USA to be an estimated 34% of the adult population, and the prevalence increases with age. Other risk factors include obesity, race, pre-existing diabetes, cardiovascular disease, family history of diabetes, nonalcoholic fatty liver disease, and polycystic ovary syndrome.

Mindfulness–moment-to-moment awareness without judgment. Empirical mindfulness benefits include emotion regulation and cognitive flexibility with decreased reactivity and increased response flexibility (sensations in the body without changing them). Benefits are suggested for affective, interpersonal, and intrapersonal dimensions (Davis & Hayes, 2010). Emotion regulation benefits promote metacognitive awareness, decreased rumination, and enhanced attentional capacities best applied for mood disorders (Chambers. Lo, & Allen, 2008). Interpersonal benefits involve looking into the eyes of another and notice what reactions, feelings, and thoughts arise.

Mindfulness-Based Stress Reduction (MBSR)- was developed by Jon Kabat-Zinn. When combined with meditation the aim is to teach clients how to quiet the mind and become aware of the present moment. During 2012, there were 477 scientific journal articles published on mindfulness practices (Pickert, 2014). This training of the brain to focus is a way to cope emotionally and behaviorally with the stressors encountered on a daily basis. Jon Kabat-Zinn believed the mind could be rewired to allow the client to pause and reset and this treatment has been recommended for anxiety issues. The typical program is once a week for eight weeks meeting two-and-half hours. The group members practice breath-awareness, a body-scan, and gentle Hatha yoga to cultivate awareness of internal present-moment experiences with accepting nonjudgmental stance. The concept is based on the fact the mind can adapt and rewire (neuroplasticity). The strategy is destressing through meditation and mindfulness practice. Research tends to support that mindfulness practice does lower cortisol levels and blood pressure, and to increase immune response.

Mixed Episode–a period lasting at least one week in which criteria are met for one or more diagnoses. The individual experiences rapidly alternating moods.

Morbidity–relating to or caused by the disease.

Munchausen Syndrome by Proxy–a disorder caused by parents who fabricate or induce physical illnesses in their children.

Negative Symptoms–involve the loss of normal functioning and resemble depression type symptoms such as loss of will, the range of affect, pleasure, and fluency of content of speech.

Neurological consultation–a one-time thorough evaluation by a neurologist that includes a complete neurological (physical) examination and neurologically specific diagnostic modalities. For example, a patient with a serious headache is referred to a neurological consultant by his family doctor. The consultant will consider the diagnostic possibilities such as brain tumor, abscess, hemorrhage, meningitis, and hydrocephalus, and blood clot, trauma to the head, sinus disease, malformation, or an aneurysm. The consultant will perform an examination and may order some diagnostic studies including blood chemistry, urinalysis, CT scan, MRI, sinus x-ray, EEG, and spinal tap. If the results point to a brain tumor, the consultant will report the findings to the referring doctor and recommend treatment by an oncologist and neurosurgeon.

Neurological examination–an examination by a neurologist, which may be repeated in follow-up visits, which is more specific and focused on the patient's complaint and may or may not include all of the diagnostic modalities that have been involved in a one-time consultation that leads to initial and follow-up treatments. For example, after the initial neurological evaluation, the neurologist may make a diagnosis of migraines and prescribe a treatment. During each follow-up visit, the neurologist will monitor changes or improvements in the patient's headaches with further neurological examinations. There may sometimes be a crossover or correlation between neurological disorders treated by a neurologist and psychiatric or mental health disorders treated by psychiatrists or other mental health professionals. Symptoms and disorders which may fall into these two camps can include brain tumors, dementia, amnesia, multiple sclerosis, Asperger's Syndrome, ADHD, chronic pain, movement disorders, complex partial seizures, fibromyalgia, Huntington's disease, Lyme Disease, encephalo-meningitis, neuroleptic malignant syndrome, Parkinson's Disease and nighttime problems (Lees, 1988), Pick's Disease, REM sleep disorder, sleep apnea, syncope, and tardive dyskinesia (Aarsland, Larsen, Cummins, & Laake, 1999).

Non-specific Chest Pain–pain in the chest, often thought by the patient to be caused by a heart condition or heart attack but which has no specific or clear cause. Such pain may be muscular in origin or related to spasm in underlying organs such as the stomach or esophagus. Patients with panic disorder often complain of non-specific chest pain, misbelieving that they have a heart attack.

Obsessive-Compulsive Behavior–involuntary dwelling on an unwelcome thought (obsession) and involuntary repetition of an unnecessary action (compulsion).

Orgasm–the climax of sexual excitement, normally marked by the ejaculation of semen by the male and by the release of tumescence in erectile organs of both sexes.

Paraphilia–recurrent and intense sexually arousing fantasies, sexual urges or behaviors that involve nonhuman objects, the suffering or humiliation of oneself or one's partner or children or other nonconsenting persons.

Pedophilic–involves sexual activity with a prepubescent child (13 years or younger). The pedophile must be at least 16 years of age and five years older than the child (victim) (APA, 1994, p. 527).

Pernicious Anemia–a metabolic disease whereby lacks absorption of vitamin B-12 in the stomach causes macrocytic (large red cells) anemia.

Persecutory–a perception that one is being conspired against.

Persistent Depressive Disorder (Dysthymia)-dysthymia and chronic major depressive disorder was combined into PDD and is a chronically depressed mood that occurs for most of the day, more days than not and accounted for by the client or others for at least two years (APA, 2013).

Pervasive Developmental Disorder–disorders in which severe and pervasive impairment in several areas of development exists.

Plethysmograph–an instrument that measures variations in the size of an organ or body part by the amount of blood passing through or present in part.

Polygraph–a physiological recording device equipped with sensors which, when attached to the body, can pick up subtle physiological changes in the form of electrical impulses. The changes are recorded on a moving roll of paper.

Positive Symptoms–symptoms ascribed to clients with schizophrenia that demonstrate distortions of normal functioning. Positive psychotic symptoms are primarily hallucinations and delusions which are found to be in contrast to negative symptoms such as depression, affective flattening, alogia, or avolition.

Post-partum (specifier)–a mood disorder or episode that begins within four weeks after delivery of a child.

Premature Ejaculation–ejaculation that occurs before a couple would prefer.

Psychiatric Evaluation–A psychiatric evaluation is often requested without necessarily resulting in medications being prescribed. This evaluation is performed by a psychiatrist (with medical training and possesses an MD degree) who is uniquely trained to understand the relationship between a psychiatric condition as well as one of many different medical conditions, an understanding of medications that the patient may be taking (for either psychiatric or medical purposes), the client's current medical conditions that may be causing or contributing to the disorder, an assessment of the patient's medications for pain, particularly opiates if they are being taken, and the patient's use/ misuse/ or abuse of substance use/abuse disorders.

Prolonged Exposure (PE)- PE is manualized 90 minutes 8 to 12 weekly sessions consisting of psychoeducation, self-assessment of subjective anxiety, in vivo exposure to external stressor reminders and objectively safe situations avoided due to exaggerated perceptions of threat, and repeated imaginal exposure to the (traumatic event) stressor (Clapp, Kemp, Cox, & Tuerk, 2016).

Psychoeducational Supportive Therapy (PST)-discussion around topics.

Psychological Flexibility-acceptance and commitment therapy (ACT) emphasizes personal values and psychological flexibility. ACT incorporate mindfulness, acceptance and cognitive defusion

(flexibility). Psychological flexibility is the ability to contact one's experience in the present moment that will include personal values and goals (Hayes, Strosahl, & Wilson, 2011; Hayes et al., 2013). This approach is aimed at managing internal conflict.

Psychopharmacological Evaluation–An evaluation for psychotropic medication does include a psychiatric evaluation but involves the specific determination as to which medications, if any, would be best prescribed for the patient.

Psychopharmacology–relates to the study of drugs and medications' effects on the mind. Medications are often the first line choice treatment for various disorders (Bender, 1999, 2008).

Psychosomatic–the interrelationship between mental or emotional activity (psyche) and physical or physiological activity (soma).

Psychosomatic Illness–the presence of physical symptoms such as pain, gastrointestinal problems, cardiovascular symptoms, or neurological complaints caused by the inter-relationship between mental or emotional activity (psyche) and physical symptoms, or physiological activity (soma).

Pharmacotherapy–the treatment of diseases and psychiatric disorders with medications.

Purging–to undergo or cause an emptying of the gastrointestinal tract, either upper or lower.

Rapid Cycling–a shifting of affective poles that occurs within a one-year period (at least four or more episodes). Coryell (2005) approximates that one of six bipolar clients presents with rapid cycling. Care is to be taken in diagnosing and distinguishing ADHD and rapid bipolar cycling in adolescents and children and distinguishing borderline personality disorder from rapid bipolar cycling for adults.

Secondary Gain–an extraneous benefit from being ill, such as increased attention from others or financial gain from disability.

Sensory Integration Therapy (SIT)—an innovation to the SIT is the snug vest (inflated vest worn by the client) intended to reduce repetitive behaviors. Clients diagnosed with autism spectrum display stereotype behaviors such as repetitive, invariant and contextually inappropriate maladaptive operants most often maintained by automatic reinforcement contingencies (Cunningham & Schreibman, 2008; Watkins & Sparling, 2014).

Schizoaffective (disorder)–a syndrome intermediately between schizophrenia and mood disorders in which individuals suffer a manic or a depressive episode while showing the symptoms of schizophrenia. The diagnosis can be confirmed when symptoms such as hallucinations or disordered thinking persist after the mood disorder (mania or depression) has cleared.

Schizophreniform (disorder)–a schizophrenic episode that lasts for more than two weeks but less than six months, with or without a precipitating event.

Sexual Aversion Disorder–the aversion or active avoidance of genital sexual contact with a sexual partner.

Sexual Masochism–involves the act of being humiliated, beaten, bound, or otherwise made to suffer and is a chronic disorder (APA, 1994, p. 529).

Sexual Sadism–involves acts in which the individual derives sexual excitement from the psychological or physical suffering of the victim (APA, 1994, p. 530). The satisfaction may be derived from causing others physical or social pain (humiliation).

Shared Psychotic Disorder–a disorder in which delusions develop in an individual involved in a close relationship with another person, which is similar to or the same as those experienced by the person who already has a psychotic disorder with prominent delusions.

Sleep Restriction-Sleep restriction is recommended to re-establish a destabilized or irregular sleep-wake rhythm for insomnia. The goal is to increase 'sleep pressure' starting with a specified number of hours considered to be the needed sleep time for a client. If that number is 7 hours, the client is instructed to go to bed only from 11:00 PM. to 5:00 AM. If the client complies, the bedtime will increase 30 minutes weekly. The next weekly step would be 11:00 pm to 5:30 am. Followed by 11:00 pm. to 6:00 am. Compliance is the major issue for this method especially for the elderly (Stepp et al., 2011)

Social-effectiveness Therapy (SET-C)-SET-C is recommended for children and adolescents experiencing a social anxiety disorder. The program format is to be administered during 24 sessions over a 12-week period. Each week one session is devoted to exposure and the second session to social skills training.

Social Skills Training (SST)–Social skills training, was developed by Michel Hersen for depressed women (Hersen et al., 1984). The use of modeling, behavioral rehearsal, corrective feedback, social reinforcement, and homework assignments to teach effective social behavior. Heimberg and Juster (1995) believed that social phobia resulted from deficient verbal (e.g., appropriate speech content) and nonverbal (e.g., eye contact, posture, and gestures).

Solution-focused Therapy–the focus is on solutions rather than causes whereas problem focused therapy focuses on the causes. SFT is a short-term approach that empowers the client to orient towards solutions with the assistance of the counselor. SFT is future-oriented.

Somatization–physical symptoms that lack good medical explanation, frequently involving some physical pain, gastrointestinal problem, sexual symptom or neurological complaint. The complaints or symptoms of somatization disorder appear when there is no demonstrable organic cause.

Stress Inoculation Training (SIT; developed by Meichenbaum) – the combination of cognitive restructuring with training in verbal self-instruction and behavioral self-management techniques; clients are encouraged to apply these skills to a series of increasingly stressful situations as therapy progresses.

Sundowning – a condition commonly found with Alzheimer's client's neurological deficit characterized by nocturnal episodes of confusion and disorientation in the evening that is known to reverse the sleep schedule (awake at night and sleep during the day). Behaviors associated with

sundowning are deliria like behavior changes consisting of agitation, wandering, illusions, hallucinations, and disorganized thinking and speech (McCurry, Reynolds & Ancoli-Israel, 2000).

Supportive Counseling-utilizes psychoeducation, progressive muscle relaxation, and homework.

Thyrotoxicosis–an endocrine disease caused by excessive thyroid activity significant enough to cause a toxic metabolic state.

Tolerance–the need to consume increasing amounts of a substance to achieve intoxication or to control a condition such as the use of narcotics to control pain.

Transsexualism–the desire to live permanently in the social role of the opposite gender via a sex reassignment.

Transvestite Fetishism–involves cross-dressing and usually, while masturbating, imagines he to be both the male and female in the sexual fantasy (APA, 1994, p. 531). This disorder is typically reserved for males who cross-dress in clothing worn by women.

12-Step Programs–Alcoholics Anonymous (AA) was founded in 1935 and has historically been the most successful program to initiate and maintain abstinence for those who have a primary diagnosis of alcohol dependency. AA's success is based on its 12-Step program, spiritual emphasis, group support, frequency and predictability of meetings, and the presence of individual sponsors. Cocaine Anonymous (CA), Narcotics Anonymous (NA), Overeaters Anonymous (OA), Co-Dependents Anonymous and Debtors Anonymous are examples of other 12-Step programs which have developed after AA's original program. The basic principles of 12 step programs include the following: admitting that one cannot control one's addiction or compulsion; recognizing a greater power that can give strength; examining past errors with the help of a sponsor (experienced member); making amends for these errors; learning to live a new life with a new code of behavior; helping others that suffer from the same addictions or compulsions. Although the 12-Step Program has had great community support this approach lacks evidence-based treatment as addiction treatment (Sindewald, 2017).

Alcoholic Anonymous 12 steps include:

1. admitted we were powerless over alcohol - that our lives had become unmanageable
2. came to believe that a Power greater than ourselves could restore us to sanity
3. decided to turn our will and our lives over to the care of God as we understood Him
4. made a searching and fearless moral inventory of ourselves
5. admitted to God, to ourselves, and to another human being the exact nature of our wrongs
6. were entirely ready to have God remove all these defects of character
7. humbly asked Him to remove our shortcomings
8. made a list of all persons we had harmed and became willing to make amends to them all
9. made direct amends to such people wherever possible, except when to do so would injure them or others
10. continued to take personal inventory and when we were wrong promptly admitted it

11. sought through prayer and meditation to improve conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out
12. having had a spiritual awakening as the result of these steps, carry this message to alcoholics and to practice these principles in all our affairs (Alcoholics Anonymous Publishing, Inc. NY, 1955)

Vaginismus–the spasmodic contractions of the outer third of the vagina, which render intercourse either impossible or very painful.

Vegetative state- A vegetative state refers to a disorder of consciousness caused by a head injury, characterized by a coma or state of partial arousal. If it persists after four weeks it is classified a persistent vegetative state, often referred to as an unresponsive wakefulness syndrome. Symptoms include the lack of meaningful movements, making nonspecific sounds, purposeless facial expressions or eye movements, physical reactions to loud noises, inability to communicate or follow instructions (Kaplan & Sadock, 1998).

Vegetative signs-vegetative signs are somatic and physiological automatic dysfunctions and most often associated with depression however, also indications of loss or decrease of appetite (anorexia), lack of or diminished ability to sleep (insomnia), excessive sleep (hypersomnia), feelings of weariness, or irritability (fatigue), insatiable hunger and voracious eating (bulimia).

Vegetative symptoms- Vegetative symptoms are one of several components of mental illness. Vegetative signs are physiological disturbances most commonly associated with mood and found in depressed individuals and are disturbances of functions necessary to maintain life (vegetative functions) but may also appear in some other conditions. Vegetative symptoms are to be observed for anorexia may be weight loss, insomnia, fatigue and mental slowing.

Voyeurism–involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. The onset of voyeurism is typically before the age of 15.

Waitlist or Waiting list-the group that is randomly assigned to receive the intervention later becomes the comparison research controls. The wait list does receive the treatment or intervention after the study is completed. The waitlist is a preference to a study with no control group (Heimbert, & Juster, 1995). Brown, Wyman, Guo, and Pena (2006) reported a class of waitlists defined as one in which the subjects are randomly assigned to different groups, and all groups receive the intervention, but the intervention is timed for the different groups. The advantage of this method is that none of the participants have to wait a period to receive the intervention.

Withdrawal–temporary psychological and physiological disturbances resulting from the body's attempt to readjust to the absence of a drug.