Appendices, Figures, and Tables

Provided to Supplement

Psychotherapy for the Advanced Practice Psychiatric Nurse

Second Edition

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The Nurse Psychotherapist and a Framework for Practice

TABLE 1.1 Basic Education, Orientation, and Setting of Psychotherapy Practitioners

Discipline	Education	Orientation/Setting
Psychiatrist	MD (medical doctor) or DO (Doctor of Osteopathy); 3-year psychiatric residency after medical school	Biological treatment, acute care, psychopharmacology and specific psychotherapy competencies for psychiatric MD residents; often inpatient orientation
Psychologist	PhD (research doctorate in psychology) or PsyD (clinical doctorate in psychology); both usually 1-year internship after doctorate	Psychotherapy and psychological testing
Master's level psychologist	MA (Master of Arts) or MS (Master of Science) or MEd (Master of Education)	Psychotherapy: some modalities, psychological testing
Social worker	MSW (Master of Social Work)	Psychotherapy: interpersonal, family, group; community orientation
Marriage and family therapists	MA (Master of Arts)	Systems and family therapy, marriage counseling; community outpatient orientation
Counselor	MA (Master of Arts in counseling) or MEd (Master of Education in counseling)	Counseling, vocational, and educational testing; outpatient orientation
Advanced practice psychiatric nurse (APPN) (clinical specialist in psychiatric nursing or psychiatric-mental health nurse practitioner)	MSN (Master of Science in Nursing) or DNP (Doctor of Nursing Practice)	Psychopharmacology and psychotherapy; group and individual, sometimes family

TABLE 1.2 Comparison of Benner's Model and the Stages of Learning

Stages of Learning	Benner's Model
Unconscious incompetency	Novice no experience, governed by rules and regulations
Conscious incompetency	Advanced beginner recognizes aspects of situations and makes judgments
Conscious competency	Competency/Proficiency 2 to 5 years experience, coordinates complex care and sees situations as wholes, and long-term solutions
Unconscious competency	Expert flexible, efficient, and uses intuition

TABLE 1.3 Timeline of the History of the Nurse Psychotherapist

1947	Eight programs established for advanced preparation of nurses to care for psychiatric patients
1952	Hildegard Peplau establishes the first master's in clinical nursing and a "Sullivanian" framework for practice for psychotherapy with inpatients and outpatients
1963	*Perspectives in Psychiatric Care* first published as a forum for interprofessional psychiatric articles
1967	American Nurses Association (ANA) Position Paper on Psychiatric Nursing—PCS (psychiatric clinical specialist) assumes role of individual, group, family, and milieu therapist
1979	ANA certification of PMHCNS
2000	American Nurses Credentialing Center (ANCC) certification of PMHNP
2001	Family PMHNP ANCC Exam
2003	PMHNP Competencies developed and delineate "conducts individual, group, and/or family psychotherapy" for PMHNP practice
2011	APNA and ISPN endorse PMHNP as the entry role for all advanced practice psychiatric nurses
2013	PMHNP Competencies revised
2014	Only PMHNP Across the Life Span ANCC certification

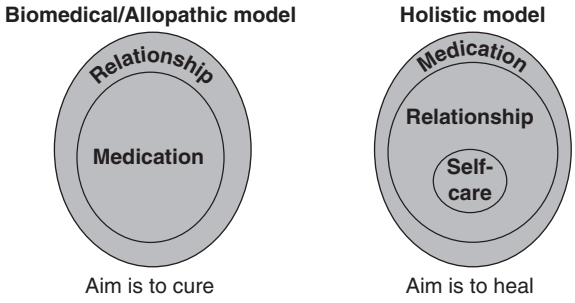


FIGURE 1.1 Paradigms of care.

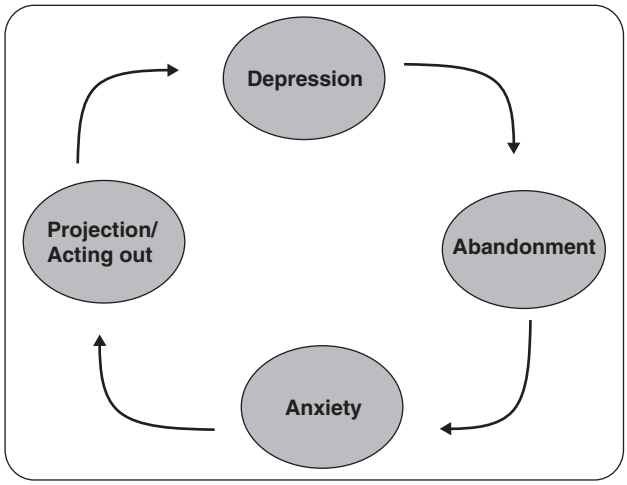


FIGURE 1.2 Cyclical psychodynamics of a person with borderline personality disorder.

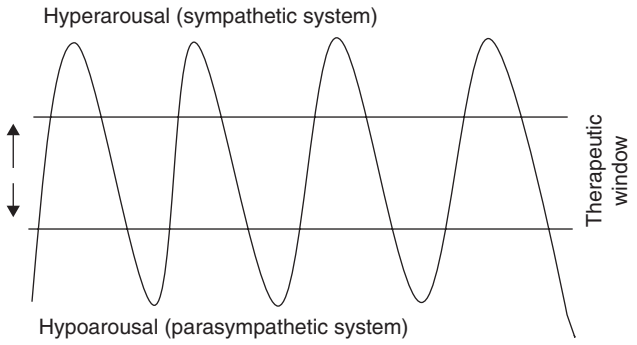


FIGURE 1.3 Therapeutic window of arousal.

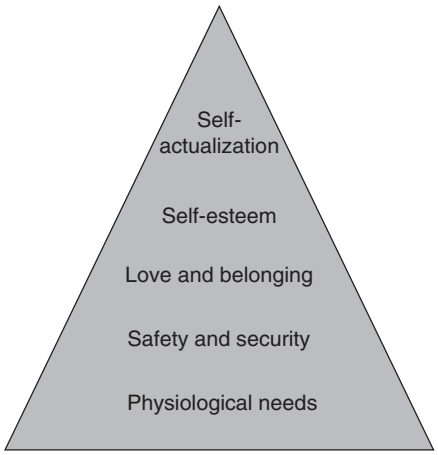


FIGURE 1.4 Maslow's hierarchy of needs.
Adapted from Maslow, A. H. (1972). *The farther reaches of human nature*. New York: Viking.

TABLE 1.4 Cultural Competence: Have You *Asked* the Right Questions?

Awareness	Are you aware of your personal biases and prejudices toward cultures different than your own?
Skill	Do you have the skill to conduct a cultural assessment and perform a culturally based physical exam?
Knowledge	Do you have the knowledge of the patient's worldview, cultural-bound illnesses, and the field of biocultural ecology?
Encounters	How many face-to-face encounters have you had with patients from diverse cultural backgrounds?
Desire	What is your desire to "want to be" culturally competent?

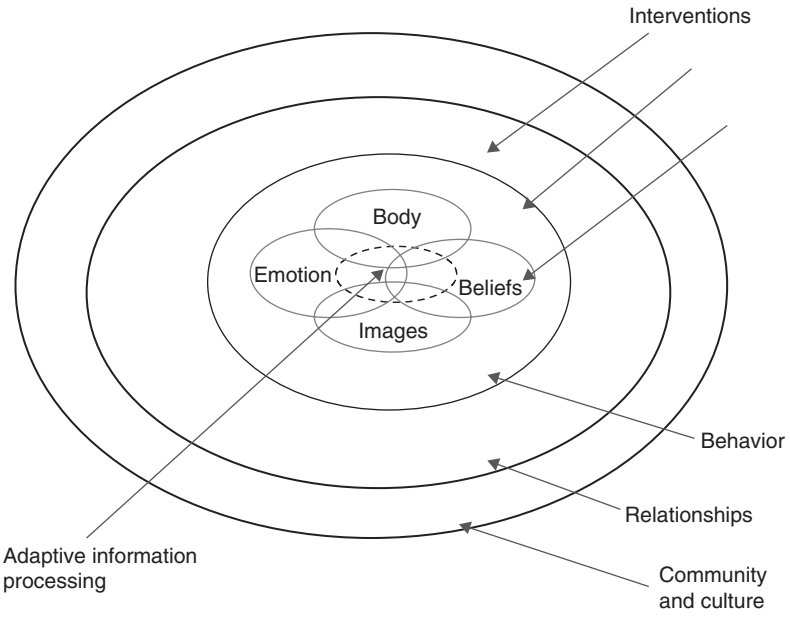


FIGURE 1.5 Adaptive information processing model.

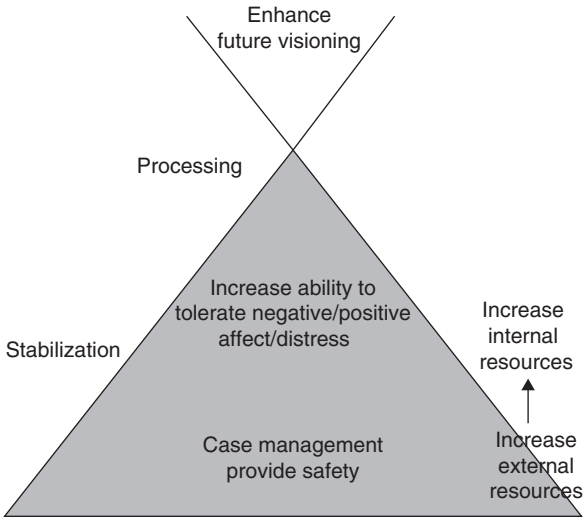


FIGURE 1.6 Treatment hierarchy framework for practice.
Adapted from Davis, K., & Weiss, L. (2004). *Traumatology: A workshop on traumatic stress disorders*. EMDR Humanitarian Assistance Programs.

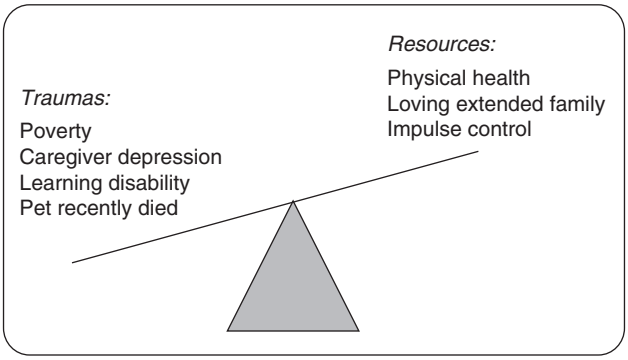


FIGURE 1.7 Trauma and resource balance.

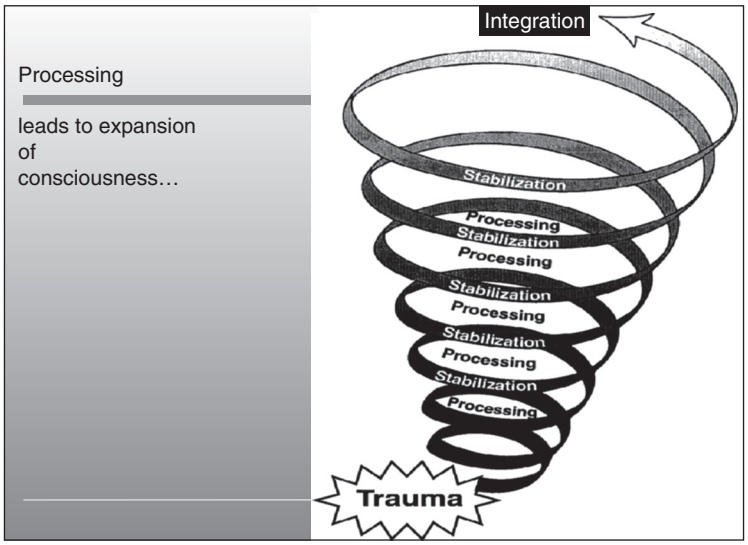


FIGURE 1.8 Spiral of treatment process.

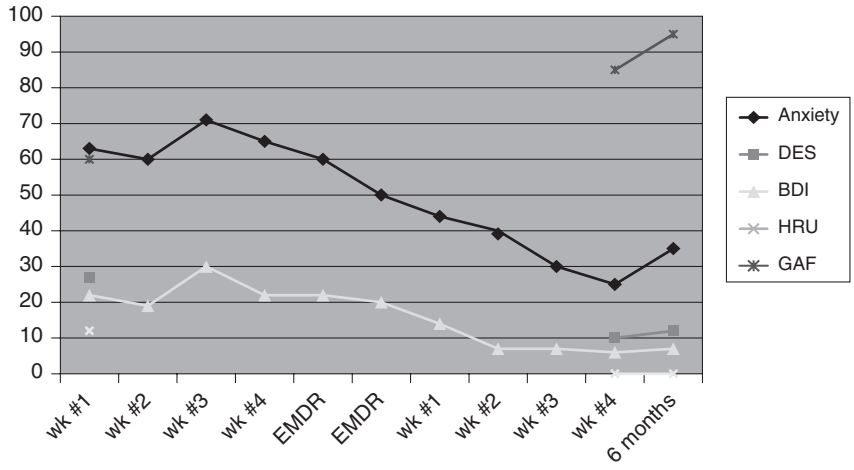


FIGURE 1.9 Ms. A's psychotherapy outcomes.

Anxiety, Spielberger trait anxiety scale; BDI, beck depression inventory; DES, dissociative experiences scale; GAF, global assessment of functioning; HRU, health resource utilization.

APPENDIX 1.1

Suggestions for Presenting a Case

Presenting a case can seem overwhelming, especially with complex patients. The following guidelines are intended to help you organize your thinking, summarize salient information about your patient in a coherent manner, identify areas where the therapy is stuck (resistance), and formulate questions that may offer insight into the process. Identifying information should be disguised.

Basic Information

Demographics: age, race/ethnicity, gender, sexual orientation, education, occupation

Family: relationship status, living arrangement, members of immediate family, extended relevant family members

Working Diagnosis and Symptoms: dissociation, anxiety, depression, eating disorder, substance abuse, self-injury, and suicide attempts, destructive or violent behavior

Relevant Medical Problems and Physical Disabilities: diabetes, asthma, chronic pain, birth defects, sensory impairment, impaired mobility, and so on

Patient's Coping Mechanisms: both healthy and unhealthy, defenses, ego functioning

Treatment History: inpatient, outpatient, how long and intensive, treatment failures and responses

Current Treatment: inpatient, outpatient, partial individual, group, family

Medication(s): current and past history

Case Conceptualization

1. What are the reasons the patient came for treatment now?
2. What are the patient's goals? How would the person know if the treatment was successful?
3. When did the current symptoms start?
4. What other situations may be contributing to the problem now?
5. Speculate on what experiential contributors from the past might be driving the current symptoms?
6. Is there a current crisis?
7. Resources and strengths
8. Draw a timeline with the patient of the most disturbing and pleasant events in the person's life and rate disturbances on a 0 to 10 scale with 10 being the most disturbing. See Chapter 13 for example of timeline.

Questions to Ponder

What's going well in the therapeutic process, and what is problematic? Have you established a therapeutic alliance? Is the patient's life stabilized? Is the patient avoiding or working on issues? Undermining the therapy? Flooding with memories or decompensating?

What makes you want to present this patient? What's unusual, special, difficult, confusing, arousing, frustrating, scary, overwhelming?

What do you experience with this patient that is unusual for you? Do you feel intense emotions, like or dislike, anger, admiration, humiliation, fear, revulsion, sleepy, dizzy, disoriented, a desire to nurture or rescue, the urge to confront. Do you wish you could get rid of this patient, or are you afraid of losing him or her?

Treatment Hierarchy

Based on this information and the hierarchy of treatment in your book, what do you think is the most appropriate interventions/treatment for this person now? What are treatment priorities?

APPENDIX 1.2

Weekly Plan for Increasing Resources

Check off, in the column to the left, all activities that you currently do and keep track of how often you do them for 1 week in the columns to the right. Then put a + in the column to the left of those activities you would like to try in the future. Select one with your therapist to try for the following week, and check off how often you do it. Some of these are learned skills that your therapist may teach you. The idea is to gradually build up and integrate more resources into your life.

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
	Practice deep breathing technique							
	Practice safe place							
	Practice yoga							
	Practice meditation/mindfulness							
	Practice progressive muscle relaxation							
	Exercise for 30 minutes							
	Keep a thought diary							
	Develop a list of positive attributes of self							
	Practice stopping negative self-talk							
	Use affirmations to counter mistaken beliefs							
	Practice imagery							
	Chant or pray or sing							
	Engage in soothing activities (warm bath, nature walk, gardening, …)							
	Practice real-life desensitization							
	Keep a feelings journal							
	Identify and rate feelings (0–10)							
	Express feelings							
	Practice assertive communication							
	Develop a list of actual positive memories							
	Practice grounding techniques (counting, holding object, stomping feet, …)							
	Take a step toward achieving goal(s)							
	Keep a dream journal							
	Develop a healing ritual for a specific loss							
	Implement a contingency contract							
	Keep a food diary							
	Eliminate caffeine/sugar/stimulants							

(*continued*)

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
	Eat only whole unprocessed food (especially fruits & vegetables)							
	Color, draw, or paint							
	Keep a log about life's purpose and meaning							
	Watch inspiring or funny movies							
	Keep alcohol consumption to one or less drinks per day							
	Use spiritual beliefs and practices							
	Read self-help literature							
	Listen to helpful audiotapes							
	Reach out to others							
	Listen to or play music							
	Talk to a nurturing person							
	Attend an appropriate group (AA, support group, …)							
	Pet and/or play with dog or cat							
	Sleep 6 to 8 hours at night							

APPENDIX 1.3

Weekly Plan

Please fill in two to three goals for the week and check off each day that you meet that goal.

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Goal #1								
Goal #2								
Goal #3								

APPENDIX 1.4

Treatment and Case Management

Client:

Address:

Date:

Phone:

Insurance:

Note: At the end of this form is the form for Client Case Management Needs, which clients can fill out before the session to identify their key areas of need. However, it is still important for the therapist to assess each goal directly, because clients may not be aware of some needs.

1. **Housing Characteristics**
   - Goal: Stable and safe living situation.
   - Notes: Unhealthy living situations include short-term shelter, living with a person who abuses substances, an unsafe neighborhood, and a domestic violence situation.
   - Status: If the goal is already met, check here _____ and describe.
     If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.
2. **Individual Psychotherapy**
   - Goal: Treatment that client finds helpful.
   - Notes: Try to get every client into individual psychotherapy. Inquire whether the client has any preferences (e.g., gender, theoretical orientation).
   - Status: If the goal is already met, check here _____ and describe.
     If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.
3. **Psychiatric Medication**
   - Goal: Treatment that client finds helpful for psychiatric symptoms (e.g., depression, sleep problems) or substance abuse (e.g., naltrexone for alcohol cravings).
   - Notes: If the client has never had a psychopharmacologic evaluation, one is strongly recommended, unless the client has serious objections; even then, evaluation and information are helpful before making a decision.
   - Status: If the goal is already met, check here _____ and describe.
     If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.
4. **HIV Testing and Counseling**
   - Goal: Test as soon as possible, unless one was completed in the past 6 months and there have been no high-risk behaviors since then. For a client at risk for human immunodeficiency virus (HIV) infection who is unwilling to get testing and counseling, it is strongly suggested that the therapist hold an individual session with the client to explore and encourage these goals.
   - Notes: Assist patient with accessing community resources in your geographic area.
   - Status: If the goal is already met, check here _____ and describe.
     If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

5. Job, Volunteer Work, and School

Goal At least 10 hours per week of scheduled productive time.

Notes If the client is unable to meet the goal of 10 hours/week, have the client hand in a weekly schedule with constructive activities out of the house (e.g., library, gym).

Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

6. Self-Help Groups and Group Therapy

Goal As many groups as the client is willing to attend.

Notes Elicit the client's preferences, and consider a wide range of options (e.g., dual-diagnosis groups, women's groups, veterans' groups). For self-help groups (e.g., Alcoholics Anonymous), give the client a list of local groups, strongly encourage attendance, and mention that the sessions are free. However, do not insist on self-help groups or convey negative judgment if the client does not want to attend. If the client participates in self-help groups, encourage seeking a sponsor.

Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

7. Day Treatment

Goal As needed and based on the client's level of impairment, ability to attend a day program, and schedule.

Notes If possible, locate a specialty day program (e.g., substance abuse, post-traumatic stress disorder). If the client is able to attend (e.g., job, school, volunteer activity), do not refer to day treatment, because it is usually better to have the client keep working; however, if the client is working part-time, some programs allow partial attendance.

Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

8. Detoxification and Inpatient Care

Goal To obtain an appropriate level of care.

Notes Detox is necessary if the client's use is so severe that it represents a serious danger (e.g., likelihood of suicide, causing severe health problems, withdrawal requires medical supervision, such as for painkillers or severe daily alcohol use). If the client is not in acute danger but cannot get off substances, detox may or may not be helpful; many clients are able to stay off substances during the detox but return to their usual living environment and go back to substance use. For such clients, helping set up adequate outpatient supports is usually preferable. Inquiring about client's history (e.g., number of past detox episodes and their impact) can be helpful in making a decision.

Psychiatric inpatient care is typically recommended if the client is a serious suicide or homicide risk* (i.e., not simply ideation, but immediate plan, intent, and inability to contract for safety) or the client's psychiatric symptoms are so severe that functioning is impaired (e.g., psychotic symptoms prevent a mother from caring for her child). In some circumstances, the client may need to be involuntarily committed; seek supervision and legal advice on this topic.

Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

9. Parenting Skills and Resources for Children

Goal If the client has children, inquire about parenting skills training and about referrals to help the children obtain treatment, health insurance, and other needs.

Notes You may need to gently inquire to assess whether the client's children are being abused or neglected. If so, *you are required by law to report it to your local protective service agency.* The same rule applies for elder abuse or neglect.

Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

10. Medical Care

Goals Annual examinations for (1) general health, (2) vision, (3) dentistry, and (4) gynecology (for women), including (5) instruction about adequate birth control and prevention of sexually transmitted diseases.

Notes Other medical care may be needed if the client has a particular illness.
Status If all five goals are already met, check here _____ and describe.
If any of the five goals is not met or other medical issues need attention, check here _____ and fill out the Case Management Goal Sheet for each.

11. Financial Assistance (e.g., food stamps, Medicaid)
Goal Health insurance and adequate finances for daily needs.
Notes It is crucial to help the client obtain health insurance and entitlement benefits (e.g., food stamps, Medicaid), if needed. The client may need help filling out the forms; the client may be unable to manage the task alone, because the bureaucracy of these programs can be overwhelming. If much help is needed, you may want to refer the client to a social worker or other professional skilled in this area. If the client is a parent, be sure to check whether the children are eligible.
Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

12. Leisure Time
Goal At least 2 hours per day in safe leisure activities.
Notes Leisure includes socializing with safe people and activities such as hobbies, sports, outings, and movies. Some clients are so overwhelmed with responsibility that they do not find time for themselves. Adequate leisure is necessary for maintaining a healthy lifestyle.
Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

13. Domestic Violence and Abusive Relationships
Goal Freedom from domestic violence and abusive relationships.
Notes It may be extremely difficult to get the client to leave a situation of domestic violence. Be sure to consult a supervisor and a domestic violence hotline representative.
Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

14. Impulses to Harm Self or Others (e.g., suicide, homicide)
Goal Absence of such impulses, or if such impulses are present, a clear and specific safety plan is in place.
Notes Many clients have thoughts of harming self or others; however, to determine whether the client is at serious risk for action and how to manage this risk, see the guidelines developed by the International Society of Study for Dissociative Disorders in Chapter 3.
Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

15. Alternative Treatments (e.g., acupuncture, meditation)
Goal The client is informed about alternative treatments that may be beneficial.
Notes Clients should be informed that some people in early recovery benefit from acupuncture, meditation, and other nonstandard treatments. Try to identify local referrals for such resources.
Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

16. Self-Help Books and Materials
Goal The client is offered one or two suggestions for self-help books and other materials, such as audiotapes or Internet sites, that offer education and support.
Notes All clients should be encouraged to use self-help materials outside of sessions as much as possible. For clients who do not like to read, alternative modes (e.g., audiotapes) are suggested. Self-help can address posttraumatic stress disorder, substance abuse, or any other life problems (e.g., study skills, parenting skills, relationship skills, leisure activities, medical problems).
Status If the goal is already met, check here _____ and describe.
If the goal is not met, check here _____ and fill out the Case Management Goal Sheet.

17. Additional Goal
Goal
Notes

*For homicide risk or any other intent to physically harm another person, the therapist must follow "duty to warn" legal standards, which usually involve an immediate warning to the specific person the client plans to assault. Always seek supervision and legal advice, and be knowledgeable in advance about how to manage such a situation.

CASE MANAGEMENT GOAL SHEET

Client:

Date:

Goal:

Referrals given to client, date given, and deadline (if any) for each:

Describe client's motivation to work on this goal:

Emotional obstacles that may hinder completion (and strategies implemented to help client overcome these):

Therapist to do:

Follow-up (date and update):

CLIENT CASE MANAGEMENT NEEDS

Do you need help with any of the following? (circle one)	
1. Housing characteristics	Yes/Maybe/No
2. Individual psychotherapy	Yes/Maybe/No
3. Psychiatric medication	Yes/Maybe/No
4. HIV testing and counseling	Yes/Maybe/No
5. Job, volunteer work, and school	Yes/Maybe/No
6. Self-help groups and group therapy	Yes/Maybe/No
7. Day treatment	Yes/Maybe/No
8. Detoxification and inpatient care	Yes/Maybe/No
9. Parenting skills and resources for children	Yes/Maybe/No
10. Medical care	Yes/Maybe/No
11. Financial assistance (e.g., food stamps, Medicaid)	Yes/Maybe/No
12. Leisure time	Yes/Maybe/No
13. Domestic violence and abusive relationships	Yes/Maybe/No
14. Impulses to harm self or others (e.g., suicide, homicide)	Yes/Maybe/No
15. Alternative treatments (e.g., acupuncture, meditation)	Yes/Maybe/No
16. Self-help books and materials	Yes/Maybe/No
17. Additional goal	Yes/Maybe/No

Adapted from Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York, NY: Guilford Press.

APPENDIX 1.5

Stage I

STABILIZATION CHECKLIST

Please check all indicators below to help assess whether client is stabilized and ready to move to Stage II.

	Comfort with own body and physical experience
	Client is able to establish a useful distance from the traumatic event
	No current life crisis such as impending litigation or medical problems
	Client accepts diagnosis and has a working knowledge of trauma
	Client's mood is stable, even if depressed
	Client has at least two or more people to count on
	Client knows and uses self-soothing techniques
	Client gives honest self-reports
	Client's living situation is stable
	Client is able to communicate
	Client has stable therapeutic relationship and adequate trust of others
	Client has adequate impulse control, no injurious behavior to self or others
	Client stays grounded and oriented x3 when distressed
	No major dissociation present
	Client can identify triggers and reports significant symptoms
	Client can set limits and is able to leave dangerous situations if necessary
	Client can tolerate positive and negative affect, and shame
	If DID, is cooperative and has contractual agreement among parts
	Client can establish "useful distance" from traumatic event

APPENDIX 1.6

Stage II

PROCESSING CHECKLIST

Please check all indicators below to help assess whether client has adequately processed trauma and is moving to Stage III, future visioning. The stabilization checklist should already have been achieved.

	No significant affect changes
	Self-referencing cognitions are positive in relation to past event
	Can dismiss thoughts of trauma at will
	Relationships are adaptive
	Work is productive
	Good quality of decision making
	Creativity begins to emerge
	Boundaries improve
	Complaints tend to deal with present day events
	Affect is proportionate to current events
	Congruence between behavior, thoughts, and affect

APPENDIX 1.7

Safe-Place Exercise

The safe-place exercise described below helps the client to enhance skills during stabilization as well as to decrease distress after processing. Through the ability to create one's own safe place, the person is empowered. As with all learning, the more it is practiced, the more readily available it is when needed. Thus, it should be used on a day-to-day basis. If a client feels there is no place—real or imaginary—that is safe, have the client focus on one time in his or her life when he or she felt safe or on a person he or she admires who exemplifies positive attributes, such as strength or control. If the person still cannot find a safe place, ask them to think of a place where they feel relaxed or comfortable. Sometimes clients become more distressed when they relax and it may take some time before the person is able to identify a positive resource. Identifying a safe place resource may take several sessions. Ask the person to sit with his or her feet firmly planted on the floor. Sometimes this exercise is conducted with soothing music and/or background nature sounds. Some therapists tape the exercise with their voice to give to the client to practice at home. The safe-place exercise follows.

Ask the person to identify an image of a safe place that he or she can easily evoke that creates a personal feeling of calm and safety. Use soothing tones to enhance the imagery, asking the person to "see what you see," "feel what you feel," "notice the sounds, smells, and colors in your special place." Once identified, ask the person to focus on the image, feel the emotions, and identify the location of the pleasing physical sensations and where he or she is in the body. "Concentrate on those pleasant sensations in your body and just enjoy as you breathe deeply, relaxing and feeling safe." After you have slowly deepened his or her experience of this, slowly ask the person to come back and tell you a description of the place. Ask for details so that you can assist the person in accessing this place in the future. Ask how he or she feels and if the experience has been difficult for the person and/or no positive emotions are experienced, explore other resources that might be helpful. If at any time the person indicates that he or she is not feeling safe, the exercise should be stopped immediately.

If successful in accessing a safe place, the person is asked for a single word that fits the picture (i.e., beach, forest…) and then asked to repeat the exercise using the person's words for the experience along with deep breathing. Then ask the person to repeat on his or her own, bringing up the image, emotions, and body sensations. Reinforce, after this exercise, that his or her safe place can be used as a resource and ask the client to practice over the next week, once a day.

During the next session, practice again with the person. Then ask the client to bring up a minor annoyance and notice the negative feelings while guiding the person through the safe place until the negative feelings have dissipated. Then ask the person to bring up a negative disturbing thought once again and to access the safe place but this time on his or her own without your assistance.

Occasionally the safe-place exercise triggers intense negative affect. Clients should be made aware about the possible activation of issues during the safe-place exercise. Reassure the person that even if temporary activation of issues does occur, this is not beyond the limits of expectation, and that it may identify issues that will be addressed in the course of therapy anyway.

APPENDIX 1.8

Container Exercise

This exercise is an important affect management strategy that can be taught to the client and practiced so that the person can feel in control and develop mastery over his or her emotions. It also assists with self-soothing, decreasing arousal, and reinforces a sense of safety. The person should already have a safe place. This exercise should be initiated toward the end of the session when the person has intense negative feelings of anxiety, anger, fear, and/or sadness.

The therapist introduces by saying something like: "Did you know that we can put those bad feelings into a container so you won't feel so overwhelmed when you leave?" The person's curiosity is usually piqued at this point even if he or she does not believe you. Continue with: "I can help you do this and then you can take out those feelings when you want and deal with them the next time we meet or when you decide it is okay." Usually the person agrees if for no other reason than he or she is curious and may think you are really strange to suggest such a thing. The therapist continues in a soothing tone: "So, just imagine you have a container, you can close your eyes or not as you wish. It can be made out of anything that you want and be any size you want but be sure it has a tight lid that you can cover or lock because we are going to put all those negative feelings in. Let me know once you have an image in your head." Once the person says he or she has the image, ask him or her for a few details regarding size and so on. Then ask the client to "return to the image and imagine all those bad feelings going into the container. Once you have all the bad feelings in the container, lock it up. Let me know when they are in there." Once the person says they are in the container, ask the person whether there is any percentage that is still not in the container and usually the person will say something like 10% or 20%. At that point, ask the person: "Do you need a bigger container to accommodate all the bad feelings? You can make it as big as you want. See whether you can put the rest of those feelings in the container now. Let me know when the rest of the feelings are all in the container and locked." If more negative feelings come up, continue with either imaging another container or making the one he or she has bigger. Ask the person what this was like for him or her, checking to see whether he or she is okay.

It is important to do this exercise slowly and use pacing so that the person does not feel rushed. The session can then be ended with the safe place exercise. Ask the person to practice the container exercise during the week when negative feelings come up. The client can also practice allowing the feelings to come out if they think they can manage this and journal about these feelings between sessions. Asking the person at in the next session: "What was different for you this past week?" and exploring how feelings were or were not manageable are important follow-up steps and help to assess how to increase the effectiveness of this exercise.

Modified and adapted with permission from Ginger Gilson, from Gilson, G., & Kaplan, S. (2000). *The therapeutic interweave in EMDR*.

2

The Neurophysiology of Trauma and Psychotherapy

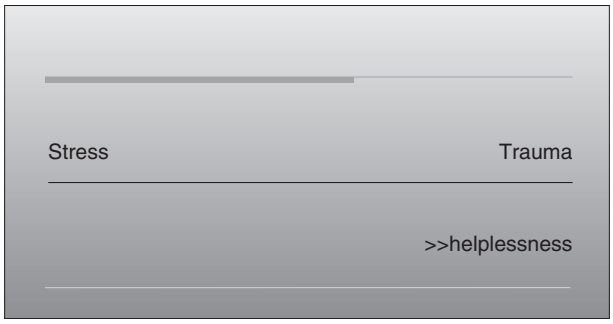


FIGURE 2.1 Continuum of stress/trauma.

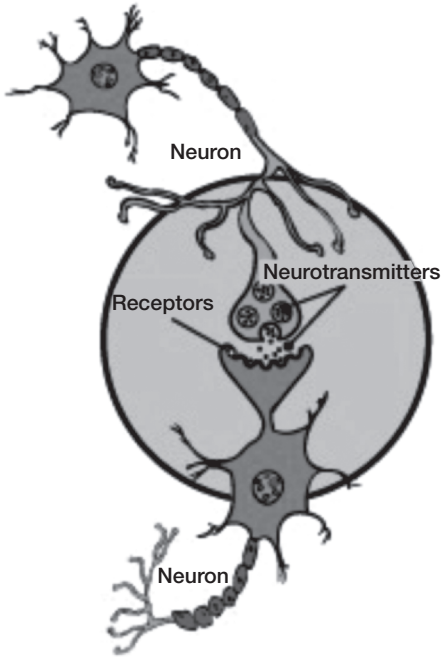


FIGURE 2.2 Neuron and receptor site.

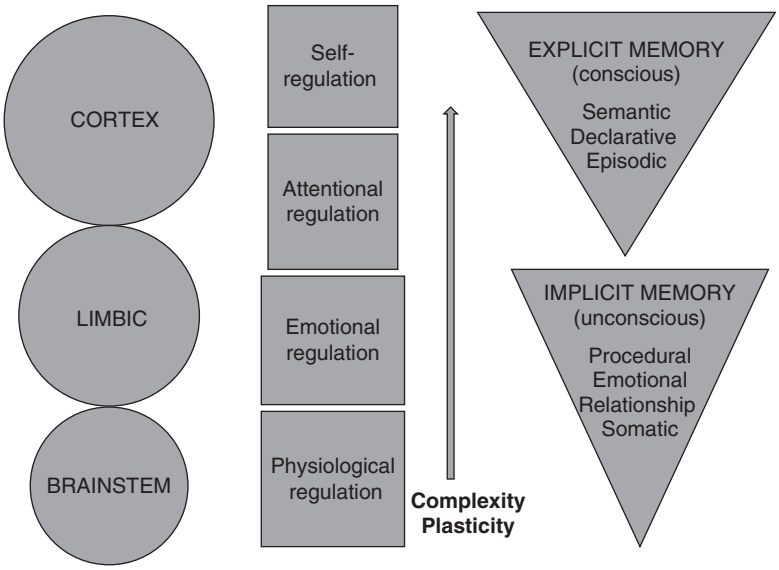


FIGURE 2.3 Stages of brain development, regulation, and memory.

TABLE 2.1 Attachment Schemas

Infant Strange Situation	Adult Attachment Interview
Secure	Secure/Autonomous
Avoidant	Dismissing
Ambivalent/Resistant	Preoccupied
Disorganized/Disoriented	Unresolved/Disorganized

Source: Ainsworth, M. D. (1967). *Infancy in Uganda*. Baltimore: Johns Hopkins; Hesse, E. (1999). The adult attachment interview: Historical and current perspectives. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 395–433). New York, NY: Guilford Press.

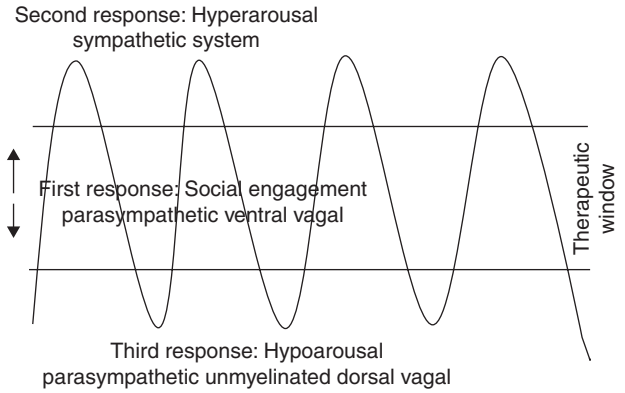


FIGURE 2.4 Therapeutic window of arousal.
Adapted from Porges, S. W. (2011). *The polyvagal theory*. New York, NY: W.W. Norton.

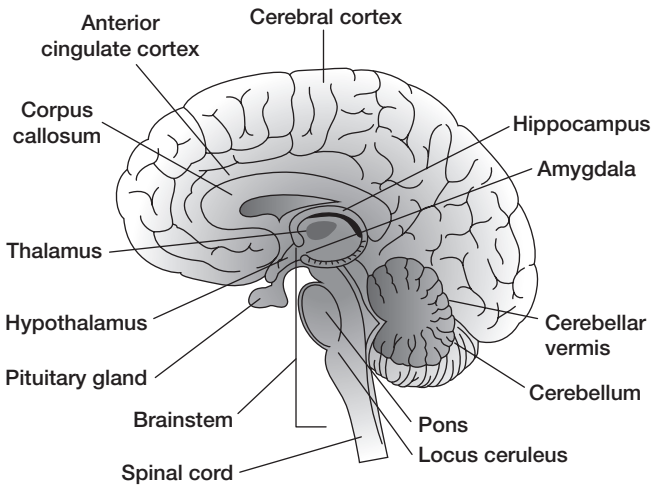


FIGURE 2.5 Structures of the brain.

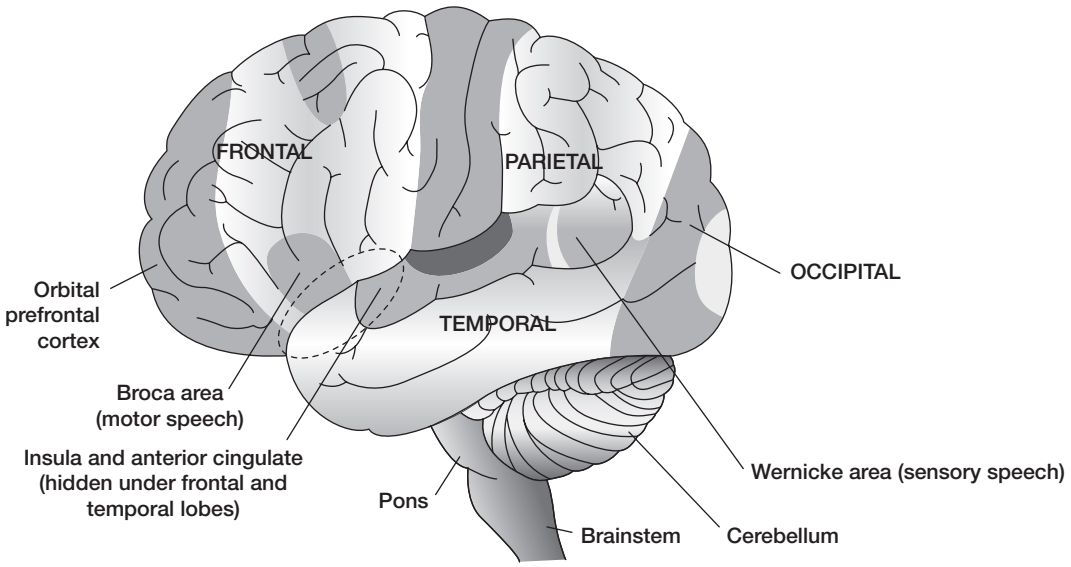


FIGURE 2.6 Cerebral cortex and brainstem.

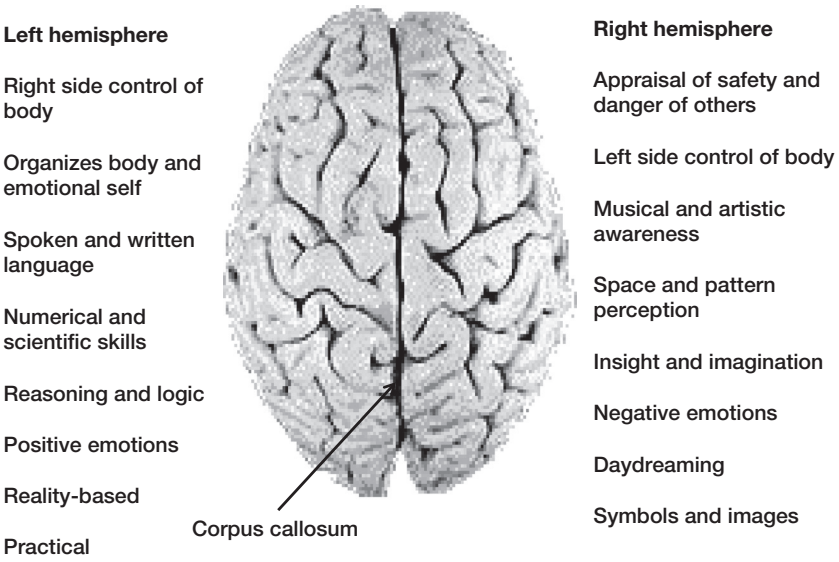


FIGURE 2.7 Right- and left-hemisphere functions.

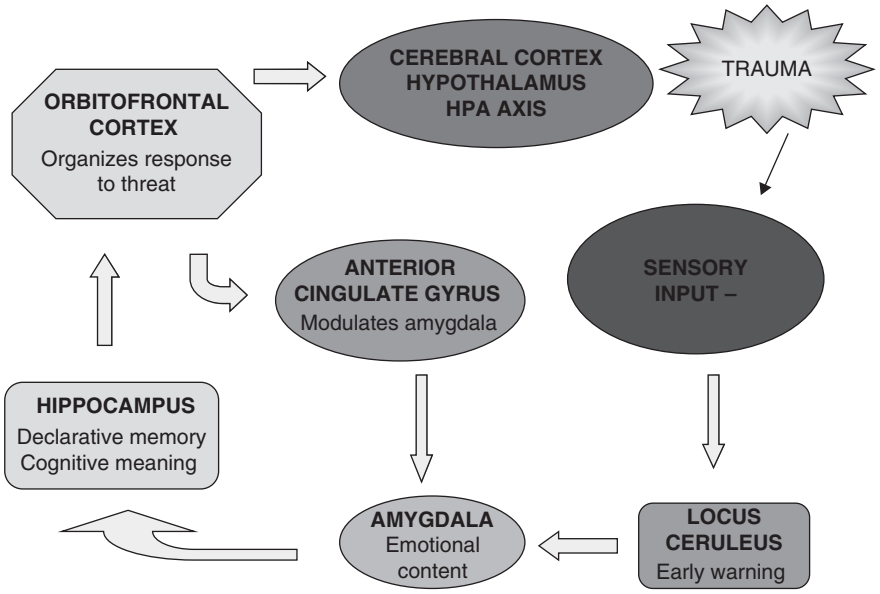


FIGURE 2.8 Trauma response pathway.
Courtesy of Scaer, R. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York, NY: W.W. Norton & Co.

3

Assessment and Diagnosis

TABLE 3.1 Assessment Questions: Continuum of Openness

Type	Example
Open-Ended Types	
Open-ended questions	What brings you in today? How can I help you? How would you describe your relationship with…?
Gentle commands	Tell me about your family situation. Try to describe how you felt when… Share with me what you think a good outcome would be.
Intermediate Types	
Swing questions (client can say "no" or client can elaborate)	Can you describe the depressive symptoms? Can you tell me anything more about that? Can you tell me what you're thinking right now?
Qualitative questions	How have you been sleeping? How is school going? How have you been getting along with your mom?
Statements of inquiry	So you have never before received any therapy? Your mother decided to go back to school when you did? You say you just want to stay in bed all the time?
Empathic statements	You must have been so hurt by that. That is very frustrating. It is hard to lose someone you love.
Facilitating statements	Go on. I see.
Closed-Ended Types	
Closed-ended questions	How many drinks did you have? How often do you feel that way?
Closed-ended statements	You can sit down here. We'll take about 50 minutes to… Medications can be very effective in these cases.

Adapted from Shea, S. C. (1998). *Psychiatric interviewing: The art of understanding* (2nd ed.). Philadelphia: W. B. Saunders.

TABLE 3.2 Ego Functions for Assessment

Reality Testing	Differentiating Inner From Outer Stimuli
Judgment	Aware of appropriateness and likely consequences of intended behavior
Sense of reality of the world and of the self	Experiences external events as real; differentiates self from others
Affect and impulse control	Maintains self-control; can tolerate intense affect and delay of gratification
Interpersonal functioning	Sustains relationships over time despite separations or hostility
Thought processes	Attention, concentration, memory, language, and other cognitive processes are intact; thinking is realistic and logical
Adaptive regression in the service of the ego	Relaxation of ego controls, allowing creative perceptual or conceptual integrations to increase adaptive potential
Defensive functioning	Defenses satisfactorily prevent anxiety, depression, and other unpleasant affects
Stimulus barrier	Aware of sensory stimuli without stimulus overload
Autonomous functioning	Cognitive and motor functions (i.e., primary autonomy) and routine behavior (i.e., secondary autonomy) are free from disturbance
Synthetic-integrative functioning	Integrates contradictory attitudes, values, affects, behavior, and self-representations
Mastery competence	Performance consistent with existing capacity
Object constancy	Ability to provide for oneself, caretaking and soothing in the absence of the caretaker

Adapted from Bellak, L. (1989). The broad role of ego function assessment. In S. Wetzler & M. Katz (Eds.), *Contemporary approaches to psychological assessment* (pp. 270–295). New York, NY: Brunner/Mazel.

TABLE 3.3 Observer-Rated Ego Function Assessment Tool*

Assessment Item	Ego Function
1. When dealing with strong feelings, has trouble with getting too upset or losing control with words or actions	Regulation and control of affects and impulses
2. Explains problems as being caused almost entirely by others	Defensive functioning; interpersonal functioning
3. Has trouble sitting back and looking at own behavior in a realistic way	Defensive functioning; interpersonal functioning
4. Believes he or she is basically a good person, worth caring about, but with some problems	Synthetic-integrative functioning
5. Seems to feel good or bad about self, depending mostly on how others are feeling about him or her	Affect regulation and control of affect; synthetic-integrative functioning
6. Seems able to recognize how he or she is feeling	Regulation and control of affect; defensive functioning
7. Seems able to express his or her feelings in an appropriate manner	Regulation and control of affect and impulses
8. Seems really weird, bizarre, or out of touch with reality	Reality testing; sense of reality of the world and of the self; thought processes
9. Able to look at self fairly realistically in terms of good and bad qualities	Sense of reality of the world and of the self; synthetic-integrative functioning
10. Explains his or her problems by means of hallucinations, false beliefs, control by supernatural power	Reality testing; sense of reality of the world and of the self; thought processes
11. Seems as if he or she does not notice other people exist	Interpersonal functioning
12. Seems afraid of being close to others	Interpersonal functioning
13. Tends to see others as having both good and bad qualities	Synthetic-integrative functioning
14. Seems to need others to lean on	Interpersonal functioning
15. Can structure his or her own time and enjoy it	Autonomous functioning
16. Tends to lump people together and see them as much the same	Interpersonal functioning
17. When left alone, has a hard time taking care of himself or herself	Autonomous functioning
18. Seems to perform up to his or her capabilities	Mastery competence
19. Seems basically to trust other people	Interpersonal functioning
20. Seems to use people to get things he or she needs	Interpersonal functioning
21. Sees his or her problems as resulting from being a bad person	Regulation of affect; synthetic-integrative functioning
22. Seems able to recognize and respond to the feelings of others in an appropriate manner	Regulation and control of affect and impulses
23. Is the type of person others want to be friends with	Interpersonal functioning
24. Recovers from significant emotional upset relatively quickly with previous capacities intact or improved	Adaptive regression in the service of the ego

Always (1)	Almost Always (2)	Usually (3)	Sometimes (4)	Hardly Ever (5)	Never (6)

*Not a validated tool.

Adapted from Tulloch, J. D. (1984). *Unpublished handout.* Denver, CO: University of Colorado Health Sciences Center.

TABLE 3.4 A Fragment of the Inventory of Interpersonal Problems

It is hard for me to:	**How much have you been distressed by this problem?**				
Not At All (0)	**A Little Bit (1)**	**Moderately (2)**	**Quite a Bit (3)**		**Extremely (4)**
Example					
1. Get along with my relatives	0	1	2	3	4
Part I. The following are things you find hard to do with other people:					
1. Trust other people	0	1	2	3	4
2. Say "no" to other people	0	1	2	3	4
3. Join in on groups	0	1	2	3	4
4. Keep things private from other people	0	1	2	3	4
5. Let other people know what I want	0	1	2	3	4
6. Tell a person to stop bothering me	0	1	2	3	4

Adapted from Horowitz, L. M., Rosenberg, S. E., & Bartholomew, K. (1993). Interpersonal problems, attachment styles, and outcome in brief dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 61*(4), 549–560. Copyright 1993, with permission from the American Psychological Association.

TABLE 3.5 A Portion of the World Health Organization's Spirituality, Religiousness, and Personal Beliefs Field-Test Instrument

1 = Not at all
2 = A little
3 = A moderate amount
4 = Very much
5 = An extreme amount

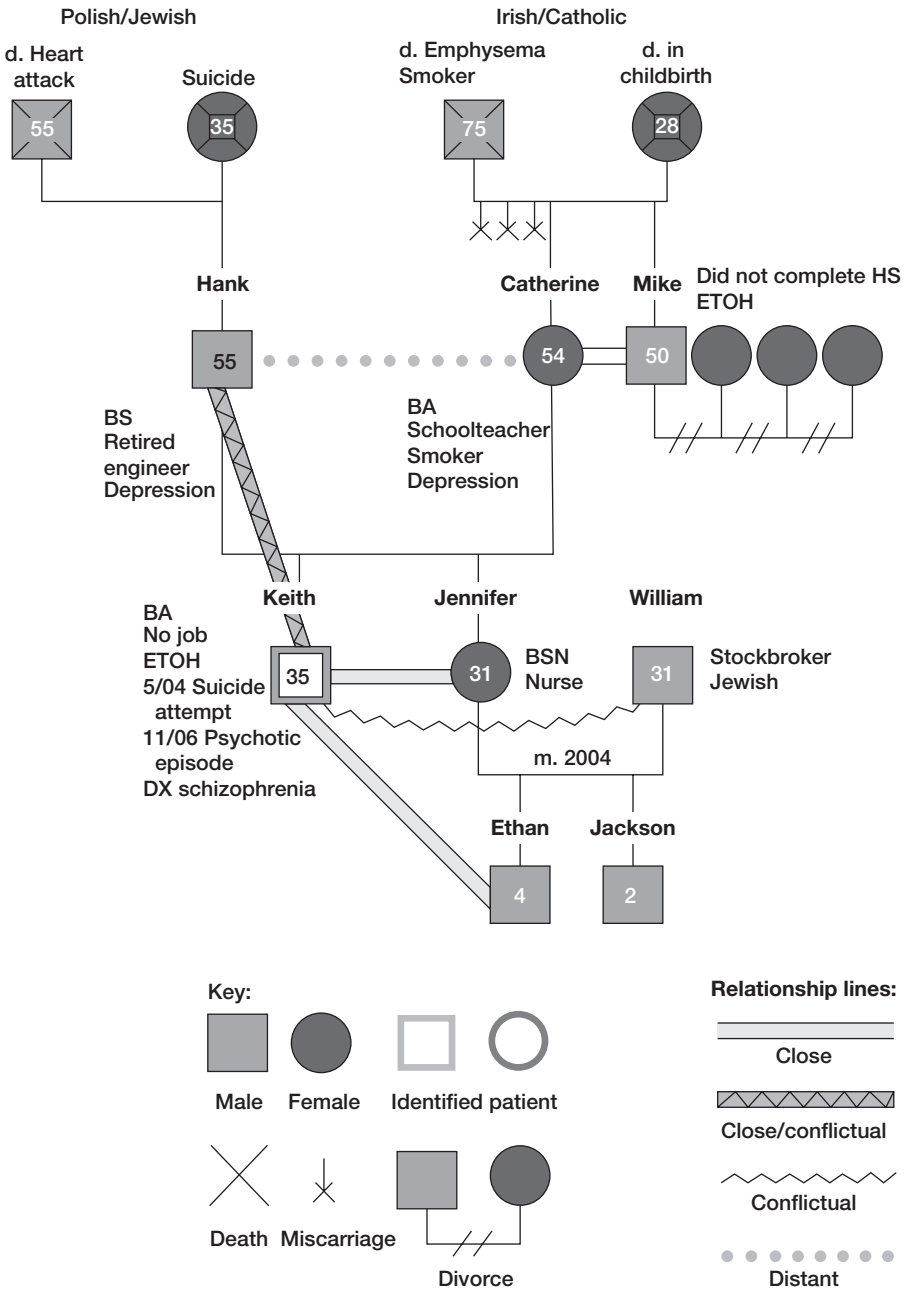
To what extent does any connection to a spiritual being help you to get through hard times?	1	2	3	4	5
To what extent does any connection to a spiritual being help you to understand others?	1	2	3	4	5
To what extent does any connection to a spiritual being provide you with comfort/reassurance?	1	2	3	4	5
To what extent do you find meaning in life?	1	2	3	4	5
To what extent do you feel your life has a purpose?	1	2	3	4	5
To what extent does faith contribute to your well-being?	1	2	3	4	5
To what extent does faith give you comfort in daily life?	1	2	3	4	5
To what extent does faith give you strength in daily life?	1	2	3	4	5
To what extent do you feel spiritually touched by beauty?	1	2	3	4	5
To what extent are you grateful for the things in nature that you can enjoy?	1	2	3	4	5
To what extent are you able to experience awe from your surroundings, for example, nature, art, music?	1	2	3	4	5
To what extent do you feel any connection between your mind, body, and soul?	1	2	3	4	5
To what extent do you feel the way you live is consistent with what you feel and think?	1	2	3	4	5
How much do your beliefs help you to create coherence between what you do, think, and feel?	1	2	3	4	5
How much does spiritual strength help you to live better?	1	2	3	4	5
To what extent does your spiritual strength help you to feel happy in life?	1	2	3	4	5
To what extent do you feel peaceful within yourself?	1	2	3	4	5
To what extent do you feel a sense of harmony in your life?	1	2	3	4	5
To what extent does faith help you enjoy life?	1	2	3	4	5
How satisfied are you that you have a balance between body, mind, and soul?	1	2	3	4	5
To what extent do you consider yourself to be a religious person?	1	2	3	4	5
To what extent do you consider yourself to be a part of a religious community?	1	2	3	4	5
To what extent do you have spiritual beliefs?	1	2	3	4	5

Adapted from the World Health Organization (WHO). (2002). *WHOQOL-SRPB field-test instrument*. Retrieved from www.who.int/mental_health/media/en/622.pdf

TABLE 3.6 Commonly Used Clinical Rating Scales

Scale	Reference
Quality of Life Scales	
Quality of Life Enjoyment and Satisfaction Questionnaire Q-LES-Q	Endicott et al. (1993)
Quality of Well-Being Scale (QWB)	Kaplan and Anderson (1988)
Quality of Life in Depression Scale (QLDS)	Hunt and McKenna (1992)
Medical Outcome Survey (MOS)	Ware and Sherbourne (1992)
Mental Health Status and Functioning Scales	
Clinical Global Impression (CGI)	NIMH (1970)
Endicott Work Productivity Scale	Endicott and Nee (1997)
Global Assessment of Functioning (GAF)	APA, 2000: *DSM-IV-TR*
Sheehan Disability Scale	Leon et al. (1992)
Social and Occupational Functioning Assessment Scale (SOFAS)	APA, 2000: *DSM-IV-TR*
Work and Social Adjustment Scale	Mundt et al. (2002)
Adverse Effects Scales	
Abnormal Involuntary Movement Scale (AIMS)	Guy (1976)
Simpson–Angus Extrapyramidal Symptom Rating Scale	Simpson and Angus (1970)
Cognitive Disorders Scales	
Delirium Rating Scale Revised—98 (DRS—R98)	Trzepacz et al. (2001)
Mini-Mental State Examination (MMSE)	Folstein et al. (1975)
Alcohol Use Disorders Scales	
CAGE Questionnaire	Ewing (1984)
Michigan Alcoholism Screening Test (MAST)	Selzer (1971)
Mood Disorders Scales	
Beck Depression Inventory, 2nd Revision (BDI-II)	Beck et al. (1961)
Hamilton Depression Rating Scale (HAM-D)	Hamilton (1960)
Inventory of Depressive Symptomatology (IDS)	Rush et al. (1996)
Quick Inventory of Depressive Symptomatology (QIDS)	Rush et al. (2003)
Patient Health Questionnaire (PHQ-9)	www.pfizer.com
Geriatric Depression Scale (GDS)	Yesavage et al. (1983)
Montgomery–Asberg Depression Rating Scale (MADRS)	Montgomery and Asberg (1979)
Zung Self-Rating Depression Scale (ZSRDS)	Zung (1965)
Young Mania Rating Scale (YMRS)	Young et al. (1978)
Anxiety Disorders Scales	
Hamilton Anxiety Rating Scale (HAM-A)	Hamilton (1959)
Yale-Brown Obsessive–Compulsive Scale (Y-BOCS)	Goodman et al. (1989)
Psychotic Disorders Scales	
Brief Psychiatric Rating Scale (BPRS)	Overall and Gorham (1962)
Positive and Negative Symptom Scale (PANSS)	Kay et al. (1987)
Aggression and Agitation Scale	
Overt Aggression Scale—Modified (OAS-M)	Coccaro et al. (1991)

Sources: APA. (2006). Practice guideline for psychiatric evaluation of adults. In *American Psychiatric Association practice guidelines for the treatment of psychiatric disorders: Compendium 2006*. Washington, DC: American Psychiatric Association; Bresee, C., Gotto, J., & Rapaport, M. H. (2009). Treatment of depression. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *The American psychiatric publishing textbook of psychopharmacology* (4th ed., chapter 53). Arlington, VA: American Psychiatric Publishing.



d., died; DX, diagnosis; ETOH, alcohol; HS, high school; m., married.

FIGURE 3.1 An elaborated genogram with demographic, occupational, and major life event information.
Adapted from Varcarolis, E. M., Carson, V. B., & Shoemaker, N. C. (Eds.). (2006). *Foundations of psychiatric mental health nursing* (5th ed.). Philadelphia, PA: W. B. Saunders.

APPENDIX 3.1

Outline of the Comprehensive Psychiatric Database

I. Identifying data
   A. Age
   B. Sex/Gender preference
   C. Race/Ethnicity
   D. Marital status
   E. Children
   F. How arrived?
   G. Who referred? Why?
   H. Mental health providers?
   I. Sources of information
   J. Number of times seen in this setting
II. Client-identified problem
   A. What the client states he or she wants help with
   B. Verbatim statement
      1. "I'm depressed."
      2. "My mother brought me. I don't need help."
III. History of current illness
   A. Onset, duration, or change in symptoms over time
      1. Organized chronologically
      2. Client's perception of changes in himself or herself over time
      3. Others' perception of changes in the client (e.g., spouse, employer, and friend)
   B. Precipitating factors
      1. Why now?
   C. Baseline functioning
   D. Last period of stability
IV. Psychiatric history
   A. Inpatient
      1. Location, dates, and lengths of stay
      2. Diagnoses
      3. Previous episodes of current symptoms
      4. Previous episodes of other disorders not described in history of current illness
      5. Legal status
      6. Use of medications or other treatments, including doses, blood levels, clinical response
      7. Perception of helpfulness
   B. Outpatient
      1. Dates, duration, and frequency of sessions
      2. Location, type, and focus of treatment or therapy
      3. Perception of helpfulness
V. Medical history
   A. Past and current medical problems
      1. Illnesses, operations, and hospitalizations, especially history of open or closed head injury, birth trauma, seizure disorder, and encephalitis or meningitis

- B. Past and current medications
  1. Dosages, blood levels, and clinical response
  2. Adherence
- C. Primary care physician, specialists, and phone numbers
- D. Allergies (and reactions)

VI. History of substance use and abuse
- A. Episodes of alcohol abuse
  1. What, how much, and consequences (e.g., charges for driving under the influence [DUI], other legal sequelae, and loss of relationships, jobs, and opportunities)
  2. Does the client or others think he or she has a problem?
  3. Typical pattern of use
  4. History of blackouts, seizures, complicated withdrawal, or delirium tremens
  5. History of suicide ideation, gestures, or attempts while intoxicated or withdrawing
  6. Longest period of sobriety
  7. What facilitates sobriety?
  8. Previous treatments (e.g., detoxification, rehabilitation, counseling, and Alcoholics Anonymous)
- B. Episodes of illicit or prescription drug abuse
  1. What, amount, route of administration, and consequences (e.g., DUIs, other legal sequelae, and loss of relationships, jobs, and opportunities)
  2. Does the client or others think he or she has a problem?
  3. Typical pattern of use
  4. History of suicide ideation, gestures, or attempts while intoxicated or withdrawing
  5. Longest period of sobriety
  6. What facilitates sobriety?
  7. Previous treatments (e.g., detoxification, rehabilitation, counseling, and Narcotics Anonymous)
- C. Tobacco
  1. Number of cigarettes or packs per day
  2. Years client has smoked
  3. Cessation attempts
- D. Caffeine
  1. Form (coffee, cola, tea, and pills)
  2. Amount consumed per day
  3. Cessation attempts
- E. Over-the-counter drugs or "herbal" medications
  1. What, how much, purpose, frequency, side effects, and interactions with prescribed medications
  2. Perceptions of helpfulness or efficacy

VII. Developmental history
- A. Developmental milestones and family of origin
  1. Information about mother's pregnancy and delivery
  2. Were developmental milestones reached as expected?
  3. Childhood temperament and important family events (e.g., death, separation, and divorce)
  4. Information about early experiences and relationships (e.g., school experiences, academic performance, delinquency, family of origin relationships, family stability, early sexual experiences, and history of abuse or neglect)
  5. Important cultural or religious influences
  6. Values, beliefs, or framework for meaning
- B. Educational history
- C. Occupational and military history
  1. Number and types of jobs; reasons for termination
  2. Highest rank attained; conditions of discharge
  3. History of disciplinary problems or combat
- D. Legal history

VIII. Family history
- A. Psychiatric or substance use disorders
  1. Have any family members undergone psychiatric or substance abuse treatment (inpatient or outpatient), attempted or completed a suicide, had problems with drugs or alcohol, and behaved strangely?

2. Have any family members successfully used any psychotropic medications for the same or similar symptoms?
3. Family attitudes toward mental illness

B. Pertinent medical disorders in blood relatives (e.g., seizure disorder or thyroid disease)

IX. Social history
A. Current social situation
1. Living arrangements (e.g., where, with whom, for how long, how stable, and how satisfactory or desirable)
2. Employment (e.g., where, for how long, how stable, and how satisfactory or desirable)
3. Financial (e.g., current sources of income, how stable, and how adequate)
4. Insurance coverage

B. Breadth of client's social life
1. Is he or she a loner or involved in an intimate relationship?
2. How difficult is it to get into and out of relationships?

C. Past and present levels of functioning
1. Marriage, parenting, and work
2. Client strengths and strategies used to manage stress, resources, or positive memories (draw a line and place important positive memories and events)
3. Current functional deficits (e.g., activities of daily living, task performance, and relationships)

X. Trauma history
A. Ten most significant disturbing events in life
B. Violence
1. To self
a. What, when, where, how, why; warning signs or symptoms, triggers, and consequences
b. How intense, specific, and controllable is current ideation
2. To others or property
a. What, when, where, how, why; warning signs or symptoms, triggers, and consequences
b. How intense, specific, and controllable is current ideation
3. Current access to weapons
a. What, where, why; plan for use; plan for disposition of weapon
b. How will disposition of weapons be verified?

XI. Psychiatric review of systems (ROS)
A. Includes all symptoms *not* part of the current episode or presentation
B. May have to ask specific questions about the presence or absence of these symptoms
1. "Are you now or have you ever had any of the following …"

C. Anxiety symptoms
1. Shortness of breath, heart palpitations, panic attacks, sweating, flushing, hyperventilation, sense of doom, fear of death or collapse, cold or clammy skin, and tingling sensations in extremities

D. Mood symptoms
1. Sadness, irritability, anergia, fatigue, lethargy, tearfulness, increased or decreased appetite or energy, changes in sleep or libido, suicide ideation, homicide ideation, hypomania (e.g., spending sprees, increased energy, and religious preoccupation beyond baseline), and feelings of hopelessness, helplessness, or worthlessness

E. Psychotic or cognitive symptoms
1. Hallucinations, delusions, thought insertion, thought blocking, thought broadcasting, flight of ideas, hyper-religiosity, tangentiality, looseness of associations, and circumstantiality

XII. Mental status examination (MSE)
A. Informal: begins immediately on contact with the client and includes an informal assessment of the client's characteristics
1. Appearance
2. Manner of relating
3. Use of language
4. Mood and affect
5. Content of speech
6. Perceptions
7. Abstracting ability
8. Judgment
9. Insight

B. Formal: focused, structured assessment of the client's characteristics
   1. Appearance: overall appearance, dress, grooming
   2. Attitude: attitude toward examiner (e.g., hostile, cooperative, evasive)
   3. Behavior and psychomotor activity: gait, carriage, posture, activity level
   4. Speech
   a. Rate, amount, tone, impairment, aphasia
   5. Mood and affect
      a. Mood (i.e., how the client reports feeling) in relation to affect (i.e., emotional expression observed by the therapist)
      b. Depth and range of emotional expression
   6. Perception
      a. Hallucinations
         i. Auditory
         ii. Visual
         iii. Gustatory: taste (temporal lobe dysfunction?)
         iv. Olfactory: smell (temporal lobe dysfunction?)
         v. Tactile: Skin sensations (alcohol withdrawal and intoxication?)
         vi. Kinesthetic: feeling movement when none occurs
         vii. Hypnagogic: occurs while falling asleep
         viii. Hypnopompic: occurs while waking up
      b. Illusions: misinterpretations of actual sensory stimuli
      c. Depersonalization: feels detached and views self as unreal
      d. Derealization: experiences objects and persons outside of self as unreal
   7. Thought process
      a. The pattern of a client's speech allows the therapist to observe the quality of the thought process, including its flow, logic, and associations. Abnormalities include the following:
         i. Loose associations (LOAs)
         ii. Tangentiality
         iii. Circumstantiality
         iv. Thought blocking (TB)
         v. Thought insertion (TI)
         vi. Flight of ideas (FOAs)
         vii. Perseveration
         viii. Echolalia
   8. Content of thought
      a. Delusions
         i. Paranoid or persecutory
         ii. Grandiose
         iii. Nihilistic
         iv. Somatic
         v. Bizarre
      b. Ideas of reference
      c. Obsessions
      d. Suicidal thoughts
      e. Homicidal thoughts
   9. Judgment
      a. An assessment of social judgment involves determining whether a client understands the consequences of his or her actions
      b. Must recognize differences in cultural values when assessing judgment
      c. "What would you do if you found a sealed, stamped, addressed envelope on the sidewalk?"
   10. Insight
      a. Must assess whether a person is aware of a problem, the cause of the problem, and what type of help is needed to address the problem
   11. Cognition
      a. A formal mental status examination measures the ability of the brain to function by assessing the following cognitive functions:
         i. Consciousness: alert, confused, drowsy, somnolent, obtunded, delirious, stuporous, and comatose

ii. Orientation: knows who he or she is, where he or she is, and what day it is
iii. Memory: can remember what was eaten for breakfast today; has remote memory for long-past events
iv. Recall: can recall three objects after 5 minutes
v. Registration: can name three objects immediately
vi. Attention: can spell *world* forward and backward
vii. Calculation: can do serial 7's or count backward from 20
viii. Language: can name items, repeat a phrase, follow simple commands, read, write, and copy a design

XIII. *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*) differential diagnosis
- A. On a single axis, lists the principal psychiatric, neurodevelopmental, neurocognitive, and other disorders requiring further assessment, along with the corresponding ICD code(s)
- B. Includes so-called "rule-out" and/or "provisional" diagnoses
- C. ICD-9 codes are listed before each disorder name, followed by ICD-10 codes in parentheses
- D. ICD-9 codes will be used in the United States through September 30, 2014. IDC-10 codes will be used starting October 1, 2014.

XIV. Case formulation
- A. Presents a brief summary of the client and rationalizes the diagnoses
  1. Minimal identifying data, including past diagnosis
  2. Abbreviated recapitulation of presenting symptoms, onset, and course
  3. Draws from all sections of the database as needed
- B. Outlines the contributing factors, precipitants, and stressors
- C. Summarizes the logic behind the differential diagnoses
- D. Identifies information still needed to confirm the diagnoses

XV. Treatment plan
- A. Biologic
  1. Medications (e.g., name, dose, route, for what purpose, and client's level of understanding of medication education)
  2. Diagnostic tests (e.g., where, when, and who will administer)
  3. Referrals for primary care
- B. Psychological
  1. Therapeutic modalities to be used and with what focus
     a. Individual psychotherapy?
     b. Group psychotherapy?
     c. Family therapy?
     d. Case management?
- C. Social
  1. Support or self-help groups
  2. Mobilization of family resources
  3. Vocational rehabilitation
  4. Financial planning
- D. Strengths
  1. Overt identification of client strengths, values, and beliefs to support or draw from in implementing the identified treatment plan

Data from APA. (2006). Practice guideline for psychiatric evaluation of adults. In *American Psychiatric Association practice guidelines for the treatment of psychiatric disorders: Compendium 2006*. Washington, DC: American Psychiatric Association; Gordon, C., & Goroll, A. (2003). Effective psychiatric interviewing in primary care medicine. In T. A. Slavin, J. B. Herman, & P. L. Slavin (Eds.), *The MGH guide to psychiatry in primary care* (pp. 19–26). New York, NY: McGraw-Hill; Marken, P. A., Schneiderhan, M. E., & Munro, S. (2005). Evaluation of psychiatric illness. In J. T. DiPrio, R. L. Talbert, G. C. Yee, G. R. Matzke, B. G. Wells, & L. M. Posey (Eds.), *Pharmacotherapy: A pathophysiologic approach* (6th ed., pp. 1123–1132). New York, NY: McGraw-Hill; Morrison, J. (2008). *The first interview* (3rd ed.). New York, NY: Guilford Press; Sadock, B. J., Sadock, V. S., & Ruiz, P. (2009). *Kaplan & Sadock's comprehensive textbook of psychiatry* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins; Scully, J. H., & Thornhill, J. T., IV. (2012). The clinical examination. In J. T. Thornhill, IV (Ed.), *The national medical series for independent study: Psychiatry* (6th ed., pp. 1–16). Philadelphia, PA: Lippincott Williams & Wilkins; Shea, S. C. (1998). *Psychiatric interviewing: The art of understanding* (2nd ed.). Philadelphia: W. B. Saunders.

APPENDIX 3.2

Sample Assessment Form

INITIAL CLINICAL ASSESSMENT

Identifying Data

Name of Client: _____

Date: _____

DOB:_____ Age: _____

Sex: _____ Sexual Preference: _____

Marital Status: _____Children: _____

Race/Ethnicity: _____

Religious Preference: _____

Client-Identified Problem (Client's Own Words) and Referral Source

1. History of current illness
   A. Stressors and symptoms: include current stressors and detailed chronologic history of symptoms for each diagnosis on axes I and II. Detail current substance abuse and the amount and pattern of use.
   B. Recent suicide or homicide ideation or behavior: include all ideation, gestures, attempts, presence or absence of hopelessness, and extent of actions or plans in the past month.
2. Psychiatric history
   A. Episodes and treatment: describe previous episodes of current disorder and all other disorders, including treatment modalities such as hospitalization, psychotherapy, and medications and their dosages.
   B. History of trauma: list the 10 most significant traumas. Do a timeline, and rate the disturbance for each event on a scale of 0 to 10; you can also ask for significant positive and negative events in the person's life. Administer the Impact of Events Scale and Dissociative Experiences Scale if trauma is suspected or reported.
   C. History of violence
      To self:
      To others:
      To property:
3. Psychiatric review of systems: circle all relevant symptoms, and add any not listed
   A. Mood: sadness, tearfulness, depressed mood, irritability, fatigue, lethargy, anergia, anhedonia, sleep changes, appetite changes, decreased libido, hopelessness, helplessness, worthlessness, suicide ideation, homicide ideation, spending sprees, increased energy or activity, decreased need for sleep, increased libido, pressured speech, tangentiality, and flight of ideas.

B. Anxiety: anxious mood, excessive worry, shortness of breath, heart palpitations, panic attacks, sweating, flushing, hyperventilation, sense of impending doom, fear of death or collapse, cold/clammy skin, and tingling sensations in extremities.
C. Thought disorder: auditory or visual hallucinations, other hallucinations, ideas of reference, paranoia, delusions, thought insertion, thought blocking, thought broadcasting, flight of ideas, hyper-religiosity, tangentiality, looseness of associations, and bizarre behavior.

4. Drug and alcohol history
   A. Episodes and treatment: describe previous episodes of current disorder and all other disorders, including treatment modalities such as hospitalization, psychotherapy, and medications and their dosages.
   B. Substance abuse profile:

Substance	Current Amount	Date Last Used
Alcohol (use CAGE if abuse suspected but denied)		
Tetrahydrocannabinol (THC)		
Cocaine, crack, speed		
LSD, mescaline, psilocybin		
Barbiturates, other sedatives		
Caffeine, tobacco		
Over-the-counter drugs, herbal medications		

5. Medical history: List significant past illnesses, surgeries, or hospitalizations
   A. Primary care physician: _____
   B. Allergies: _____
   C. Medications: use the table to document:

Current Medication	Dosage	Taken as Prescribed?	
		Yes	No

6. Psychosocial history
   A. Education:
   B. Family relationships, social relationships, and abuse history:
   C. Employment record and military history:
   D. Religious background, belief system, or meaning framework:
   E. Client's strengths: include client resources and how client self-soothes and manages stress.
7. Family history
   A. Genogram:

CASE FORMULATION

Assessment of suicide or violence risk:_____

Treatment recommendations:_____

Admit to: _____

One-time consultation: _____

Refer to: _____

Referred for:

_____ Physical examination

_____ Individual psychotherapy

_____ Psychological testing

_____ Group psychotherapy

_____Hospitalization

_____Medications

_____Support group

_____Community support program services

Diagnostic summary:

Axis	Diagnoses, Factors, or Status	Codes	Alternatives to Rule Out
I. Clinical psychiatric syndromes	1. 2. 3.		
II. Personality and specific development disorders	1. 2. 3.		
III. Medical problems	1. 2. 3.		
IV. Psychosocial stressors*	1. 2. 3.		
V. Global assessment of functioning (GAF)	Current GAF Highest GAF in past year		
*Prioritize and rank severity: 1, none; 2, mild; 3, moderate; 4, severe; 5, extreme; 6, catastrophic; 7, unspecified.			

Clinician's signature: _____

Date: _____

Location of assessment: _____

Adapted from Shea, S. C. (1998). *Psychiatric interviewing: The art of understanding* (2nd ed.). Philadelphia: W. B. Saunders.

APPENDIX 3.3

Dissociative Experiences Scale (DES)

Name _____ **Date** _____ **Age** _____ **Sex** _____

Directions: This questionnaire consists of 28 questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are *not* under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

Example:

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

1. Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear all or part of what was said. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something as if they were looking at another person. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

8. Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

   0% 10 20 30 40 50 60 70 80 90 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

12. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

13. Some people sometimes have the experience of feeling that their body does not belong to them. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

18. Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

19. Some people find that they are sometimes able to ignore pain. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were different people. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, and so on). Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

25. Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

27. Some people find that they sometimes hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people or objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

    0% 10 20 30 40 50 60 70 80 90 100%

Adapted from Carlson, E. B., & Putnam, F. W. (1993). *Manual for the dissociative experiences scale*. Lutherville, MD: Sidran Foundation.

APPENDIX 3.4

The Impact of Event Scale (IES)

The table contains comments made by people after stressful life events. Using the scale, please indicate how frequently each of these comments was true for you during the past 7 days.

Comment	0 Not at All	1 Rarely	3 Sometimes	4 Often
I thought about it when I did not mean to.				
I avoided letting myself get upset when I thought about it or was reminded of it.				
I tried to remove it from memory.				
I had trouble falling asleep or staying asleep because of pictures or thoughts about it that came into my mind.				
I had waves of strong feelings about it.				
I had dreams about it.				
I stayed away from reminders of it.				
I felt as if it had not happened or was not real.				
Pictures about it popped into my mind.				
Other things kept making me think about it.				
I was aware that I still had a lot of feelings about it, but I did not deal with them.				
I tried not to think about it.				
Any reminder brought back feelings about it.				
My feelings about it were kind of numb.				
Total Score _____ > 26 = moderate or severe impact				

Adapted from Horowitz, M., Wilner, M., & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209–218; Weiss, D., & Marmar, C. (1997). The impact of event scale—revised. In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and PTSD*. New York, NY: Guilford Press.

APPENDIX 3.5

Zung Self-Rating Depression Scale (ZSRDS)

Please read each sentence carefully. For each of the 20 statements, place a check mark in the column that best describes how often you have felt that way during the past two weeks.

Comment	None or Little of the Time	Some of the Time	Good Part of the Time	Most of the Time
1. I feel downhearted, blue, and sad.				
2. Morning is when I feel the best.				
3. I have crying spells or feel like it.				
4. I have trouble sleeping through the night.				
5. I eat as much as I used to.				
6. I still enjoy sex.				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beats faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to do.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

Adapted from Zung, W. W. (1965). A self-rating depression scale. *Archives of General Psychiatry, 4*, 561–571.

APPENDIX 3.6

Geriatric Depression Scale (GDS) (Short Form)

Circle the appropriate answer.

1.	Are you basically satisfied with your life?	Yes	No
2.	Have you dropped many of your activities and interests?	Yes	No
3.	Do you feel that your life is empty?	Yes	No
4.	Do you often get bored?	Yes	No
5.	Are you in good spirits most of the time?	Yes	No
6.	Are you afraid that something bad is going to happen to you?	Yes	No
7.	Do you feel happy most of the time?	Yes	No
8.	Do you often feel helpless?	Yes	No
9.	Do you prefer to stay at home rather than go out and do new things?	Yes	No
10.	Do you feel you have more problems with memory than most?	Yes	No
11.	Do you think it is wonderful to be alive now?	Yes	No
12.	Do you feel pretty worthless the way you are now?	Yes	No
13.	Do you feel full of energy?	Yes	No
14.	Do you feel that your situation is hopeless?	Yes	No
15.	Do you think that most people are better off than you are?	Yes	No

Score: _____/15

Assign 1 point for "No" to questions 1, 5, 7, 11, and 13
Assign 1 point for "Yes" to other questions

Results:

0–4	normal, depending on age, education, and complaints
5–8	mild
8–11	moderate
12–15	severe

Adapted from Yesavage, J. A., Brink, T. L., Rose, T. L., Lum, O., Huang, V., & Adey, M. B. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research, 17*, 37–49.

APPENDIX 3.7

Patient Health Questionnaire-9 (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

Total Score: _____

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APPENDIX 3.8

Young Mania Rating Scale (YMRS)

Elevated Mood:
0 Absent
1 Mildly, or possibly elevated on questioning
2 Definite subjective elevation: optimistic, cheerful, self-confident; appropriate to content
3 Elevated; inappropriate to content; humorous
4 Euphoric; inappropriate laughter; singing

Increased Motor Activity/Energy:
0 Absent
1 Subjectively increased
2 Animated; gestures increased
3 Excessive energy; hyperactive at times; can be calmed
4 Motor excitement; continuous hyperactivity; cannot be calmed

Sexual Interest:
0 Normal; not increased
1 Mildly, or possibly increased
2 Definitive subjective increase on questioning
3 Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report
4 Overt sexual acts (toward interviewer, staff, patients)

Sleep:
0 Reports no decrease in sleep
1 Sleeping less than normal by up to 1 hour
2 Sleeping less than normal by more than 1 hour
3 Reports decreased need for sleep
4 Denies need for sleep

Irritability:
0 Absent
1 Subjective increased
2 Irritable at times during interview; recent episodes of anger or annoyance on ward
3 Frequently irritable during interview; short and curt throughout interview
4 Hostile; uncooperative; interview impossible

Language/Thought Disorder:
0 Absent
1 Circumstantial; mild distractibility; quick thoughts
2 Distractible; loses goal of thought; changes topics frequently; racing thoughts
3 Flight of ideas; tangentiality; difficult to follow
4 Incoherent; communication impossible

Content:
0 Normal
2 Questionable plans; new interests
4 Special projects; hyper-religious
6 Grandiose or paranoid; ideas of reference
8 Delusions; hallucinations

Disruptive/Aggressive Behavior:
0 Absent; cooperative
2 Sarcastic; loud at times; guarded
4 Demanding; threats on ward
6 Threatens interviewer; shouting; interview difficult
8 Assaultive; destructive; interview impossible

Appearance:
0 Appropriate dress and grooming
1 Minimally unkempt
2 Poorly groomed; moderately disheveled; overdressed
3 Disheveled; partly clothed; garish makeup
4 Completely unkempt; decorated; bizarre garb

Insight:
0 Present; admits illness; agrees with need for treatment
1 Possibly ill
2 Admits behavior change, but denies illness
3 Admits possible behavior change, but denies illness
4 Denies any behavior change

Speech (Rate and Amount):
0 No increase
2 Feels talkative
4 Increased rate or amount at times; verbose
6 Push; consistently increased rate or amount; difficult to interrupt
8 Pressured; uninterruptible; continuous speech

Guide for scoring items—the purpose of each item is to rate the severity of the abnormality in the patient. When several keys are given for a particular grade of severity, the presence of only one is required to qualify for that rating.

APPENDIX 3.9

Hamilton Anxiety Rating Scale (HAM-A)

0 = None
1 = Mild
2 = Moderate
3 = Severe
4 = Grossly disabling

Anxious: worries, anticipates the worst, irritable	0	1	2	3	4
Tension: tense, fatigued, startles easily, trembling, restless, unable to relax	0	1	2	3	4
Fears: of the dark, strangers, animals, crowds, traffic, being alone	0	1	2	3	4
Insomnia: difficulty falling asleep or staying asleep, fatigue on waking, dreams, nightmares, night terrors	0	1	2	3	4
Intellectual: difficulty concentrating, poor memory	0	1	2	3	4
Depressed mood: loss of interest, lack of pleasure in activities, early waking, diurnal swing, depression	0	1	2	3	4
Somatic complaints (muscular): muscle aches and pains, bruxism, stiffness, myoclonus, unsteady voice	0	1	2	3	4
Somatic complaints (sensory): tinnitus, blurred vision, flushing, weakness, tingling sensations	0	1	2	3	4
Cardiovascular symptoms: tachycardia, chest pain, palpitations, throbbing vessels, feeling faint	0	1	2	3	4
Respiratory symptoms: shortness of breath, sighing, chest pressure or constriction, choking sensation	0	1	2	3	4
Gastrointestinal symptoms: difficulty swallowing, nausea, vomiting, constipation, bloating, weight loss	0	1	2	3	4
Autonomic symptoms: dry mouth, pallor, flushing, sweating, tension headache, goose bumps	0	1	2	3	4
Behavior at the interview: fidgeting, pacing, tremor, swallowing, sighing, belching, dilated pupils	0	1	2	3	4

Adapted from Hamilton, M. (1959). The assessment of anxiety states by rating. *British Journal of Medical Psychology, 32*, 50–55.

APPENDIX 3.10

Generalized Anxiety Disorder Questionnaire (GAD-7)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
	0	1	2	3
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

Total Score: _____

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APPENDIX 3.11

Yale-Brown Obsessive–Compulsive Scale (Y-BOCS)

Circle the average occurrence of each item during the prior week up to and including the time of interview.

Obsession Rating Scales

1. Time spent on obsessions
- 0 = 0 hr/day
- 1 = 0–1 hr/day
- 2 = 1–3 hr/day
- 3 = 3–8 hr/day
- 4 = > 8 hr/day

2. Interference from obsessions
- 0 = None
- 1 = Mild
- 2 = Definite but manageable
- 3 = Substantial impairment
- 4 = Incapacitating

3. Distress from obsessions
- 0 = None
- 1 = Mild
- 2 = Moderate but manageable
- 3 = Severe
- 4 = Near constant/disabling

4. Resistance to obsessions
- 0 = Always resists
- 1 = Much resistance
- 2 = Some resistance
- 3 = Often yields
- 4 = Completely yields

5. Control over obsessions
- 0 = Complete control
- 1 = Much control
- 2 = Some control
- 3 = Little control
- 4 = No control

Compulsion Rating Scale

6. Time spent on compulsions
- 0 = 0 hr/day
- 1 = 0–1 hr/day
- 2 = 1–3 hr/day
- 3 = 3–8 hr/day
- 4 = > 8 hr/day

7. Interference from compulsions
- 0 = None
- 1 = Mild
- 2 = Definite but manageable
- 3 = Substantial impairment
- 4 = Incapacitating

8. Distress from compulsions
- 0 = None
- 1 = Mild
- 2 = Moderate but manageable
- 3 = Severe
- 4 = Near constant/disabling

9. Resistance to compulsions
- 0 = Always resists
- 1 = Much resistance
- 2 = Some resistance
- 3 = Often yields
- 4 = Completely yields

10. Control over compulsions
- 0 = Complete control
- 1 = Much control
- 2 = Some control
- 3 = Little control
- 4 = No control

Obsession subtotal (add items 1–5): _____

Compulsion subtotal (add items 6–10): _____

Y-BOCS total score (add items 1–10): _____

Range of severity (scores for clients who have both obsessions and compulsions):

Subclinical: 0–7

Mild: 9–15

Moderate: 16–23

Severe: 24–31

Extreme: 32–40

Adapted from Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. I., Hill, C. L., … Charney, D. S. (1989). The Yale-Brown obsessive-compulsive scale I. Development, use, and reliability. *Archives of General Psychiatry, 46*, 1006–1011.

APPENDIX 3.12

Quality-of-Life Scale (QOL)

Please read each item and circle the number that best describes how satisfied you are at this time. Answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or dissatisfied with not doing the activity or having the relationship.

Scoring
7 = Delighted
6 = Pleased
5 = Mostly satisfied
4 = Mixed
3 = Mostly dissatisfied
2 = Unhappy
1 = Terrible

Material comforts (e.g., home, food, conveniences, financial security)	7	6	5	4	3	2	1
Health (i.e., being physically fit and vigorous)	7	6	5	4	3	2	1
Relationships with parents, siblings, other relatives (e.g., communicating, visiting, helping)	7	6	5	4	3	2	1
Having and rearing children	7	6	5	4	3	2	1
Close relationships with spouse or significant other	7	6	5	4	3	2	1
Close friends	7	6	5	4	3	2	1
Helping and encouraging others, volunteering, giving advice	7	6	5	4	3	2	1
Participating in organizations and public affairs	7	6	5	4	3	2	1
Learning (e.g., attending school, improving understanding, getting more knowledge)	7	6	5	4	3	2	1
Understanding yourself (e.g., knowing your assets and limitations, knowing what life is all about)	7	6	5	4	3	2	1
Work (job or in home)	7	6	5	4	3	2	1
Expressing yourself creatively	7	6	5	4	3	2	1

Socializing (e.g., meeting other people, doing things, parties)	7	6	5	4	3	2	1
Reading, listening to music, or observing entertainment	7	6	5	4	3	2	1
Participating in active recreation	7	6	5	4	3	2	1
Independence (i.e., doing for yourself)	7	6	5	4	3	2	1

Adapted from Flanagan, J. D. (1982). Measurement of quality of life: Current state of the art. *Archives of Physical Medicine and Rehabilitation, 63*, 56–59; Burckhardt, C. S., Woods, S. L., Schultz, A. A., & Ziebarth, D. M. (1989). Quality of life in adults with chronic illness: A psychometric study. *Research in Nursing and Health, 12*, 347–354.

APPENDIX 3.13

CAGE Questionnaire

Name: _____

Date: _____

CAGE score: _____

1. Have you ever felt you should **C**ut down on your drinking?	Yes	No
2. Have people **A**nnoyed you by criticizing your drinking?	Yes	No
3. Have you ever felt bad or **G**uilty about your drinking?	Yes	No
4. Have you had an **E**ye-opener first thing in the morning to steady nerves or get rid of a hangover?	Yes	No

Scoring: Assign 1 point for each "Yes" answer. A score of 1 to 3 should alert the examiner and warrants further evaluation.

Score of 1: 80% are alcohol dependent
Score of 2: 89% are alcohol dependent
Score of 3: 99% are alcohol dependent
Score of 4: 100% are alcohol dependent

Adapted from Ewing, J. A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association, 252*(14), 1905–1907.

APPENDIX 3.14

Michigan Alcohol Screening Test (MAST)–Revised

Circle the response to each item that best describes how you have felt over the past 12 months.

1.	Do you feel you are a normal drinker?	Yes	No
2.	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes	No
3.	Does any near relative or close friend ever worry or complain about your drinking?	Yes	No
4.	Can you stop drinking without difficulty after one or two drinks?	Yes	No
5.	Do you ever feel guilty about your drinking?	Yes	No
6.	Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes	No
7.	Have you ever gotten into physical fights when drinking?	Yes	No
8.	Has drinking ever created problems between you and a near relative or close friend?	Yes	No
9.	Has any family member or close friend gone to anyone for help about your drinking?	Yes	No
10.	Have you ever lost friends because of your drinking?	Yes	No
11.	Have you ever gotten into trouble at work because of drinking?	Yes	No
12.	Have you ever lost a job because of drinking?	Yes	No
13.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	Yes	No
14.	Do you drink before noon fairly often?	Yes	No
15.	Have you ever been told you have liver trouble such as cirrhosis?	Yes	No
16.	After heavy drinking have you ever had delirium tremens (DTs), severe shaking, visual or auditory hallucinations?	Yes	No
17.	Have you ever gone to anyone for help about your drinking?	Yes	No
18.	Have you ever been hospitalized because of drinking?	Yes	No
19.	Has your drinking ever resulted in your being hospitalized in a psychiatric ward?	Yes	No
20.	Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?	Yes	No
21.	Have you been arrested more than once for driving under the influence of alcohol?	Yes	No
22.	Have you ever been arrested, even for a few hours, because of other behavior while drinking?	Yes	No

Scoring: Allocate 1 point to each "Yes" answer, except for questions 1 and 4, to which 1 point is allocated for each "No" answer. Total the responses.

Adapted from Selzer, M. L. (1971). The Michigan alcoholism screening test: The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127*, 1653–1658. Tool available at www2.uchsc.edu/pharm/arc_misc/mast.asp

APPENDIX 3.15

Child Attachment Interview (CAI) Protocol

Introduction: This is an interview not a test; want to know what things are like in your family; want to understand your point of view.

1. Can you tell me about the people in your family?
   - The people living together in your house?
   - Extended family?
2. Tell me three words that describe you, that is, what sort of person you are.
   - Examples.
3. Can you tell me three words to describe your relationship with your Mom, that is, what it is like to be with your Mom?
   - Examples for each.
4. What happens when your Mom gets cross with you or tells you off?
   - Story. (Questions 3 and 4 repeated for Dad or other main caregivers)
5. Can you tell me about a time when you were really upset and wanted help?
   - Story.
6. Do you ever feel that your parents don't really love you?
   - When? Do they know you feel that?
7. What happens when you are ill?
   - Example.
8. What happens when you get hurt?
   - Example.
9. Have you ever been hit or hurt by an older child or a grown-up in your family?
   - Story.
   - Have you been badly hurt by someone outside your family?
10. (Elementary school-age children:) Have you ever been touched in the private parts of your body by someone much older than you? (For older children:) Have you ever been touched sexually by someone when you did not want him or her to do it?
    - Story.
11. Has anything (else) really big happened to you that upset, scared, or confused you?
    - Story.
12. Has anyone important to you ever died? Has a pet you cared about died?
    - Story. What did you feel? What did others feel?
13. Is there anyone whom you cared about who is not around anymore?
    - Story.
14. Have you been away from your parents for longer than a day? (If child is not living with parents [e.g., is in foster care], ask about a time when he or she left parents.)
    - Story. How did you and your parents feel? What was it like when you saw them again?
15. Do your parents sometimes argue?
    - Story. How do you feel?
16. In what ways would you like/not like to be like your Mom/Dad?
17. If you could make three wishes when you are older, what would they be?

Shmueli-Goetz, Y., Target, M., Fonagy, P., & Datta, A. (2008). The child attachment interview: A psychometric study of reliability and discriminant validity. *Developmental Psychology, 44*(4), 939–956. Adapted with permission from the publisher: American Psychological Association.

APPENDIX 3.16

Adverse Childhood Experiences Scale

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often** ...
   Swear at you, insult you, put you down, or humiliate you?

   or

   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often or very often** ...
   Push, grab, slap, or throw something at you?

   or

   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever** ...
   Touch or fondle you or have you touch their body in a sexual way?

   or

   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____
4. Did you **often or very often** feel that ...
   No one in your family loved you or thought you were important or special?

   or

   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____
5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1_____
6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?

   or

   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

   or

   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____
10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____. This is your ACE Score.

4

The Initial Contact and Maintaining the Frame

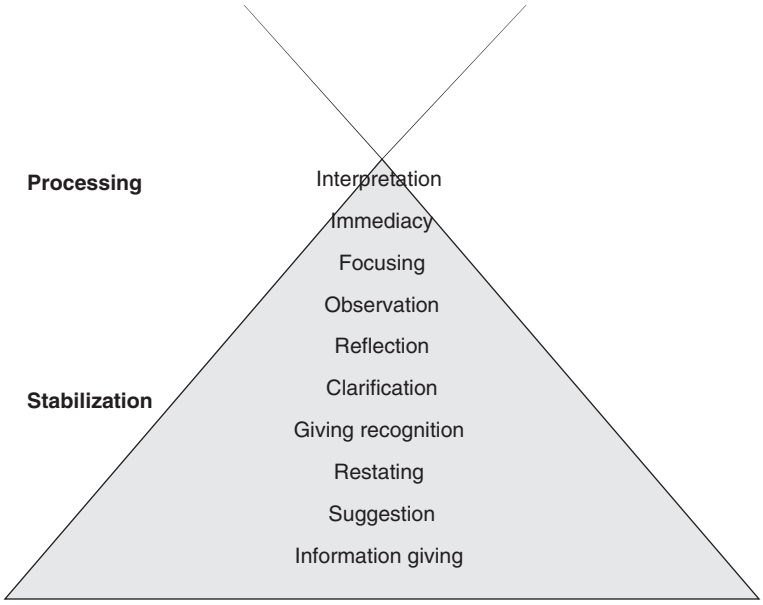

FIGURE 4.1 Treatment hierarchy and continuum of therapeutic communication.

TABLE 4.1 Selected Therapeutic Communication Techniques

Technique	Example
Broad opening	Where shall we begin?
Information giving	I recommend that you take this medication at bedtime because it may make you feel tired.
Giving recognition	You were able to do well this week with the goals we set last week.
Restating	You cannot study and have trouble concentrating.
Suggestion	It may help to keep a journal of your thoughts this week.
Clarification	Would you tell me more about what you mean by "upset"?
Reflection	You are asking me what to do about your wife's drinking and are very frustrated by the situation.
Exploring	How did you feel when your friend said that to you?
Focusing	Yes, your relationship with your mother is important, and it may help you understand better what goes on for you in other relationships by discussing this further.
Observation	It seems that whenever you begin to talk about your mother, you change the subject.
Immediacy	Perhaps you are feeling that I am not giving you what you need here.
Interpretation	From what you have told me, it seems that when you get close in a relationship, you become anxious and then protect yourself by finding fault with the other person.

APPENDIX 4.1

Notice of Privacy Practices

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operation purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- *"Treatment, payment, and health care operations"*
  - Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - Payment is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health care operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my (office, clinic, practice group, and so on) such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my (office, clinic, practice group, and so on), such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures With Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child abuse:** When in my professional capacity, I have received information which gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, I must report such to the county Department of Social Services, or to a law enforcement agency in the county where the child resides or is found. If I have received information in my professional capacity which gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by acts or omissions that would be child abuse or neglect if committed by a parent, guardian, or other persons responsible for the child's welfare, but I believe that the act or omission was committed by a person other than the parent, guardian, or other persons responsible for the child's welfare, I must make a report to the appropriate law enforcement agency.
- **Adult and domestic abuse:** If I have reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited, I must report the incident within 24 hours or the next business day to the Adult Protective Services Program. I may also report directly to law enforcement personnel.
- **Health oversight:** The State Board of Examiners has the power, if necessary, to subpoena my records. I am then required to submit to them those records relevant to their inquiry.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious threat to health or safety:** If you communicate to me the intention to commit a crime or harm yourself, I may disclose confidential information when I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. In this situation, I must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.
- **Workers' compensation:** If you file a workers' compensation claim, I am required by law to provide all existing information compiled by me pertaining to the claim to your employer, the insurance carrier, their attorneys, the South Carolina Workers' Compensation Commission, or you.

IV. Patient's Rights and Psychologist's Duties

PATIENT'S RIGHTS

- **Right to request restrictions:** You have the right to request restrictions on certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction you request.
- **Right to receive confidential communications by alternative means and at alternative locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- **Right to inspect and copy:** You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- **Right to amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an accounting:** You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- **Right to a paper copy:** You have the right to obtain a paper copy of the notice from me on request, even if you have agreed to receive the notice electronically.

NURSE PSYCHOTHERAPIST'S DUTIES

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will mail you a copy of the new notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may _____. If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint _____. You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2004.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

APPENDIX 4.2

Contract

Welcome to my practice. The following includes some essential information regarding psychotherapy. Please read and sign at the bottom to indicate that you have reviewed this information.

Length and Frequency of Treatment

Psychotherapy typically involves regular sessions, usually 45 minutes in length. Duration and frequency vary depending on the nature of your problem and your individual needs.

Confidentiality

Information you share with me will be kept strictly confidential and will not be disclosed without your written consent. By law, however, confidentiality is not guaranteed in life-threatening situations involving yourself or others, or in situation in which children are put at risk (such as by sexual or physical abuse or neglect). If I need to discuss your treatment with a colleague, I will take pains to disguise identifying information, including using a pseudonym.

Fee Policies

My fee for an individual therapy session is _____ per session. If you need to cancel an appointment, please tell me at least 24 hours ahead of time; otherwise, you will be charged for the missed session. Please be aware that insurance carriers will not cover cancellation charges.

If you carry Anthem Blue Cross insurance coverage where I am a provider, I will bill your carrier and assist with insurance reimbursement. In this circumstance, the insurance carrier limits the fee charged for the session and you will not be charged for the difference between my ordinary fee and the cap placed by insurance. Any copayment necessary should be made at the time of the office visit. Unless we make another explicit arrangement, you are responsible for filing insurance claims for all other carriers where I am not a provider. I will give you a bill at the beginning of the month for the previous month and would like to receive payment at that time or at the next session.

Phone and Emergency Contact

If you need to contact me by phone, do not hesitate. When I am not available, my answering machine will take a message. I am usually able to return calls the same day. You will not be charged for phone calls unless we have a scheduled conversation of an information-exchanging or problem-solving nature that lasts more than 10 minutes. If you cannot reach me in an emergency, you can find help at the Emergency Services number of the local hospital: Norwalk Hospital, 203-852-2000.

Physician Contact

Physical and psychological symptoms often interact. I encourage you to seek medical consultation if warranted. It may benefit your treatment for me to speak to your primary care provider, in which case, I will ask your permission first.

Freedom to Withdraw

You have the right to end therapy at any time. If you wish, I will give you the names of other qualified psychotherapists.

Informed Consent

I have read and understood the preceding statements. I have had an opportunity to ask questions about them, and I agree to enter a professional psychotherapy relationship with Dr. Kathleen Wheeler.

Notice of Privacy Practices

I have read the NOTICE OF PRIVACY PRACTICES given to me by Kathleen Wheeler PhD, APRN. I have been given a copy to keep. I understand my rights and responsibilities and know that I may ask questions about my personal health information and its safekeeping at any time.

Signed: _____ Date: _____

APPENDIX 4.3

Process Note

This page is a psychotherapy process note under the Health Insurance Portability and Accountability Act (HIPAA) regulations. It must not be included in or attached to any other part of the client's health care records except with other psychotherapy notes. Clients may request access to these notes only under exceptional circumstances and access may be denied if it is deemed harmful to the client. Releasing these notes requires a special authorization.

Client name:

(for each entry, date code, time, and signature)

APPENDIX 4.4

Progress Note

Kathleen Wheeler, PhD, PMHCNS-BC, PMHNP-BC, APRN, FAAN
3 Cedar Pond Road
Westport, CT 06880
203-919-1984

Client name: _____

Diagnoses (*DSM-5*): _____

Date: _____

S:

O:

A:

P:

CPT code: _____

Prognosis: _____

Signature: _____

Visit time: _____

APPENDIX 4.5

Process Recording

Purpose

The process recording is a written account of a session between a client and therapist. Through the reconstruction of the interaction, the student is provided with an opportunity to retrospectively examine and analyze your facilitative communication skills and therapeutic use of self and the client's contribution to the interaction. Through an analysis of what is said (the content of the interaction) and the flow of the interaction (the process of the interaction), awareness is increased of your own feelings, values, attitudes, expectations, assumptions, and verbal responses and how all influence the interaction with the client. The analysis also helps you to distinguish between your own thoughts and feelings and gain insight into how this influences the perception of the client, the client's situation, and how the client is coping.

The therapist analyzes what is said (the content) and the flow of the interaction (the process of the interaction). This analysis is then used to increase self-awareness of your own feelings, values, attitudes, and beliefs and how they influenced the interaction with the client. This analysis also helps to distinguish between your own thoughts and feelings, and gain insight about how each influences your perception of the client. The process recording also provides you with an opportunity to retrospectively examine and analyze a client's behavior. Through this analysis, inconsistencies or consistencies between what the client says and does can be identified and used to help clients gain insight about their problems and function more effectively.

Directions

There should be four columns, the first designated as *Therapist Said*, the second, *Client Said*, the third, *Therapist Thought/Feeling* column, and the fourth, the *Analysis* column plus a *Summary* page. See criteria on the next page regarding what should be in each column and form for how to set up. At the end of the session, write down everything you can remember that the person said in the *Client Said* column, then go back and fill in what you think you said in the *Therapist Said* column, then fill out the *Therapist Thought/Feeling* column, and the *Analysis* column last. After reading over, write a summary of the interaction on a separate page.

If you have gaps in your memory or cannot recall the exact flow of the interaction, indicate this in the *Analysis* column and examine why you think you might have "forgotten" (e.g., "I wonder whether the topic was anxiety provoking to me?"). Don't write while talking with the person. The process recording is an efficient way to provide students with help with their communication skills; therefore, choose an interaction that was difficult or problematic (e.g., you were stuck, speechless, and overwhelmed). You will probably think of alternative ways of dealing with the situation after reading it over. Openness about problems encountered during the interaction will facilitate helpful feedback that will enhance both your communication skills and therapeutic use of self.

Some of the clients that you will encounter come from very different cultural and socioeconomic backgrounds, and have very different values, expectations, perceptions, and behavior. An important part of the learning experience is to identify those differences and how they influence your ability to be sensitive, empathetic, nonjudgmental, accepting, and therapeutic.

CRITERIA FOR EVALUATION OF PROCESS RECORDING

Therapist _____
Client's initials _____
Date _____

In Therapist Said Column

Reconstruct an interaction with a client using the assigned format.

Document, in the "student said" column, verbatim statements (what you said as closely as you can remember) during the interaction.

In Client Said Column

Document, in the "client said" column, verbatim statements (what the client said as closely as you can recall) during the interaction.

In Therapist Thought/Feeling Column

Separate out your thoughts and feelings and indicate by a T for Thought or F for Feeling at the end of each sentence.

Document the cognitive responses (what you thought) during the interaction. (T)

Document your affective response (your feelings and emotions such as anxiety and sadness) in response to what occurred during the interaction. (F)

In Analysis Column

- Identify how thoughts and feelings influence own behavior.
- Identify own values, beliefs, attitudes, expectations, and assumptions, and how they influence perceptions and responses to the client.
- Identify own expectations and how they influence perceptions and responses to the client. Identify inconsistencies between what the client is saying and doing, or between the client's situation and efforts to function effectively.
- Identify discrepancies between verbal and nonverbal behavior.
- Identify discrepancies between the client's perception of potential or existing problems and the reality of these problems.

On Summary Page

- Identify client resistances to disclosing and examining potential or existing problems.
- Identify nonverbal behavior that indicates resistance to dealing with existing or potential problems.
- Identify verbal behavior that indicates resistance to dealing with existing or potential problems.
- Identify any defenses that you thought the client manifested.
- Identify responses to the client that were ineffective or nontherapeutic.
- Identify the verbal input that was a barrier to facilitating the relationship with client.
- Label the barrier to facilitating the relationship with the client.
- Identify alternative effective responses that would have facilitated the interaction with the client.
- Identify examples of latent communication.

Use the attached format to document the interaction.

When documenting the interaction, set up the columns so that the reader can see the flow by staggering what is documented in the "therapist" and "client" columns.

Therapist Said	Client Said	Therapist Thought/Feeling	Analysis

APPENDIX 4.6

Sample Termination Letter

Date _____

Dear_____,

The last session we had was on _____ (date) and you have missed two scheduled appointments since then. I did leave you two telephone messages but you have not responded. I hope you are okay and will contact me in the near future to resume treatment. As the contract you signed stated when you initially came to therapy, regular appointments are important in order to continue to make progress. I believe it is not in your best interests to terminate now. I would like to continue to work with you but if you would like a referral elsewhere, please call me and I can help make some suggestions for ongoing treatment. If I do not hear from you by _____ (date 2 weeks away), I will consider your treatment under my care to be terminated. If you have any difficulties, please go to your nearest emergency room. I hope to hear from you soon.

Best Regards,
Kathleen Wheeler, PhD, PMHCNS-BC, PMHNP-BC, APRN, FAAN

5

Supportive and Psychodynamic Psychotherapy

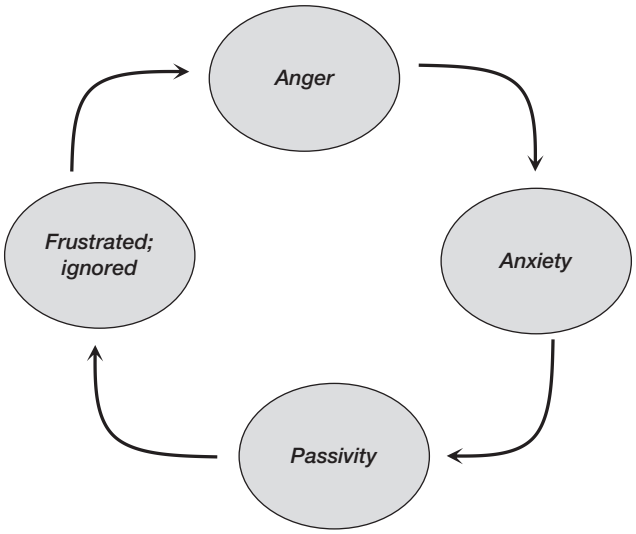

FIGURE 5.1 Cyclical psychodynamics.

TABLE 5.1 Freud's Psychosexual Stages

Stage	Age	Task	Problematic Traits
Oral	Birth to 18 months	To establish trust; comfortable expression and gratification of oral needs	Excessive dependency; envy and jealousy; narcissism; pessimism; excessive optimism
Anal	18 months to 3 years	Learning independence and control	Orderliness; obstinacy; frugality; heightened ambivalence; messiness; defiance; rage; obsessive compulsive; sadomasochism
Phallic/ Oedipal	3 to 6 years	Identification with same sex parent; development of sexual identity	Sexual identity issues; castration in males; penis envy in females; excessive guilt
Latency	6 to 12 years	Sexuality sublimated; emphasis on same sex peers	Inability to sublimate energies to learn; excessive inner control; obsessive traits
Genital	13 to 20 years	Establishment of separation from parents and mature nonincestuous relationships with others	Reworking all the previous developmental issues; establishing a life not dependent on parents

Adapted from Sadock, B. J., Sadock, V. S., & Ruiz, P. (2009). *Kaplan & Sadock's comprehensive textbook of psychiatry* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

TABLE 5.2 Mahler's Stages of Separation–Individuation

Phase	Age	Task
Normal autism	Birth to 1 month	Fulfillment of basic need for survival and comfort
Symbiosis	1 to 5 months	Awareness of external source for need fulfillment
Separation–Individuation		
Differentiation	5 to 10 months	Recognizes separateness from caretaker
Practicing	10 to 16 months	Increased independence and separateness of self
Rapprochement	16 to 24 months	Seeks emotional refueling from caretaker in order to maintain feeling of security; borderline pathology is thought to evolve from problems in this phase.
Consolidation	24 to 36 months	Sense of separateness established; on the way to object constancy; resolution of separation anxiety

Adapted from Mahler, M., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant.* New York, NY: Basic Books.

TABLE 5.3 Erikson's Psychosocial Stages

Age	Stage	Pathological Outcome
Infancy (birth to 18 months)	Trust vs. mistrust	Psychosis, addictions, depression
Early childhood (18 months to 3 years)	Autonomy vs. self-doubt	Paranoia, obsessions, compulsions, impulsivity
Late childhood (3 to 6 years)	Initiative vs. guilt	Conversion disorder, phobias, psychosomatic disorder
School age (6 to 12 years)	Industry vs. inferiority	Inertia, creative inhibition
Adolescence (12 to 20 years)	Identity vs. role confusion	Delinquency, gender-related identity disorders, borderline psychotic episodes
Young adulthood (20 to 30 years)	Intimacy vs. isolation	Schizoid personality
Adulthood (30 to 65 years)	Generativity vs. stagnation	Midlife crisis, premature invalidism
Old age (65 years to death)	Ego integrity vs. despair	Extreme alienation, despair

Adapted from Erikson, E. (1964). *Insight and responsibility*. New York, NY: W.W. Norton; Erikson, E. (1968). *Identity, youth and crisis*. New York, NY: W.W. Norton.

TABLE 5.4 Comparison of Classical Psychodynamic Therapy With Relational Psychodynamic Therapy

	Classical Psychodynamic	Relational Psychodynamic
Therapist role	Objective	Participant–observer
Perspective	One-person psychology	Two-person psychology
Motivation	Drives; sex and/or aggression	Emotional communication and affect regulation
Focus of exploration	Then and there; genetic roots of the problem (how a person's transference reaction is linked to feelings belonging to a person from the past)	Here and now; both patient and therapist contributions to the interaction; and patient's experience
Aim	Make the unconscious conscious	Resolve ruptures in the therapeutic alliance
Change agent	Insight	Mindfulness
Symptom	Psychopathology	A communication
Transference	Interprets in light of the past	Cautious about generalizing to past
Countertransference	Caused by the patient; less disclosure by therapist	Co-constructed; use of countertransference disclosure
Resistance	Intrapsychic event that involves a defense working against change	Co-constructed unconscious rupture of the therapeutic alliance; interpersonal ruptures outside therapy
Interpretation	Of wish/defense conflicts	Of alliance ruptures outside as well as inside therapy

TABLE 5.5 Selected Meta-Analytic Studies of Psychodynamic Psychotherapy

Study	Description	Effect Size	Number of Studies Analyzed
Town et al. (2012)	The impact of audio/video recording, tx manuals, and checks on outcomes in PT	1.01	46 studies
Messer and Abbass (in press)	Personality disorders, general sx improvement	0.91 after 18.9 minutes post treatment _____	7 studies
Leichsenring and Rabung (2011)	CBT/BT compared with PT focusing on depressive sx general psychiatric sx, and social functioning	1.8 _____ 1.25 after 23 minutes follow-up	10 studies
Driessen et al. (2010)	PT compared to control conditions at post-treatment, pretreatment to post-treatment, and PT to other therapies	0.83 group 1.48 individual	23 studies
Abbass, Kisely, and Kroenke (2009)	PT treatment for somatic disorders, and change in general psychiatric sx	0.69	8 studies
de Maat et al. (2009)	Systematic review of long-term psychoanalytic therapy, pretreatment to post-treatment	0.78 _____ 0.94 after 3.2 years post-treatment	10 studies
Leichsenring and Rabung (2008)	Long-term PT treatment of personality disorders, pretreatment to post-treatment	1.46	14 studies
Diener, Hilsenroth, and Weinberger (2007)	Therapist facilitation of affective experience and outcomes	0.30	10 studies
Abbass et al. (2006)	Short-term PT for various disorders, general sx improvement, somatic sx, anxiety sx	0.97 = general; 0.81 = somatic; 1.08 = anxiety _____ 1.51 after 9 minutes post-treatment	23 studies
Leichsenring, Rabung, and Leibing (2004)	Short-term PT for various disorders	Change in target problems 1.17 _____ 1.57 after 13 minutes post-treatment	7 studies
Leichsenring and Leibing (2003)	Meta-analysis of PT and CBT to treat personality disorders	Pretreatment to post-treatment 1.46 after 1.5 years follow-up	14 studies
Anderson and Lambert (1995)	Short-term PT for various disorders and outcomes	0.85	9 studies

Adapted from Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65*(2), 98–109.
BT, behavior therapy; CBT, cognitive behavioral therapy; PT, psychodynamic psychotherapy; sx, symptoms; tx, treatment

TABLE 5.6 Practice Guidelines for Psychiatric Disorders

Practice Guideline	Psychiatric Disorder	Special Considerations
American Psychiatric Association (APA) (2009)	Panic disorder recommended with moderate clinical confidence as an initial treatment (panic focused psychodynamic psychotherapy)	Special focus on transference as the agent promoting change and confront the emotional significance of the sx
Department of Veterans Affairs, Department of Defense (2009)	Major depressive disorder Short-term psychodynamic psychotherapy (SDPP)	Psychodynamic therapy combined with pharmacotherapy: STPP plus antidepressant medication is superior to antidepressant medication and supportive care for initial treatment response
National Institute for Health and Clinical Excellence (NICE) (2011)	Self-harm is used in this guideline to refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting	Three to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm
Medicus (2012)	Use of psychodynamic psychotherapy for a wide range of clinical problems in children aged 3 to 12	Provides specific recommendations for clinical standard and clinical guideline rating
National Collaborating Centre for Mental Health (2009)	Not considered a first line treatment for schizophrenia	Health care professionals may consider using psychoanalytic and psychodynamic principles to help them understand the experiences of people with schizophrenia and their interpersonal relationships in early post-acute period
American Psychiatric Association (2010)	Borderline Personality Disorder Two psychotherapeutic approaches have been shown in randomized controlled trials to have efficacy: psychoanalytic/ psychodynamic therapy and dialectical behavior therapy	The treatment provided has three key features: weekly meetings with an individual therapist, one or more weekly group sessions, and meetings of therapists for consultation/supervision

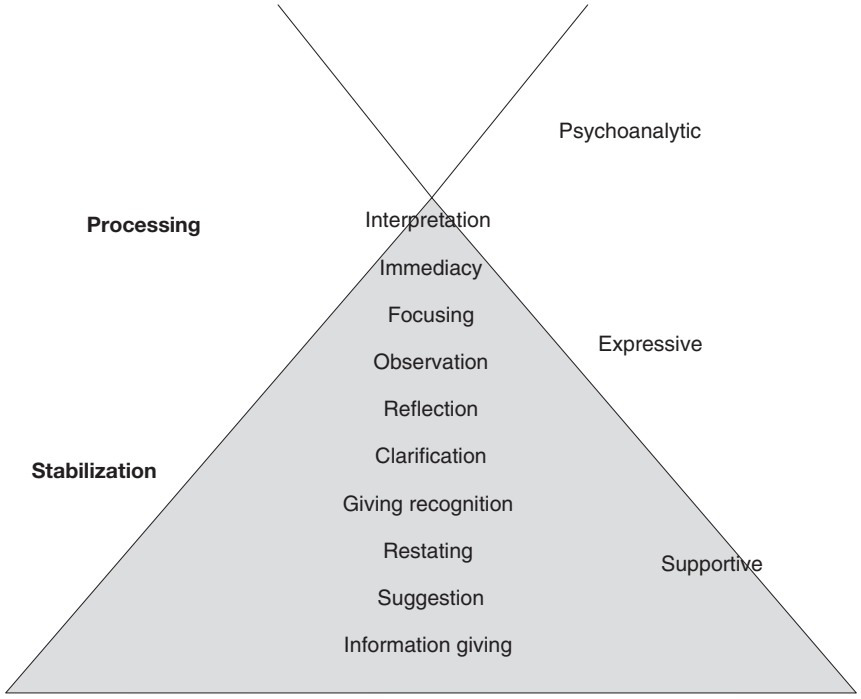

FIGURE 5.2 Psychodynamic case formulation.

TABLE 5.7 Basic Strategies of Dynamic Supportive Therapy

Strategy #1: Formulate the case	Serves as a roadmap for future interventions; why does this person have this problem now; evolves as more information becomes available; involves a developmental assessment
Strategy #2: Be a good parent	"…to the extent that the patient is functioning at a childlike level in significant domains of life, the supportive therapist assumes a parental role" (p. 175)
Strategy #3: Foster and protect the therapeutic alliance	First and primary goal throughout the therapy; respect the patient with compassion, empathy, and commitment; align with the healthy parts of the person; collaboratively set goals and strategies to attain these; interpersonally active treating the patient as the therapist would want to be treated
Strategy #4: Manage the transference	Do need to explore the childhood experiences that underlie negative transference feelings but they must be corrected or the person may leave treatment; therapist acknowledges openly, explicitly, and nondefensively and/or apologizes
Strategy #5: Hold and contain the patient	Provide empathy, understanding, soothing, helping the person to modulate affect, set limits when necessary, restrict acting out and impulsivity; may require medication and/or hospitalization; securing social services and so on while protecting the person's autonomy
Strategy #6: Lend psychic structure	Help as needed with reality testing, problem solving, impulse control, affect modulation, interpersonal awareness, social skills, and empathy
Strategy #7: Maximize adaptive coping mechanisms	Support high level of defenses such as humor, altruism, sublimation, rationalization, and intellectualization and decrease use of denial, splitting, projection, and acting out; enhance coping skills such as mindfulness, dialectical behavior therapy and cognitive behavioral strategies to build distress tolerance skills and emotional regulation
Strategy #8: Provide a role model for identification	Use judicious self-disclosure; be present, available, and real
Strategy #9: Decrease alexithymia	Help the person to identify and name feelings; focus on somatic sensations associated with particular emotions; encourage use of metaphor to describe feelings
Strategy # 10: Make connections	Make associations between an event or situation and the person's feelings such as how false negative beliefs about himself or herself have undermined self-esteem and prevented the person from setting and/or achieving goals, seeking out healthy relationships, and so on
Strategy #11: Raise self-esteem	Foster competency in real skills; role play skills; correct cognitive distortions; unravel unconscious guilt; normalize thoughts, feelings, and behaviors; explain why counterproductive behavior in the present may have been adaptive attempts to deal with earlier adverse life situations
Strategy #12: Ameliorate hopelessness	Use CBT, reframing, case management such as helping the person to obtain disability, housing, job, transportation, community resources
Strategy # 13: Focus on the here and now	Address primary issues: (1) safety, (2) therapy interfering behaviors, (3) future-foreclosing events or plans, (4) treatment noncompliance, (5) negative transference
Strategy #14: Encourage patient activity	Help the person to take action through setting concrete behavioral goals, devising a plan of action, behavioral rehearsal, role playing, relaxation, visualization, imagery, graded exposure, and serving as cheerleader for patient efforts
Strategy #15: Educate the patient and family	Teach about medication(s) side effects and so on, diagnosis/illness, relapse symptoms, specific tasks or functions that the person cannot do on his or her own
Strategy #16: Manipulate the environment	Intervene as appropriate with agencies or persons in order to advocate for the person; do for the person what he or she cannot do for himself or herself always with an aim toward maximum independence and growth

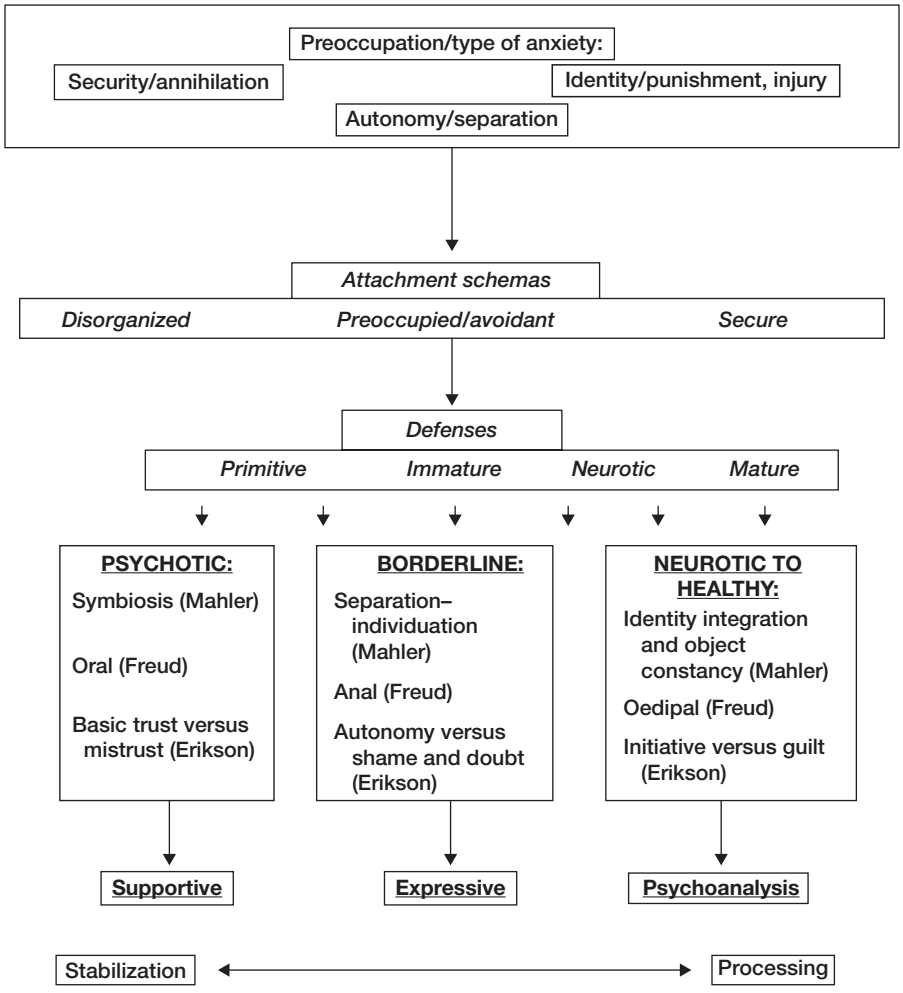

FIGURE 5.3 Case formulation and psychodynamic therapy.

6

Eye Movement Desensitization and Reprocessing Therapy

TABLE 6.1 EMDR Research: Selected Randomized Clinical Trials and Meta-Analyses

Author	Study	Results
Meta-Analyses		
Bisson and Andrew (2007)	Psychological treatment PTSD. *Cochrane Database of Systemic Reviews*	Trauma focused CBT and eye movement desensitization and reprocessing have the best evidence for efficacy at present and should be made available to PTSD sufferers (p. 16).
Bradley, Greene, Russ, Dutra, and Westen (2005)	A multidimensional meta-analysis of psychotherapy for PTSD	EMDR is equivalent to exposure and other cognitive behavioral treatments. It should be noted that exposure therapy uses 1 to 2 hours of daily homework and EMDR uses none.
Davidson and Parker (2001)	A meta-analysis of EMDR	EMDR is equivalent to exposure and other CBT treatments. Exposure uses 1 to 2 hours of daily homework and EMDR uses none.
Maxfield and Hyer (2002)	Relationship between efficacy and methodology in studies investigating EMDR for PTSD	Meta-analysis reported that the more rigorous the study, the larger the effect.
Rodenburg, Benjamin, de Roos, Meijer, and Stams (2009)	Efficacy of EMDR in children: A meta-analysis	Results indicate efficacy of EMDR when effect sizes are based on comparisons between EMDR and non-established trauma treatment or no-treatment control groups, and incremental efficacy when effect sizes are based on comparisons between EMDR and established (CBT) trauma treatment.
Seidler and Wagner (2006)	Comparing the efficacy of EMDR and trauma-focused CBT in the treatment of PTSD: A meta-analytic study	Results suggest that in the treatment of PTSD, both therapy methods tend to be equally efficacious.
Randomized Clinical Trials		
Abbasnejad, Mahani, and Zamyad (2007)	Efficacy of "eye movement desensitization and reprocessing" in reducing anxiety and unpleasant feelings due to earthquake experience	EMDR is effective in reducing earthquake anxiety and negative emotions (e.g., PTSD, grief, fear, intrusive thoughts, depression, etc.) resulting from earthquake experience. Furthermore, results show that improvement due to EMDR was maintained at a 1-month follow-up.
Ahmad, Larsson, and Sundelin-Wahlsten (2007)	EMDR treatment for children with PTSD: Results of a randomized controlled trial	Thirty-three 6- to 16-year-old children with a *DSM-IV* diagnosis of PTSD were randomly assigned to eight weekly EMDR sessions or the WLC group. EMDR was found to be an effective treatment in children with PTSD from various sources and who were suffering from a variety of comorbid conditions.

(*continued*)

Author	Study	Results
Arabia, Manca, and Solomon (2011)	EMDR for survivors of life-threatening cardiac events: Results of a pilot study	Forty-two patients undergoing cardiac rehabilitation . . . were randomized to a 4-week treatment of EMDR or imaginal exposure (IE) . . . EMDR was effective in reducing PTSD, depressive, and anxiety symptoms and performed significantly better than IE for all variables . . . Because the standardized IE procedures used were those employed in-session during [prolonged exposure] the results are also instructive regarding the relative efficacy of both treatments without the addition of homework.
Chemtob, Nakashima, Hamada, and Carlson (2002)	Randomized clinical trial (RCT) of brief treatment for children with disaster-related PTSD	EMDR found effective for children who had not responded to another intervention.
Cvetek (2008)	EMDR treatment of distressful experiences that fail to meet the criteria for PTSD	EMDR treatment of disturbing life events (small "t" trauma) was compared to active listening, and wait list. EMDR produced significantly lower scores on the Impact of Event Scale (mean reduced from "moderate" to "subclinical") and a significantly smaller increase on an anxiety inventory after memory recall.
de Roos et al. (2011)	A randomised comparison of CBT and EMDR in disaster exposed children	Children (n = 52, aged 4–18) were randomly allocated to either CBT (n = 26) or EMDR (n = 26) in a disaster mental health after-care setting after an explosion of a fireworks factory. . . . Both treatment approaches produced significant reductions on all measures and results were maintained at follow-up. Treatment gains of EMDR were reached in fewer sessions.
Edmond, Sloan, and McCarty (2004)	RCT of sexual abuse survivors' perceptions of effectiveness of EMDR	Qualitative and quantitative; narratives reflect that EMDR produces greater trauma resolution compared with eclectic therapy.
Hogberg et al. (2007)	On treatment with eye movement desensitization and reprocessing of chronic PTSD in public transportation workers: A randomized controlled study	Employees who had experienced "person-under-train accident or had been assaulted at work were recruited." Six sessions of EMDR resulted in remission of PTSD in 67% compared to 11% in the wait list control. Significant effects were documented in Global Assessment of Function (GAF) and Hamilton Depression (HAM-D) score. Follow-up: Högberg et al. (2008).
Ironson, Freund, Strauss, and Williams (2002)	RCT comparing prolonged exposure and EMDR for traumatic stress	Both reduced PTSD and depression symptoms with 70% for EMDR vs. 29% for the exposure group.
Jaberghaderi et al. (2004)	RCT comparing CBT with EMDR for sexually abused Iranian girls	Both produced significant reduction in PTSD and behavior problems with EMDR using half the number of sessions to achieve results.
Jarero, Artigas, and Luber (2011)	The EMDR protocol for recent critical incidents: Application in a disaster mental health continuum of care context	Participants were treated two weeks following a 7.2 earthquake in Mexico. One session of EMDR-PRECI produced significant improvement on symptoms of posttraumatic stress for both the immediate-treatment and waitlist/delayed treatment groups, with results maintained at 12-week follow-up, even though frightening aftershocks continued to occur frequently.
Kemp, Drummond, and McDermott (2010)	A wait-list controlled pilot study of EMDR for children with PTSD symptoms from motor vehicle accidents	An effect for EMDR was identified on primary outcome and process measures including the Child Post-Traumatic Stress–Reaction Index, clinician rated diagnostic criteria for PTSD, Subjective Units of Disturbance and Validity of Cognition scales. All participants initially met two or more PTSD criteria. After EMDR treatment, this decreased to 25% in the EMDR group but remained at 100% in the wait-list group.

(*continued*)

TABLE 6.1 EMDR Research: Selected Randomized Clinical Trials and Meta-Analyses (*continued*)

Author	Study	Results
Lee, Gavriel, Drummond, Richards, and Greenwald (2002)	RCT comparing stress inoculation training with exposure with EMDR	All produced positive results with EMDR achieving greater improvement on intrusive symptoms, requiring less homework and greater gains at 3-month follow-up.
Marcus, Marquis, and Sakai (1997)	RCT with 3 and 6 month follow-up of EMDR treatment of PTSD in HMO setting	Small number of sessions resulted in substantial benefits that were maintained over time.
Nijdam et al. (2012)	Brief eclectic psychotherapy vs. eye movement desensitisation and reprocessing therapy in the treatment of PTSD: Randomised controlled trial	A comparison of the efficacy and response pattern of a trauma-focused CBT modality, brief eclectic psychotherapy for PTSD, with EMDR. . . . Although both treatments are effective, EMDR results in a faster recovery compared with the more gradual improvement with brief eclectic psychotherapy.
Power et al. (2002)	RCT of EMDR vs. exposure and cognitive restructuring vs. waitlist for PTSD	All produced significant improvement. EMDR was more beneficial for depression and required fewer treatment sessions.
Rothbaum, Astin, and Marsteller (2005)	RCT comparing EMDR with exposure for PTSD rape victims	NIMH funded study found all subjects did well but EMDR used no homework and less exposure time.
Soberman, Greenwald, and Rule (2002)	Controlled study of EMDR for boys with behavior problems	Addition of three sessions of EMDR resulted in large and significant reductions of memory-related distress and problem behaviors.
Taylor et al. (2003)	RCT of exposure, EMDR and relaxation training for PTSD	Exposure better than EMDR on two subscales using in vivo exposure; 50 hours' homework for exposure and no homework for EMDR.
van der Kolk et al. (2007)	RCT of EMDR, fluoxetine and pill placebo in PTSD	EMDR superior to both control conditions in improvement of PTSD and depressive symptoms; post-termination, EMDR continued to improve while medication group again became symptomatic.
Wanders, Serra, and de Jongh (2008)	EMDR versus CBT for children with self-esteemand behavioral problems: A randomized controlled trial	Twenty-six children (average age 10.4 years) with behavioral problems were randomly assigned to receive either four sessions of EMDR or CBT. Both were found to have significant positive effects on behavioral and self-esteem problems, with the EMDR group showing significantly larger changes in target behaviors.

Adapted from handout Shapiro, F. (2012). *Getting past your past: Take control of your life with self-help techniques from EMDR therapy*. New York, NY: Rodale. EMDRIA Conference, Arlington, VA.

TABLE 6.2 EMDR Clinical Applications

Population	Research Studies
Combat veterans	Blore (1997a); Carlson et al. (1996); Carlson et al. (1998); Daniels et al. (1992); Lipke (2000); Lipke & Botkin (1992); Russell (2008a, 2008b); Russell et al. (2007); Shapiro (1989); Silver & Rogers (2001); Silver, Rogers, & Russell (2008); Thomas & Gafner (1993); Wesson & Gould (2009); White (1998); Young (1995); Zimmermann et al. (2005)
Phobias, panic disorder, obsessive–compulsive disorder, and generalized anxiety disorder	Böhm & Voderholzer (2010); De Jongh (2012); De Jongh et al. (2010); De Jongh & Ten Broeke (1998); De Jongh, Ten Broeke, & Renssen (1999); De Jongh, van den Oord, & Ten Broeke (2002); de Roos & de Jongh (2008); de Roos, Veenstra, et al. (2010); Doctor (1994); Fernandez & Feretta (2007); Feske & Goldstein (1997); Gattinara (2009); Gauvreau & Bouchard (2008); Goldstein (1992); Goldstein & Feske (1994); Grey (2011); Gros & Antony (2006); Howard & Cox (2006); Kleinknecht (1993); Marr (2012); Muris & Merckelbach (1997); Muris, Merckelbach, Holdrinet, & Sijenaar (1998); Nadler (1996); Nazari et al. (2011); Newgent, Paladino, & Reynolds (2006); O'Brien (1993); Protinsky, Sparks, & Flemke (2001a); Schurmans (2007)
Crime victims, police officers, fire fighters, and field workers	Baker & McBride (1991); Dyregrov (1993); Goldstein, deBeurs, Chambless, & Wilson (2000); Jensma (1999); Kitchiner (2004); Kitchiner & Aylard (2002); Kleinknecht & Morgan (1992); Lansing et al. (2005); McNally & Solomon (1999); Page & Crino (1993); Rost, Hofmann, & Wheeler (2009); Shapiro & Solomon (1995); Solomon (1995, 1998); Solomon & Dyregrov (2000); Wilson et al. (2001)
Unresolved grief	Gattinara (2009); Lazrove et al. (1998); Puk (1991a); Shapiro & Solomon (1995); Solomon (1995, 1998); Solomon & Kaufman (2002); Solomon & Rando (2007); Solomon & Shapiro (1997); Sprang (2001)
Sexual assault victims	Ahmad et al. (2007); Bae, Kim, & Park (2008); Beer & Bronner (2010); Bronner et al. (2009); Chemtob et al. (2002); Cocco & Sharpe (1993); Datta & Wallace (1994, 1996); Edmond, Rubin, & Wambach (1999); Fernandez (2007); Fernandez, Gallinari, & Lorenzetti (2004); Greenwald (1994, 1998, 1999, 2000, 2002); Hensel (2006, 2009); Jaberghaderi et al. (2004); Jarero, Artigas, & Hartung (2006); Johnson (1998); Korkmazler-Oral & Pamuk (2002); Lovett (1999); Maxfield (2007); Oras et al. (2004); Pellicer (1993); Posmontier, Dovydaitis, & Lipman (2010); Puffer, Greenwald, & Elrod (1998); Rodenburg et al. (2009); Russell & O'Connor (2002); Scheck, Schaeffer, & Gillette (1998); Shapiro (1991); Soberman, Greenwald, & Rule (2002); Stewart & Bramson (2000); Taylor (2002); Tinker & Wilson (1999); Tufnell (2005); Wadaa, Zaharim, & Alqashan (2010); Wanders, Serra, & de Jongh (2008); Zaghrout-Hodali, Alissa, & Dodgson (2008)
Victims of natural and manmade disasters	Aduriz, Bluthgen, & Knopfler (2009); Chemtob et al. (2002); Colelli & Patterson (2008); Farrell et al. (2011); Fernandez (2008); Fernandez et al. (2004); Gelbach (2008); Grainger et al. (1997); Jarero & Artigas (2010); Jarero et al. (1999); Jayatunge (2008); Knipe et al. (2003); Konuk et al. (2006); Shapiro & Laub (2008); Shusta-Hochberg (2003); Silver, Rogers, Knipe, & Colelli (2005)
Accident, surgery, and burn victims	Blore (1997b); Broad & Wheeler (2006); Hassard (1993); McCann (1992); Puk (1992); Softic (2009): Solomon & Kaufman (1994)
Victims of family, marital, and sexual dysfunction	Bardin (2004); Capps (2006); Chu et al. (2009); Errebo & Sommers-Flanagan (2007); Gattinara (2009); Keenan & Farrell (2000); Kaslow, Nurse, & Thompson (2002); Knudsen (2007); Koedam (2007); Levin (1993); Madrid, Skolek, & Shapiro (2006); Moses (2007); Phillips et al. (2009); Protinsky, Sparks, & Flemke (2001b); Reicherzer (2011); Shapiro, Kaslow, & Maxfield (2007); Snyder (1996); Stowasser (2007); Talan (2007); Wernik (1993); Wesselmann & Potter (2009)
Chemical dependency, sexual deviation/addiction, and pathological gamblers	Abel & O'Brien (2010); Amundsen & Kârstad (2006); Besson et al. (2006); Cox & Howard (2007); Hase, Schallmayer, & Sack (2008); Henry (1996); Marich (2009); Popky (2005); Ricci (2006); Ricci et al. (2006); Shapiro & Forrest (1997); Shapiro, Vogelmann-Sine, & Sine (1994); Vogelmann-Sine et al. (1998); Zweben & Yeary (2006)
Dissociative disorders	Cohen (2009); Fine (1994); Fine & Berkowitz (2001); Lazrove (1994); Lazrove & Fine (1996); Marquis & Puk (1994); Paulsen (1995); Rouanzoin (1994); Twombly (2000, 2005); Young (1994)

(*continued*)

TABLE 6.2 EMDR Clinical Applications (*continued*)

Population	Research Studies
Performance anxiety or deficits in school, business, arts, and sports	Barker & Barker (2007); Crabbe (1996); Foster & Lendl (1995, 1996); Graham (2004); Maxfield & Melnyk (2000); Silverman (2011)
Somatic problems (migraines, chronic pain, phantom limb pain, chronic eczema, GI problems, CFS, psychogenic seizures, EDO and negative body image)	Bloomgarden & Calogero (2008); Brown, McGoldrick, & Buchanan (1997); Chemali & Meadows (2004); de Roos, Veenstra, et al. (2010); Dziegielewski & Wolfe (2000); Gattinara (2009); Grant (1999); Grant & Threlfo (2002); Gupta & Gupta (2002); Kelley & Selim (2007); Kneff & Krebs (2004); Konuk et al. (2011); Kowal (2005); Marcus (2008); Mazzola et al. (2009); McGoldrick, Begum, & Brown (2008); Ray & Zbik (2001); Royle (2008); Russell (2008a, 2008b); Schneider et al. (2007, 2008); Silver, Rogers, & Russell (2008); Tinker & Wilson (2006); Torun (2010); Van Loey & Van Son (2003); Wilensky (2006); Wilson et al. (2000)
Depression	Bae, Kim, & Park (2008); Broad & Wheeler (2006); Gomez (2008); Grey (2011); Hogan (2001); Manfield (1998b); Protinsky, Sparks, & Flemke (2001a); Srivastava & Mukhopadhyay (2008); Tanaka & Inoue (1999); Uribe & Ramirez (2006)
Acute trauma/PTSD/personality (trauma-based issues)	Allen & Lewis (1996); Barol & Seubert (2010); Bisson et al. (2007); Brown & Shapiro (2006); Carbone (2008); Cohn (1993); Farrell et al. (2010); Fensterheim (1996); Forbes, Creamer, & Rycroft (1994); Gelinas (2003); Hogberg & Pagani et al. (2007); Inoue (2009); Kim & Choi (2004); Kutz, Resnik, & Dekel (2008); Hyer (1995); Ironson et al. (2002); Kitchiner (1999, 2000); Korn & Leeds (2002); Laub & Weiner (2011); Lee et al. (2002); Manfield (1998a); Manfield & Shapiro (2003); Marcus, Marquis, & Saki (1997); Marquis (1991); Maxwell (2003); McCullough (2002); McLaughlin et al. (2008); Mevissen & de Jongh (2010); Mevissen, Lievegoed, & de Jongh (2010); Mevissen et al. (2011); Parnell (1996, 1997); Pollock (2000); Power et al. (2002); Protinsky, Sparks, & Flemke (2001a); Puk (1991b); Raboni, Tufik, & Suchecki (2006); Renfrey & Spates (1994); Rittenhouse (2000); Sandstrom et al. (2008); Schneider, Nabavi, & Heuft (2005); Seidler & Wagner (2006); Shapiro (2012); Shapiro & Forrest (1997); Shapiro & Laub (2008); Spates & Burnette (1995); Spector & Huthwaite (1993); Sprang (2001); van der Kolk et al. (2007); Tofani & Wheeler (2011); van den Berg & van den Gaag (2012); Vaughan et al. (1994); Vaughan, Wiese, Gold, & Tarrier (1994); Wilson, Becker, & Tinker (1995, 1997); Wolpe & Abrams (1991); Zabukovec, Lazrove, & Shapiro (2000)

Adapted from handout Shapiro, F. (2012). *Getting past your past: Take control of your life with self-help techniques from EMDR therapy*. New York, NY: Rodale. EMDRIA Conference, Arlington, VA.

TABLE 6.3 Eight-Phase Protocol for Eye Movement Desensitization and Reprocessing

One	Patient History and Treatment Planning—assessment of stability and current life constraints; evaluation of clinical symptoms (affect tolerance and dissociation); screening for use of EMDR; identification of targets including small traumas and big traumas; developing a treatment plan
Two	Preparation—establish therapeutic alliance; educate the person about adaptive information processing (AIP) and EMDR; evaluate secondary gains; practice relaxation and safe place; resource development if needed
Three	Assessment—identify components of the target (see Figure 6.1); patient identifies: an image that represents the experience or worst part of it; a negative cognition (NC) associated with the incident or image and a positive cognition (PC) that represents what the person would like to feel about himself or herself now; the patient then rates the PC on a 1 to 7 validity of cognition (VOC) scale that represents how true the PC feels now; then the emotions associated with the event are identified with a SUD on a 0 to 10 rated scale; finally, the person is asked where they feel this in their body
Four	Desensitization—begin sets of bilateral stimulation with eye movements, sound, and/or tapping and continue until the SUD is 0 or 1
Five	Installation—install PC with bilateral stimulation
Six	Body Scan—note tension and sensations in body for any residual
Seven	Closure—instruct about keeping a log and educate about disturbances that may occur postsession
Eight	Re-evaluation—reassess and review targets that were processed at the beginning of the next session

Adapted from Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York, NY: Guilford Press.

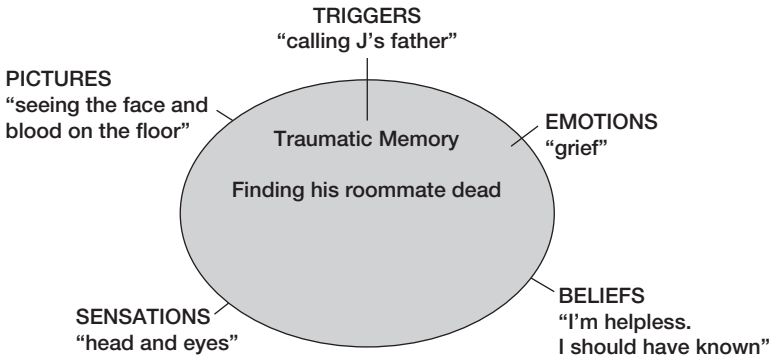

FIGURE 6.1 Components of EMDR.

APPENDIX 6.1

Lightstream Exercise

This exercise can be used for any problem, such as obsessive compulsive disorder, pain, and so on. The therapist can ask the patient to draw what the problem or pain would look like on a piece of paper with colors or else to use the following without the drawing and to visualize:

"Concentrate on the feeling in your body … if the feeling had a shape: what would it be? If it had a size … what would it be? If it had a color … what would it be? If it had a sound … would it be high pitched or low?

Which of your favorite colors might you associate with healing?

Imagine that this favorite colored light is coming in through the top of your head and directing itself at the shape in your body. Let's pretend that the source of the light is the cosmos; the more you use, the more you have available. … The light directs itself at the shape, and permeates and penetrates it … resonating and vibrating in and around it. As it does, what happens to the shape, size, or color?

As the light continues to direct itself to that area, you can allow the light to come in and gently and easily fill your entire head, easily and gently. … Now allow it to descend through your neck into your shoulders, and flow down your arms into your hands and out through your fingertips. Now allow it to come down your neck and into the trunk of your body easily and gently. Now allow it to descend down through your trunk and into your legs, streaming down your legs and flowing out your feet. …"

Give peaceful and calm suggestions until the next session.

An audiotape version is available from EMDR-HAP.

Adapted with permission from Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York, NY: Guilford Press.

APPENDIX 6.2

Circle of Strength

This exercise is designed to assist the person in developing an internal resource for support. This exercise is most helpful if used with those who have positive relationships and memories and may not be appropriate for attachment and relationship trauma. It may create distress for those whose relationships are not working so well.

"If it is okay, close your eyes, leaving them open is okay too. Take a nice deep breath and imagine yourself in the center of a wheel with people surrounding you like spokes in a wheel who are resources for you. Each person is a person who you like who has been there for you and who you feel comforted by and represents a source of strength for you. It could be someone you know from the past or a current person. As you think of each person, tell me who they are (say the name after each person is named to strengthen the image). Make the image of you surrounded by your resource people as vivid as you can with each person's image as clear as you can make it with faces, colors. Just notice as you are surrounded by (name the people again who they named) and how you feel in your body … taking a nice deep breath as you feel the strength and comfort of your resources surrounding you with caring and comfort, those who like you for you and have been there for you. Feel their love around you supporting you and notice where you feel this in your body … let me know where this is. Now, as you breathe in, notice your _____ (body part mentioned by client) and memorize that feeling and notice how calm and strong you feel as you image your circle of strength with you in the middle. Continue for a few minutes enjoying your circle of special people. Take a nice deep breath knowing that you can return to this image anytime you need."

(Ask the person to practice the image during the week several times a day. The more this is practiced, the easier it is to bring to mind when needed.)

7

Motivational Interviewing

TABLE 7.1 Meta-Analyses of Motivational Interviewing With Substance Use, Smoking, and Health-Related Behaviors

Author	Studies	Focus	Comparison Treatment	Effect Size and Relative Risk (RR)
Meta-Analyses Across Behaviors				
Burke et al. (2003, 2004)	N = 30	Drug, alcohol, diet, and exercise	No tx	0.25 to 0.57
Hettema et al. (2005)	N = 72	Alcohol, smoking, HIV, drugs, and compliance	No tx and standard tx	0.11 to 0.77
Lundahl et al. (2010)	N = 119	Substance use, health-related behaviors, gambling, and engagement in tx	Weak comparison	0.28
			Specific comparison	0.09
Meta-Analyses of Specific Behaviors				
Vasilake et al. (2006)	N = 15	Alcohol	No treatment	0.60 at 3 months 0.16 at 6 months
			Comparison	0.43
Lai et al. (2010)	N = 14	Smoking	Usual care/brief advice	1.27 RR
Hettema and Hendricks (2010)	N = 31	Smoking	No tx, brief advice, and pamphlet	0.12 < 6 months 0.17 > 6 months
Jensen et al. (2011)	N = 21	Adolescent substance abuse	Control	0.17
Armstrong et al. (2011)	N = 11	Obesity	No treatment	0.51
Smedslund et al. (2011)	N = 59	Substance use	Post tx Follow-up	0.79 0.17

tx, treatment.

8

Cognitive Behavioral Therapy

TABLE 8.1 Evidence-Based Research for CBT

Medical Disorder	Citation
Tinnitus	Andersson et al. (2005); Hesser et al. (2012)
Chronic pain	Bogduk (2004); Skinner, Wilson, & Turk (2012); Thomas (2005); Thorn (2004)
Premenstrual dysphoric disorder (PMDD)	Hunter et al. (2002); Lustyk et al. (2009)
Sexual dysfunction	Hoyer et al. (2009); Nofzinger et al. (1993)
Chronic insomnia	Espie, Inglis, & Harvey (2001); Mitchell et al. (2012)
Chronic fatigue syndrome	McCrone et al. (2012); Price & Couper (1998)
Myocardial infarction	Delisle et al. (2012)
Depression	DeRubeis et al. (2005); Hollon et al. (2006); Jakobsen et al. (2011)
Anxiety and panic disorders	Coull & Morris (2011); Heldt et al. (2005); James, Soler, & Weatherall (2005); Klinger et al. (2005); Ost, Thulin, & Ramnero (2004); Persons et al. (2005); Stanley, Diefenbach, & Hopko (2004)
Eating disorder	Glisenti, Kevin, & Esben Strodl (2012); Leung, Waller, & Thomas (2000); Pike et al. (2003)
Personality disorders	Bhar et al. (2012); Leichsenring & Leibing (2003); McMain et al. (2012)
Substance misuse disorders	Sobell & Sobell (2011); Tyrer et al. (2003); Tyrer et al. (2004)
Marriage and couple problems	Dattilio & Epstein (2005)
Posttraumatic stress disorders (PTSD)	Bisson & Andrew (2005); Chard et al. (2010); Hinton et al. (2005); Karlin et al. (2010); Otto et al. (2003); Paunovic & Ost (2001); Taylor et al. (2001)
Self-injurious behaviors	Riaz & Agha (2012); Tyrer et al. (2003)
Obsessive–compulsive disorder	Benazon, Ager, & Rosenberg (2002); McLean et al. (2001); Olatunji et al. (2013); Piacentini et al. (2002); Rufer et al. (2006); Whittal, Thordarson, & McLean (2005)
Schizophrenia and schizophrenic symptom reduction	Hofmann et al. (2012); Jones, Cormac, Silveira da Mota Neto, & Campbell (2004); Rector & Beck (2001, 2002); Turkington et al. (2004)
Health anxiety (Hypochondriasis)	Bouman & Visser (1998); McManus et al. (2012)
Antisocial behaviors	Kazdin, Marciano, & Whitley (2005)
Sexual offenders	Yates (2003)
Borderline personality disorder (using a DBT approach)	Binks et al. (2006); Kliem, Kröger, & Kosfelder (2010); Neacsiu, Rizvi, & Linehan (2010)

DBT, dialectical behavior therapy.

TABLE 8.2 Socratic Dialogue

1. History questions: How many children did you have in your first marriage? (non-SD)
2. Memory questions: (remembering that the individual's recall is influenced temporally, interference and "facts" being considered inconsequential)
   When did you first notice that your sleep patterns had changed?
3. Translation questions: (asks the patient how the data refers to the individual) When you say you become anxious, explain to me what it feels like to feel anxious to you.
4. Interpretation: (helps the patient identify relationships between facts and experiences) How does your sensitivity to criticism play out with your husband?
5. Application: (asks the individual to apply previously mastered skills to a new situation) How can you use what you learned with your boss in your discussion with your son?
6. Analysis: (requires breaking a problem into a number of parts) What evidence do you have to support this conclusion?
7. Evaluation: (asks the individual to make decisions/judgments based on data)
   On a scale of 0 to 10, where would you rate your level of anxiety today? And how does that compare to 4 months ago?

TABLE 8.3 Socratic Dialogue Basic Rules

1. The techniques are embedded in the collaborative dialogue and are goal directed and specific.
2. The therapist has a problem list that generates the plan of direction that begins the SD process. SD is not a series of drifting questions that "follow the patient." Each question must be strategically placed in order to reach the predefined goal. This is where the concept of "guided discovery" comes from for the therapeutic interaction.
3. The questions must be short, focused, and targeted. For example, "Do you experience difficulty agreeing with your husband?" "Is this similar to interactions with others?" "How does this play itself out in this situation?" "Can you think of another way to respond that may result in a less defensive response from him?"
4. The questions must progress in a manner that keeps anxiety at a minimum for the individual.
5. The SD questions should be framed in a way to elicit an affirmative response. For example, to a reluctant individual: "There are probably a lot of places you would rather be than here, right?"
6. The additional point to the above is that negative responses to questions mean that the therapist must reframe the question to gain an affirmative response. "Is it your idea to come to therapy today?" "No! I don't want to be here!" "There are probably a lot of things you would rather be doing today than sitting here." "Yeah! That's for sure!"
7. The therapist must monitor the patient's reactions and moods on an ongoing basis. If a question increases a reaction, the therapist needs to address it immediately. "What just happened—I noticed a reaction—what was that?"
8. The therapist must pace the questions to suit the individual's mood, style, and content of information.
9. The questions must be planned and in logical sequence. The therapist must have an internal map for the session and move the session in a planned direction toward the desired goal.
10. The therapist must be careful to self-monitor and not "jump in" to offer interpretations or solve the patient's problems. This is not only more respectful to the patient but it also allows for greater clarity.
11. Self-disclosure should be extremely limited and only used with extreme caution and great care as to the motive for the disclosure. Comparing what the therapist did or does with what the patient did or does moves away from SD into discussion and possibly misjudgment.
12. The therapist may use everyday experiences as therapeutic metaphors. For example, this author uses Aesop's Fables and other well-known story characters to make a point such as "sour grapes" that can elicit both content and affect.

TABLE 8.4 Cognitive Distortions

All or nothing	I'm either a success or a failure.
Mind reading	They probably think that I'm incompetent.
Emotional reasoning	Because I feel inadequate, I am inadequate.
Personalization	That comment must have been directed toward me.
Global labeling	Everything I do turns out wrong.
Catastrophizing	If I go to the party, there will be terrible consequences.
Should statements	I should visit my family every time they want me to.
Overgeneralization	Everything always goes wrong for me.
Control fallacies	If I'm not in complete control all the time, I will go out of control.
Comparing	I am not as competent as my coworkers or supervisors.
Heaven's reward	If I do everything perfectly here, I will be rewarded later.
Disqualifying the positive	This success experience was only a fluke. The compliment was false.
Perfectionism	I must do this perfectly or I will be criticized and be a failure.
Time tripping	I screwed up my past and now I must be vigilant to secure my future.
Objectifying the subjective	I have this belief that I must be funny to be liked, so it is fact.
Selective abstraction	All of the good men are taken or gay.
Externalization of self-worth	My worth is dependent on what others think of me.
Fallacy of the change of others	You should change your behavior because I want you to and it will immediately make me happier/feel better.
Fallacy of worrying	If I worry about it enough, it will be resolved.
Ostrich technique	If I ignore it, maybe it will go away.
Unrealistic expectations	I must be the best absolutely all of the time.
Filtering	I must focus on the negative details while I ignore and filter out all the positive aspects of a situation.
Being right	I must prove that I am right as being wrong is unthinkable.
Fallacy of attachment	I can't live without a partner. If I was in a relationship, all of my problems would be solved.
Fallacy of perfect effect	If I do things perfectly, the results will be perfect.

TABLE 8.5 Steps in Cognitive Restructuring

1. Tune in…keep a thought diary
2. Focus on the words that are unhealthy
3. Stop the messages
4. Change the negative to positive

TABLE 8.6 Checklist of Patient Outcomes for Contingency Contract

1. Identify target behavior
2. Explore reasons for behavior
3. Verbalize knowledge of consequences of behavior
4. Identify secondary gains from behavior, i.e., attention
5. Keep diary of when problem behavior occurs
6. Keep log of sequence and pattern of behavior (who, what, when, how, and why)
7. Identify feelings that precede and follow behavior
8. Keep diary of behavior and feelings
9. Identify alternatives to behavior
10. Write conditions under which desired behavior will occur and how behavior will be observed and measured
11. Select positive reinforcers, i.e., weight loss and rewards
12. Select aversive consequences for failure of desired behavior, i.e., chores
13. Carry out plan for one week
14. Practice desired behavior, step by step
15. Keep diary of practice
16. Involve family/friends in feedback/encouragement
17. Identify other positive aspects associated with changed behavior
18. Monitor ongoing weekly progress

Reprinted from Dykes, P., & Wheeler, K. (1998). Planning implementing, and evaluating critical pathways: A guide for health care survival into the 21st century. New York, NY: Springer Publishing Company.

TABLE 8.7 Maladaptive Schemas

Maladaptive Schema	Possible Diagnosis	Schema Beliefs
Mistrust/Abuse	Paranoid Personality Disorder	It isn't safe to confide in other people. Other people have hidden motives.
Social isolation/Alienation	Schizoid Personality Disorder	I am different than everyone. I enjoy doing things by myself.
Insufficient self-control/ Self-discipline	Antisocial Personality Disorder	Rules are meant for others and only fools follow the rules. If someone is hurt or inconvenienced by me, that is their problem.
Abandonment/Instability	Borderline Personality Disorder	I will be left and no one is there for me. I need to be close to someone, but I don't trust that anyone who gets close to me really understands me or likes me.
Entitlement/Grandiosity	Narcissistic Personality Disorder	I am a very special person entitled to special treatment and privileges. People have no right to criticize me!
Social isolation	Avoidant Personality Disorder	I am socially inept and undesirable. I don't fit in. Others are potentially critical, indifferent, demeaning, and rejecting.
Dependence	Dependent Personality Disorder	I am helpless. I can't make decisions on my own.
Unrelenting standards	Obsessive–Compulsive Personality Disorder	I have to depend on myself to see that things get done. It is important to have rules, systems, and order. If I don't perform at the highest level, I have failed.

TABLE 8.8 Hierarchy for Driving Fear of Bridges

1. Thinking about going in the car if he has to go across a bridge
2. Imagining driving across the bridge (pick a specific bridge)
3. Getting into the car with the idea you are going driving
4. Drive the car for about 2 to 3 minutes with image of the bridge
5. Riding in the car to a bridge with a friend driving, do not drive over the bridge
6. Riding in the car with a friend driving and going over a small bridge
7. Driving the car with a friend and getting off the exit before the small bridge
8. Driving the car with a friend and going across the small bridge
9. Driving the car alone and going across the small bridge
10. Driving the car alone and going over a slightly larger bridge
11. Repeat with larger bridges

TABLE 8.9 CBT Therapist Website Resources for Specific Populations

Population	Specific Approaches and Website References for Additional Information
Addiction	http://www.nida.nih.gov/TXManuals/CBT/CBT1.html *Therapy Manuals for Drug Abuse: Manual 2: A Cognitive-Behavioral Approach: Treating Cocaine Addiction*. The manual includes chapters detailing history of CBT, components of CBT, applications of CBT to cocaine dependent individuals, relapse prevention, follow-up, and empirical support for the use of CBT in treating substance dependence as well as measures to evaluate competence in therapists using CBT.
Depression	http://www.psychologyinfo.com/depression/cognitive.htm Brief overview of treating depression by Psychology Information Online developed by Donald J. Franklin, PhD. Reviews the thoughts, feelings, and behaviors common to depressive diseases as well as the therapeutic interventions used in CBT to reverse the depressive cycle. Automatic thoughts are outlined as are specific ways to cope more effectively.
Child sexual abuse	http://www.nrepp.samhsa.gov/viewintervention.aspx?id=135 Substance Abuse and Mental Health Services Administration Model Programs: Trauma Focused Cognitive Behavior Therapy Model Programs http://www.nrepp.samhsa.gov/viewintervention.aspx?id=135
Anxiety and social anxiety	http://www.socialanxietyinstitute.org/ccbtherapy.html http://www.anxietynetwork.com Dr. Thomas Richards, director of the Social Anxiety Institute, has posted several excellent monographs on treating anxiety disorders with CBT on his websites. He discusses the cognitive, behavioral, and physical components common to these disorders in easy to understand terms. The reader is "walked" through the guidelines of the CBT process of treatment and referred to additional resources.
Obsessive–compulsive disorder	http://www.ocdonline.com/definecbt.php This website outlines the basic CBT treatment of obsessive–compulsive disorder. The explanation also includes a brief explanation of the integration of behavioral techniques used within the CBT framework to augment the total CBT therapeutic armament, thereby strengthening the overall treatment effect.
Eating disorders	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928448 This website discusses CBT treatment of eating disorders, specifically self-image components, incorrect beliefs about the disorder, behavioral changes that the individual will be making (such as meal diaries), developing mastery over mood and other facets of their lives, and other very important components of the eating disorder spectrum. The outline also discusses expectations of treatment, length of treatment, relapse, and follow-up.
Chronic pain	http://www.springerpub.com/prod.aspx?prod_id=45957 *Cognitive Therapy With Chronic Pain Patients* by Winterowd, Beck, & Gruener, Springer Publishing. http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/caudill.htm&dir=trade/self&cart_id=456893.3089 *Managing Pain Before It Manages You* by Margaret Caudill Both of these volumes are excellent adjuncts to the CBT clinician working with individuals with chronic pain conditions. They contain full explanations of the physiology of pain, the cognitions association with chronic pain as well as behaviors common to chronic pain sufferers. In addition they contain the techniques used in CBT to alter the thoughts, feelings, and behaviors that cripple chronic pain sufferers.
Schizophrenia	http://www.psychologyinfo.com/schizophrenia/cognitive.htm There is a misconception that CBT cannot be used with persons who are "too dysfunctional." This is incorrect. In fact, CBT is very effective with individuals who are cognitively impaired. The therapist simply uses a greater number of behavioral techniques in these cases. In cases with individuals with schizophrenia, the therapist is often working with the family members in addition to the patient. Dr. Donald Franklin has a very brief discussion on his website of this type of treatment.
General information	Wright, Basco, and Thase (2006). *Learning Cognitive-Behavior Therapy*. American Psychiatric Publishing, Inc. Washington, DC http://en.wikipedia.org/wiki/Cognitive_behavior_therapy Online encyclopedia definition and description of CBT available at: www.appi.org/pdf/wright

APPENDIX 8.1

Automatic Thought Record					
Date	**Situation**	**Emotion(s)**	**Automatic Thoughts**	**Rational Response**	**Result of Process**
	Describe: 1. Actual event leading to unpleasant emotion, or 2. Stream of thoughts, dream, or recollections, leading to unpleasant emotion	1. Specify sad; anxious; angry; etc. 2. Rate degree of emotion, 1–10	1. Write automatic thought(s) that preceded emotion(s)—ask "why did you feel…?" 2. Rate your belief in the automatic thought(s), 0–10	1. Write rational response to automatic thought(s), (this includes facts that the person agrees are true) 2. Rate belief in rational response, 0–10	1. Re-rate your belief in the automatic thought(s) 2. Specify and re-rate your subsequent emotions, 0–10

Adapted from Gilson, M., Freeman, A., Yates, J., & Freeman, S. M. (2009). *Overcoming depression: A cognitive therapy approach: Therapist guide*. Treatments that work series. New York, NY: Oxford University Press, with permission.

9

Interpersonal Psychotherapy

TABLE 9.1 Interactive Dialogue: Evidence of Abnormal Grief Task

Task	Therapist's Questions
Multiple losses	What else was going on in your life around the time of the death? Has anyone else died or left? What has reminded you of it since it happened? Has anyone died in a similar fashion or when your circumstances were similar?
Inadequate grief in the bereavement period	In the months after the death, how did you feel? Did you have trouble sleeping? Could you carry on as usual? Were you beyond tears?
Avoidance behavior about the death	Did you avoid going to the funeral? Did you avoid visiting the grave?
Symptoms around a significant date	When did the person die? What was the date? Did you start having problems around the same time?
Fear of the illness that caused the death	What did the person die of? What were the symptoms? Are you afraid of having the same illness?
History of preserving the environment as it was when the loved one died	What did you do with the possessions? What did you do with the room? Were the possessions left the same as when the person died?
Absence of family or other social supports during the bereavement period	Who could you count on when the person died? Who helped you? Who did you turn to? Who could you confide in?

Adapted from Klerman, G., Weissman, M., Rounsaville, B., & Chevron, E. (1984). *Interpersonal psychotherapy of depression* (pp. 7, 42). New York, NY: Basic Books.

11

Group Therapy

TABLE 11.1 Examples of Theoretical Approaches and Focus of Approach

Theoretical Orientation	Focus of Approach	Example of Approach
Psychodynamic	Examine interactions among and between group members and the group leader. Group work focuses on assisting each group member to increase awareness of their unconscious motivations and unconscious needs. Group membership is founded on providing a deeper understanding of both themselves and their relationships under the guidance of the group leader.	Group member Mary has been consistently late the past three sessions and then becomes very irritable with other group members when the group topic has focused on the issue of death of a parent. **Group leader:** Mary, you have been late the last three sessions and then when you have come to group, you seemed irritated with other group members. Have you noticed this? **Group member Mary:** Traffic has been bad for the past several weeks. **Group member Bob:** Mary, I know your mom died 13 months ago; this topic must be difficult for you. **Group leader:** Thanks for acknowledging that, Bob. Mary, do you think your lateness and irritability might be related to your feelings around your mom's death? **Group member Mary:** Maybe. It's still very difficult for me to deal with the fact that she is gone. **Group leader:** Mary, it might be worth talking with the group about how you are feeling right now. You have already received support from Bob; the group might be able to provide more support as you share your feelings.
Cognitive behavioral	Focus on identifying cognitive distortions and how thinking or thoughts influence feelings and emotions, and then identify the behaviors that evolved as a result of these factors.	**Group leader:** Bob, you were angry with Tom when he criticized you for taking up too much of the group time talking about your job. Can we take a moment to talk about your response? What type of automatic thoughts are you having right now? **Group member Bob:** I am thinking people believe I am stupid, or that I must be incompetent at my job. **Group leader:** Okay, so you are thinking that the group thinks you are stupid or you are not competent. What feelings do you have that are associated with those thoughts? **Group member Bob:** I feel threatened, belittled, and stupid. **Group leader:** And as a result of those feelings, what happened? **Group member Bob:** I lashed out and yelled at Tom. **Group member Larry:** Bob could have asked for clarification from Tom about what he meant or Bob could have asked the group if we thought he was stupid or incompetent because he was talking about his job so much.

(*continued*)

TABLE 11.1 Examples of Theoretical Approaches and Focus of Approach (*continued*)

Theoretical Orientation	Focus of Approach	Example of Approach
		Group leader: Larry, those are good suggestions for Bob. Bob, do you see how Larry's suggestions might assist you in getting more information about what Tom asked rather than moving right into feeling threatened by what Larry said? **Group member Bob:** Yes, that makes sense. I tend to react a lot with anger because I always think people think I am stupid or incompetent. Maybe Tom's comment to me had nothing to do with me being stupid … maybe it just had to do with Tom wanting to talk about something, or maybe I was just taking up too much time.
Person centered	Focus of healing comes from group members; group therapist provides unconditional positive regard for the group member; group leader creates a trusting environment and honest feedback is provided to and among group members; group leader shows empathy and authenticity toward group members.	**Group member June:** I am having a very difficult time dealing with the fact that my divorce is final next week, my 16-year-old daughter has been sick with mono, and my scheduled vacation has been canceled because of increased work demands. **Group leader:** June, I can understand why you are having such a difficult time. **Group member June:** Thanks … it has been very tiring. I feel all alone. **Group leader:** Thanks for sharing your feelings … let's ask the group to share about June's experience of feeling all alone. **Group member John:** June, I am sure you are feeling all alone, but we are here to support you … we cannot take away the stress you are under right now, but we can listen and provide support to you. **Group leader:** John, thanks for acknowledging that the group is a source of support for June. It's important to remember the support that group members do get from one another.

TABLE 11.2 Evidence-Based Research for Group Psychotherapy

Study	Population	Type of Group	Outcome
Kösters, Burlingame, Nachtigall, and Strauss (2006)	Patients with mood disorders	Various types of groups	Improved depressive symptoms
Brietbart et al. (2010)	Patients with advanced stage, terminal cancer	Meaning-centered group therapy	Patient improvement noted in spiritual well-being, decreased anxiety, depression, and hopelessness, positive association with decrease in psychiatric symptoms 2 months post-treatment
Mulcahy, Reay, Ross, Wilkinson, and Owen (2010)	Women with postnatal depression	Interpersonal group therapy	Women randomly assigned to group treatment showed marked improvement in depression; group participation evidenced positive association with marital relationships and mother–infant bonding; noted longer-term effects 3 months after group participation
Scherbauma et al. (2005)	Patients with opiate abuse/dependence	Cognitive behavioral group therapy	Group therapy effective in reducing drug use when compared to methadone maintenance
Himelhoch, Medoff, and Oyeniy (2007)	HIV-positive men with depression	Various types of group therapy approaches; CBT approach suggested the strongest evidence of change	Reduction in depression ratings
Weiss et al. (2004)	Patients with substance abuse issues	Various types of group therapy approaches	Lessened substance misuse.

TABLE 11.3 Phases of Group Formation/Development

Group Phase/Stage	Characteristic of Phase/Stage
Orientation or forming	Group members are adapting to being in the group; members will seek out guidance and approval from the group leader about appropriate boundaries, limits, and behaviors; limited personal disclosure done by group members; some group members may experience anxiety and apprehension.
Storming	Group members are attempting to find their place within the group; group members may experience conflict among themselves; group members exchange ideas, which can cause group members to experience conflict; group members begin to notice differences among themselves; this stage/phase is necessary in order for the group to mature and grow.
Norming	Group members become more aligned as a whole, and identify and work to a common goal. This stage/phase allows members to experience a great sense of trust among themselves.
Performing	Group members are more autonomous and independent; group members feel ownership of group experience. Deeper sense of work is accomplished. Group members are able to be more honest with one another, and a deeper sense of sharing occurs among members.
Adjourning	Members have appreciation for other group members. It is during this phase/stage that the termination is addressed and occurs. Group members may experience more difficult emotional responses and emotions to the group ending.

Adapted from Tuckerman, B. (1965). Development sequence in small groups. *Psychological Bulletin, 63*(6), 384–399.

12

Family Therapy

TABLE 12.1 Four Major Family Therapy Approaches

Family Therapy Founder(s)	Key Concepts	Key Interventions
Systemic family therapy— Murray Bowen	Family as an emotional unit Differentiation of self Triangles Multigenerational transmission Nuclear family emotional processes Family projection process Emotional cutoff	Genogram Self-statements Transform generational patterns Anxiety and conflict interruption Detriangulation Cutoff repair Nuclear family process disruption
Structural family therapy— Salvadore Minuchin	Family structure Subsystems Boundaries Enmeshment Disengagement Coalitions Parentification	Joining and accommodating Enactments Family mapping Modifying problem interactions – Boundary making – Unbalancing – Reframing
Strategic family therapy— Jay Haley and Milton Erickson	Cybernetics Homeostasis Feedback loops Circular causality First-order change Second-order change	Directives Paradoxical interventions Pretend techniques Ordeals Rituals Invariant prescription
Emotionally focused family therapy— Les Greenberg and Sue Johnson	Emotions Primary and secondary emotions Attachment styles Attachment injuries	Empathic attunement Reflective statements Evocative questions Creative images and metaphor Encouraging acceptance Creating intimate attachments

13

Stabilization for Trauma and Dissociation

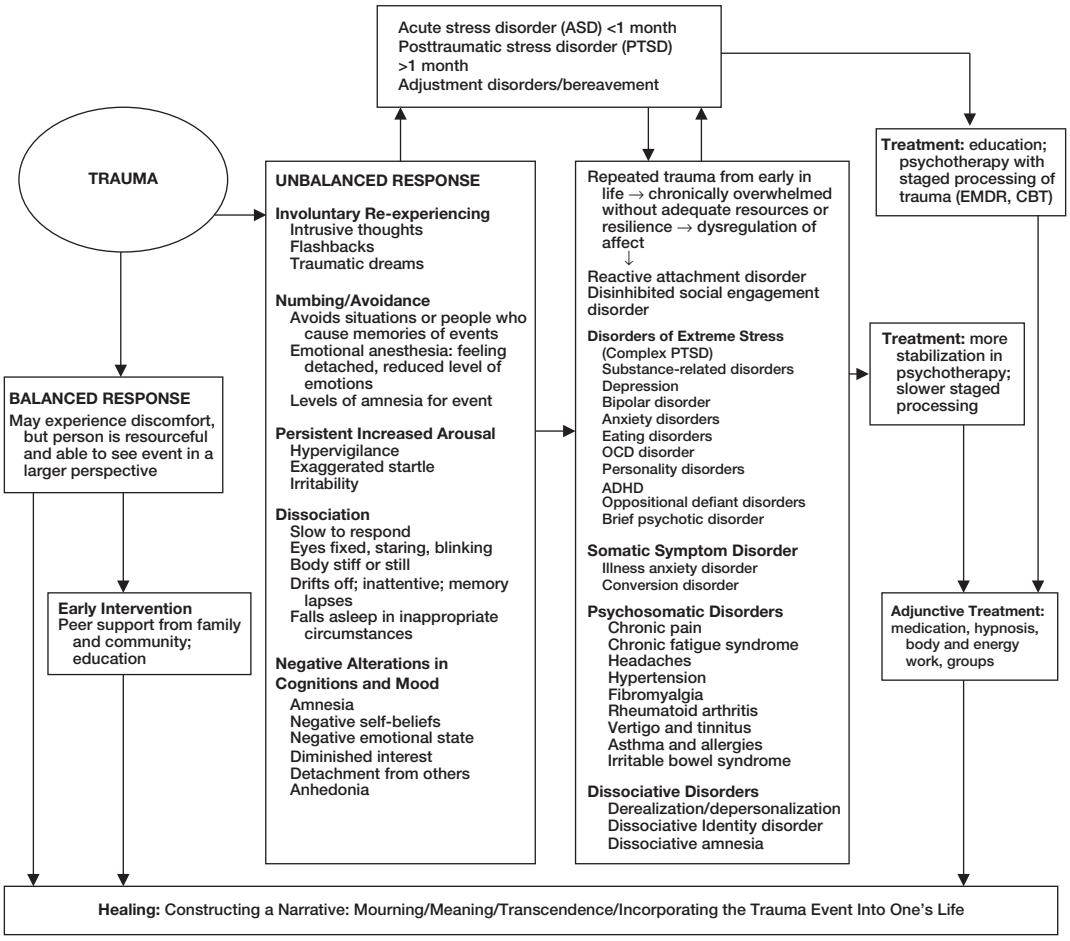

FIGURE 13.1 The spectrum of traumatic response.
Adapted from Davis, K., & Weiss, L. (2004). *Traumatology: A workshop on traumatic stress disorders.* Hamden, CT: EMDR Humanitarian Assistance Programs.

TABLE 13.1 Diseases and Disorders of Trauma

Diseases and Disorders	Examples of Abnormal Function
Diseases of abnormal autonomic regulation	Fibromyalgia, irritable bowel syndrome, chronic fatigue syndrome, gastroesophageal reflux disease, mitral valve prolapse or dysautonomia syndrome, multiple chemical sensitivities, migraine headache
Syndromes of procedural memory	Whiplash syndrome, cumulative trauma disorder, tics, phantom limb pain, chronic pain, premenstrual dysphoric syndrome, postpartum depression or psychosis
Diseases of somatic dissociation	Reflex sympathetic dystrophy, interstitial cystitis, chronic pelvic pain
Disorders of endocrine and immune system regulation	Hyperthyroidism, diabetes, rheumatoid arthritis, systemic lupus erythematosus, Sjögren's syndrome, Graves' disease, Hashimoto's thyroiditis, multiple sclerosis
Disorders of cognition and sleep	ADD, sleep-disordered breathing, sleep apnea, narcolepsy, cataplexy, hypnagogic hallucination, sleep paralysis

Adapted from Scaer, R. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York, NY: W. W Norton & Co.

TABLE 13.2 Assessment/Outcome Instruments for Dissociation

Instrument	Purpose and How to Obtain
Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986) DES-Revised (Dalenberg & Carlson, 2010)	28 items; most often used self-report screening tool for dissociation. Included in Chapter 3 Uses a Likert scale instead of percentages
Multidimensional Inventory of Dissociation (Dell, 2006)	Self-report with validity scales; available on the ISSTD's website (http:// www.isst-d.org/)
Multiscale Dissociation Inventory (Briere, 2002)	Available without cost from John Briere (http://www.johnbriere.com)
Somatoform Dissociation Questionnaire (SDQ-20 and SDQ-5) (Nijenhuis, 2011)	Two forms, 20 items on a 5-point Likert scale pertaining to both negative (analgesia) and positive dissociative phenomenon (pain)
Dissociative Disorders Interview Schedule (DDIS) (Ross, 2013)	16 sections on this thorough diagnostic tool with no total score for the entire interview; available for free from http://www.rossinst.com/sample_forms .html
The Structured Clinical Interview for *DSM-IV* Dissociative Disorders – Revised (SCID-D) (Steinberg, 1994)	Most widely used structured interview for dissociative disorders; evaluates the existence and severity of dissociative symptoms Interviewer's Guide to the *SCID-D*. Washington, DC, American Psychiatric Press

TABLE 13.3 Assessment/Outcome Instruments for Trauma

Instrument	Purpose and How to Obtain
IES-R (Weiss & Marmar, 1997)	Most widely used self-report screening tool for single incident trauma; 22 items; included in Chapter 3
Modified PTSD Symptom Scale: Self-Report Version (MPSS-SR) (Falsetti, Resnick, Resick, & Kilpatrick, 1993)	Self-report 17-item symptom checklist of PTSD symptoms; especially useful for clients with multiple traumas or where trauma history is unknown; does not key to a specific trauma Sherry Falsetti, PhD, Medical University of South Carolina, Crime Victims Research and Treatment Center, Medical University of North Carolina, 171 Ashley Ave. Charleston, SC 29425-0742
Trauma and Attachment Belief Scale (TABS) (Pearlman, 2003)	Self-report scale that evaluates the needs and expectation of trauma survivors in relation to others; taps into underlying assumptions regarding relationships Western Psychological Services, 12031 Wilshire Blvd., Los Angeles, CA 90025-1251; telephone: 310-478-2061; fax: 310-478-7838; web: www.wpspublish.com
Primary Care PTSD Screen (PC-PTSD) (Kimerling et al., 2006)	4-item screening tool for primary care and medical settings; http://www.mirecc.va.gov/docs/visn6/2_Primary_Care_PTSD_Screen.pdf
Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) (Connor & Davidson, 2001)	Eight items on a 5-point Likert scale measuring symptom severity and improvement since treatment. See Appendix 13.1 for tool
The structured interview for disorders of extreme stress (SIDES) (Pelcovitz et al., 1997)	Clinician-administered 45-item tool that measures the symptom clusters of DESNOS bvanderk@traumacenter.org HRI Trauma Center Research Dept. c/o Dr. J. Hopper 227 Babcock Str. Brookline, MA 02116
The Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1995)	The most widely used clinician-administered structured interview for PTSD; assesses frequency and intensity of symptoms as well as effect on social and occupational functioning http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp Assessment Requests National Center for PTSD (116D) VA Medical Center 215 N. Main St. White River Junction, VT 05009

APPENDIX 13.1

SPRINT 05-30-13

ID number or initials ☐☐☐☐☐☐☐☐☐☐

Date: _____

Short PTSD Rating Interview **(SPRINT)**

Please identify the most distressing traumatic event:

_____

	In the past week …	Not at all 0	A little bit 1	Moderately 2	Quite a lot 3	Very much 4
1	How much have you been bothered by unwanted memories, nightmares, or reminders of the event?					
2	How much effort have you made to avoid thinking or talking about the event, or doing things which remind you of what happened?					
3	To what extent have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?					
4	How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?					
5	How much have you been bothered by pain, aches, or tiredness?					
6	How much would you get upset when stressful events or setbacks happen to you?					
7	How much have the above symptoms interfered with your ability to work or carry out daily activities?					
8	How much have the above symptoms interfered with your relationships with family or friends?					

Sum of 1 to 8 ☐☐

9	How much better do you feel since beginning treatment? (As a percentage) (%)					

0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐

10	How much have the above symptoms improved since starting treatment?				
	Worse 1	No change 2	Minimally 3	Much 4	Very much 5

APPENDIX 13.2

Progressive Muscle Relaxation

This exercise can be practiced with the client during the session and it is often helpful if the APPN audiotapes a copy for the client to listen to at home. If done properly, it may take 20 to 30 minutes. Begin with explaining that this is a relaxation exercise that will help to decrease physical tension and enhance the ability to identify where tension is stored in the body.

What you'll be doing is alternately tensing and relaxing specific groups of muscles. After tension, a muscle will be more relaxed than prior to the tensing. Concentrate on the feel of the muscles, specifically the contrast between tension and relaxation. In time, you will recognize tension in any specific muscle and be able to reduce that tension.

Don't tense muscles other than the specific group at each step. Breathe slowly and evenly and think only about the tension–relaxation contrast. Each tensing is for 10 seconds; each relaxing is for 10 or 15 seconds. Count "1,000 2,000 ..." until you have a feel for the time span. Note that each step is really two steps—one cycle of tension–relaxation for each set of opposing muscles.

Please get in a comfortable as possible position and take a deep breath; let it out slowly. Again a nice slow deep breath … take as deep a breath as possible—and then take a little more; let it out and breathe normally for 15 seconds. Let all the breath in your lungs out—and then a little more; inhale and breathe normally for 15 seconds.

Begin with your muscles in your feet and your calves; tighten and pull your toes up while tensing each foot as tight as you can … hold that and just notice as you tense for 10 seconds … then relax your feet and next tense your calves … squeeze your calves as tight as you can … for 10 seconds 1...2...3...4...5...6...7...8...9...10... just notice and relax …

Next tense your thigh muscles 1...2...3...4...5...6...7...8...9...10... hold … just notice then relax …

Next tense the butt tightly and raise pelvis slightly off chair; relax. Dig buttocks into chair 1...2...3...4...5...6...7...8...9...10... just notice then relax…

Pull in the stomach as far as possible … push out the stomach or tense it as if you were preparing for a punch in the gut ... 1...2...3...4...5...6...7...8...9...10… just notice then relax.

Now tense your chest as tight as you can … 1...2...3...4...5...6...7...8...9...10 good, just tense then relax…

Continue to breathe deeply as you pull your shoulders back ... 1...2...3...4...5...6...7...8...9...10... relax. Push the shoulders forward (hunch) 1...2...3...4...5...6...7...8...9...10 just notice and relax…

Now flex your biceps 1...2...3...4...5...6...7...8...9...10 relax, take a deep breath … now tense your whole arm 1...2...3...4...5...6...7...8...9...10... and just notice as you relax … next flex squeeze your hands and fingers tight 1...2...3...4...5...6...7...8...9...10 and as you relax, take a deep breath.

With the shoulders straight and relaxed, the head is turned slowly to the right, as far as you can; relax. Turn to the left; relax.

Dig your chin into your chest ...1...2...3...4...5...6...7...8...9...10... relax ... exhale nice deep breath…

Now your face, scrunch your face up as tight as you can 1...2...3...4...5...6...7...8...9...10... and as you relax take a deep breath letting all the air out.

Dig your tongue into the roof of your mouth ... 1...2...3...4...5...6...7...8...9...10 and relax. Dig it into the bottom of your mouth 1...2...3...4...5...6...7...8...9...10 and relax.

Open your eyes as wide as possible (furrow your brow) 1...2...3...4...5...6...7...8...9...10 and relax. Close your eyes tightly (squint) 1...2...3...4...5...6...7...8...9...10 relax.

Now just continue to breathe deeply and blow all the air out for a while.

These exercises will not eliminate tension, but when it arises, you will know it immediately, and you will be able to "tense–relax" it away or even simply wish it away.

Please note that an exercise program of any sort that stresses and stretches a full range of muscles can be used in this fashion if only you pay attention to the differences between tensions and relaxations of the muscles. Do the entire sequence once a day if you can, until you feel you are able to control your muscle tensions. This can also be combined with soothing music.

14

Dialectical Behavior Therapy for Complex Trauma

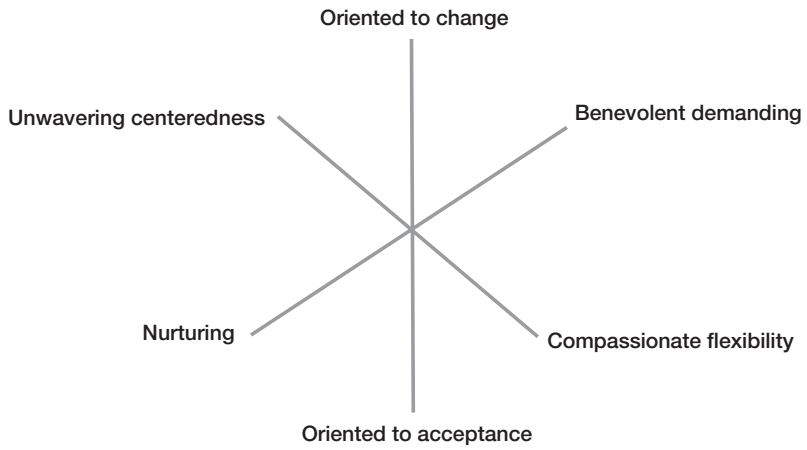

FIGURE 14.1 Characteristics of the DBT therapist.
Adapted from Linehan, M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.

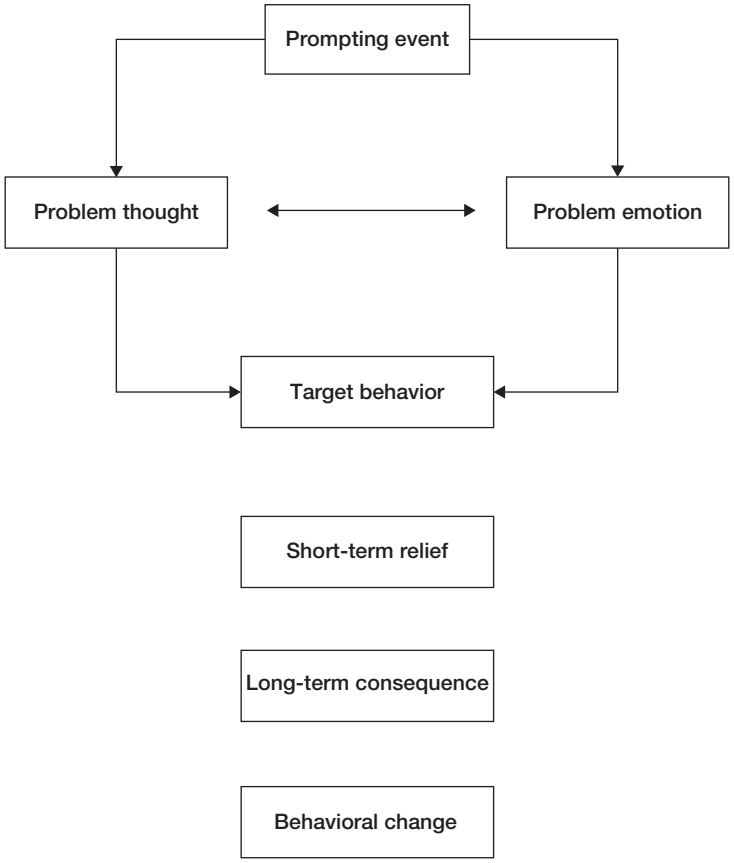

FIGURE 14.2 Behavioral chain analysis worksheet.

TABLE 14.1 Skills Modules in DBT

Module	Common Exercises
Core mindfulness	Mindful abdominal breathing Focusing/observing Describing Wise mind Judgment diffusion
Distress tolerance	Radical acceptance Distract Relaxation Self-soothing
Emotional regulation	Recognizing emotions Reducing vulnerabilities Opposite action to emotion Problem solving
Interpersonal effectiveness	Knowing what you want Making a request Passive vs. aggressive behavior Assertive listening Negotiating
Self-management	Realistic goal setting Behavior analysis Contingency management Environmental control

Adapted from McKay, M., Wood, J., & Brantley, J. (2007). *The dialectical behavior therapy skills workbook: Practical DBT exercises for learning mindfulness, interpersonal effectiveness, emotion regulation & distress tolerance*. Oakland, CA: New Harbinger Publications.

Portland DBT Program: Standard Diary Card										
Name:						Date Range:				How often did you fill out? __ Daily __ 2–3x __ Once
Day/ Date	Sad (0–5)	Guilt (0–5)	Anger (0–5)	Fear (0–5)	Happy (0–5)	SH U/A	SI U/A	Additional Target	Skills (0–5)	Notes
RATING SCALE FOR EMOTIONS AND URGES: 0 = none 1 = minimal 2 = mild 3 = moderate 4 = strong 5 = intense										
USED SKILLS 0 = Didn't think about using 1 = Thought about using, but didn't want to use 2 = Thought about using, wanted to use, but didn't 3 = Used them but didn't help 4 = Used them, helped 5 = Didn't need them, but practiced										Urge to quit Individual (0–5)__ Urge to quit Group (0–5)__ Urge to quit Meds (0–5)__ revised 5.11.2009

FRONT

	Instructions: Circle the days you worked on each skill.			How often did you use phone consult? __ daily __ 2–3x __ once __ none				
Core Mindfulness	1. Wise mind: balance mind states	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	2. Observe: just notice	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	3. Describe: put words on	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	4. Participate: enter into the experience	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	5. Nonjudgmental stance	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	6. One-mindfully: in the moment	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	7. Effectiveness: focus on what works	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Distress Tol.	8. Distract ACCEPTS	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	9. Self-soothe with the senses	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	10. IMPROVE the moment	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	11. Pros and Cons	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	12. Accepting reality (e.g. half-smile; breathing)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Emotion Reg.	13. Reduce vulnerability. PLEASE	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	14. Challenge interpretation	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	15. Build mastery	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	16. Build postive experiences	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	17. Opposite-to-emotion setion	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Int Em.	18. Objective effectiveness: DEAR MAN	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	19. Relationship effectiveness: GIVE	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	20. Self-respect effectiveness: FAST	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Prob Sol.	21. Check VITALS: motivate behavior	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	22. Remove/add antecedent/consequence	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	23. Exposure strategy	Mon	Tues	Wed	Thur	Fri	Sat	Sun

BACK

FIGURE 14.3 Sample diary card for standard DBT treatment.

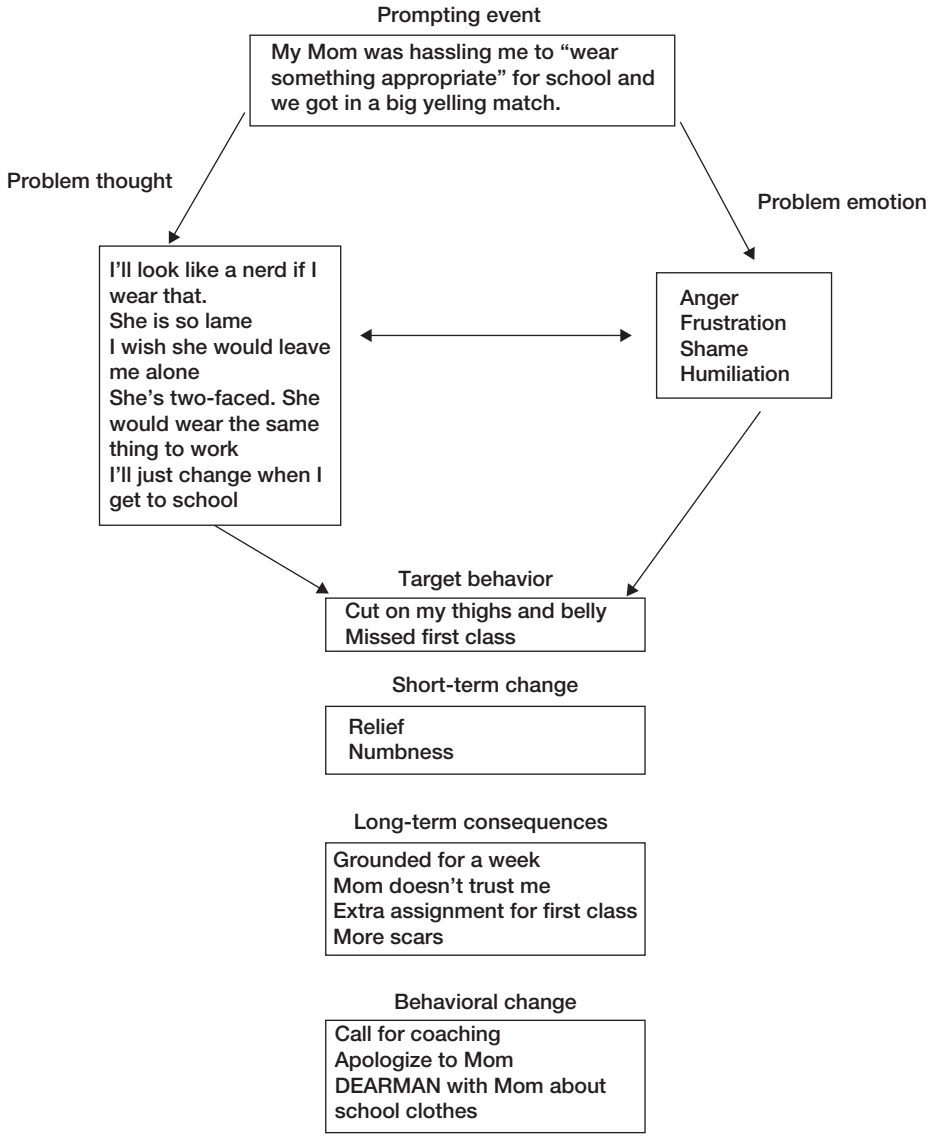

FIGURE 14.4 Sample behavioral chain analysis for teen conflict with mother.

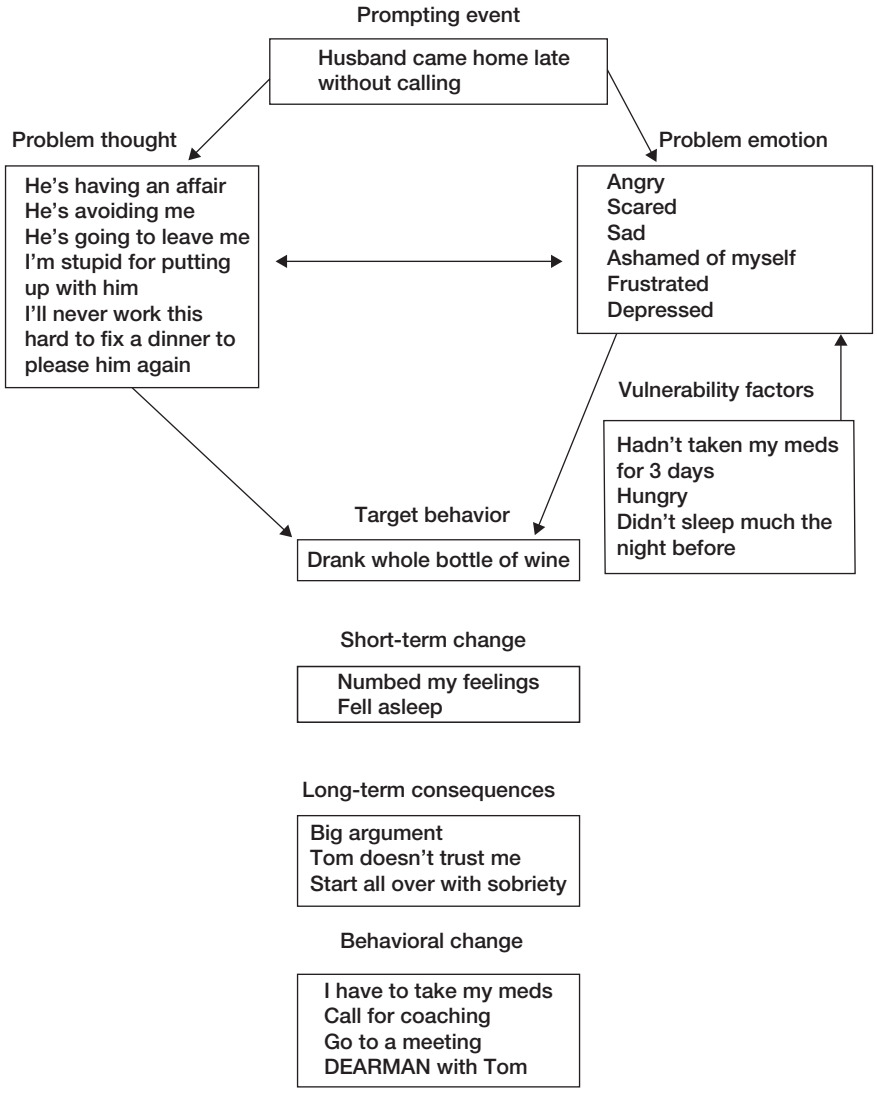

FIGURE 14.5 Sample behavioral chain analysis for medication adherence.

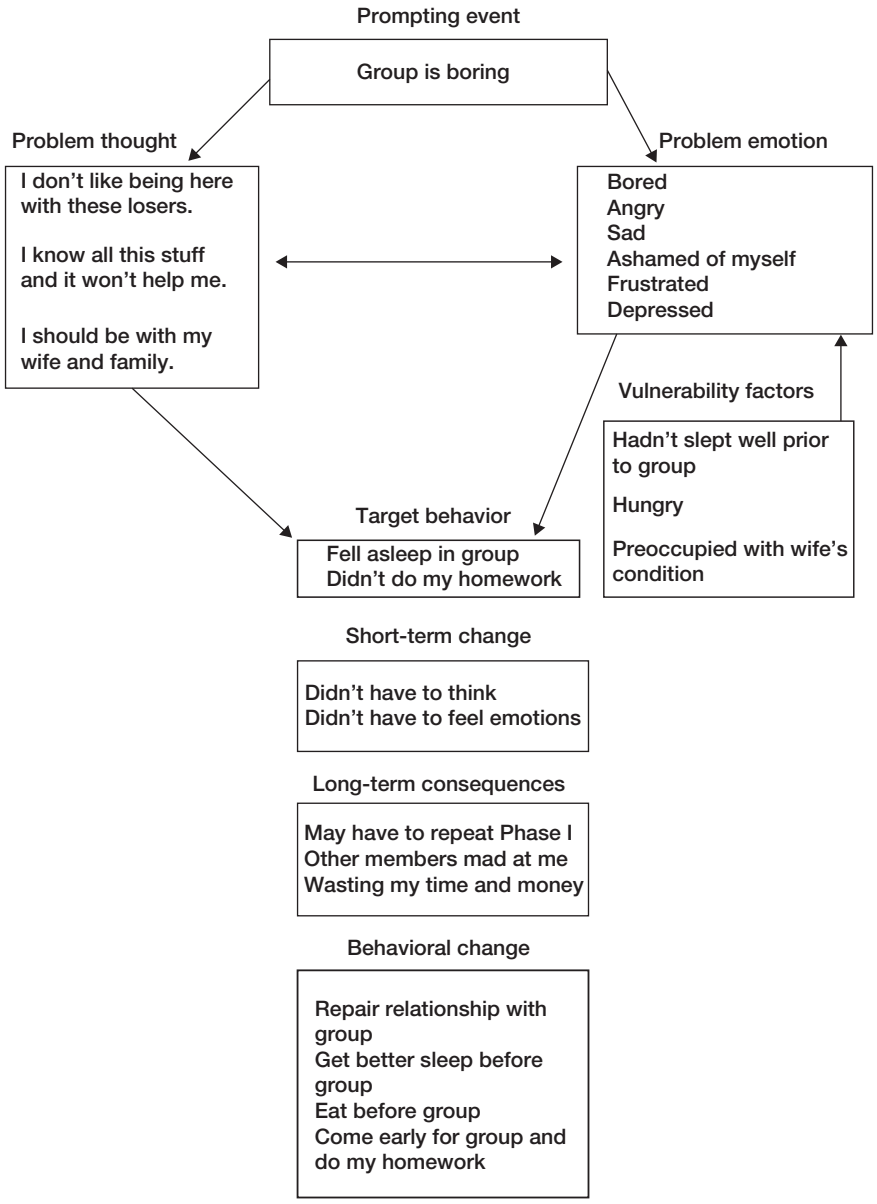

FIGURE 14.6 Behavioral chain analysis for Mr. M.

Portland DBT Program: Standard Diary Card										
Name: SM						Date Range: 1/4 - 1/10				How often did you fill out? __ Daily X 2–3x __ Once
Day/ Date	Sad (0–5)	Guilt (0–5)	Anger (0–5)	Fear (0–5)	Happy (0–5)	SH U/A	SI U/A	Additional Target	Skills (0–5)	Notes
1/4	5	5	3	0	0	0/0	0/0		3+	
1/5	5	5	4	1	0	0/0	0/0		3+	
1/6	5	5	2	0	0	0/0	0/0		4	
1/10	4	4	3	0	0	0/0	0/0		4	
RATING SCALE FOR EMOTIONS AND URGES: 0 = none 1 = minimal 2 = mild 3 = moderate 4 = strong 5 = intense										
USED SKILLS 0 = Didn't think about using 1 = Thought about using, but didn't want to use 2 = Thought about using, wanted to use, but didn't 3 = Used them but didn't help 4 = Used them, helped 5 = Didn't need them, but practiced										Urge to quit Individual (0–5) __ Urge to quit Group (0–5) 0 Urge to quit Meds (0–5) 0 revised 5.11.2009

FRONT

	Instructions: Circle the days you worked on each skill.			How often did you use phone consult? __ daily __ 2–3x __ once X none				
Core Mindfulness	1. Wise mind: balance mind states	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	2. Observe: just notice	(Mon)	(Tues)	(Wed)	(Thur)	(Fri)	(Sat)	(Sun)
	3. Describe: put words on	(Mon)	(Tues)	(Wed)	(Thur)	(Fri)	(Sat)	(Sun)
	4. Participate: enter into the experience	Mon	Tues	(Wed)	(Thur)	Fri	Sat	(Sun)
	5. Nonjudgmental stance	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	6. One-mindfully: in the moment	(Mon)	(Tues)	Wed	Thur	Fri	Sat	Sun
	7. Effectiveness: focus on what works	Mon	Tues	Wed	Thur	(Fri)	(Sat)	(Sun)
Distress Tol.	8. Distract ACCEPTS	Mon	Tues	(Wed)	(Thur)	Fri	Sat	Sun
	9. Self-soothe with the senses	Mon	Tues	(Wed)	(Thur)	Fri	Sat	Sun
	10. IMPROVE the moment	Mon	Tues	(Wed)	(Thur)	Fri	Sat	Sun
	11. Pros and Cons	Mon	Tues	Wed	Thur	(Fri)	(Sat)	Sun
	12. Accepting reality (e.g. half-smile; breathing)	(Mon)	(Tues)	(Wed)	Thur	Fri	Sat	Sun
Emotion Reg.	13. Reduce vulnerability. PLEASE	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	14. Challenge interpretation	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	15. Build mastery	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	16. Build postive experiences	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	17. Opposite-to-emotion setion	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Int Em.	18. Objective effectiveness: DEAR MAN	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	19. Relationship effectiveness: GIVE	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	20. Self-respect effectiveness: FAST	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Prob Sol.	21. Check VITALS: motivate behavior	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	22. Remove/add antecedent/consequence	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	23. Exposure strategy	Mon	Tues	Wed	Thur	Fri	Sat	Sun

BACK

FIGURE 14.7 Mr. M's early diary card.

15

Psychopharmacotherapy and Psychotherapy

APPENDIX 15.1

Collaborative Agreement

The following mutually agreed on collaborative agreement shall form the basis of a prescribing relationship between _____ APRN and _____ MD, wherein the APRN may prescribe and administer medical therapeutics and corrective measures, and may dispense drugs in the form of professional samples.

1. The categories of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures, which may be prescribed, dispensed, or administered by the advanced practice registered nurse (APRN) are as follows:
   (a) Medications, which may include but are not limited to antidepressants, antipsychotics, anxiolytics/hypnotics, mood stabilizers, antihistamines, and antiparkinsonian drugs.
   (b) Laboratory tests, medical therapeutics, diagnostic procedures, and treatment that are commonly performed in the assessment and treatment of psychiatric disorders.
2. Periodically, the APRN will randomly select cases for review with the collaborating physician. The purpose will be to review patient outcomes including a review of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures that may be prescribed, dispensed, and administered by the APRN.
3. Schedule II and III drugs may be prescribed by the APRN. Patients receiving these medications will be reviewed in the same manner as in Section 2.
4. A registered nurse may take orders for medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures from an APRN under the supervision of a collaborating physician.

_____ APRN Date: _____

_____ MD Date: _____

APPENDIX 15.2

Collaborative Agreement (Optional Language Added)

Advanced practice registered nurse (APRN) collaborative agreement for the outpatient setting.

This form is proposed as a guideline for advanced practice registered nurses in developing a collaborative agreement for their prescribing practices. It is not an authorized standard of practice, nor is it a legal document. The Connecticut Society of Nurse Psychotherapists bears no responsibility for its use.

The following mutually agreed on collaborative agreement shall form the basis of a prescribing relationship between _____ APRN and _____ MD, wherein the APRN may prescribe and administer medical therapeutics and corrective measures, and may dispense drugs in the form of professional samples.

1. The categories of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures, which may be prescribed, dispensed, or administered by the APRN are as follows:
   a. Medications, which may include but are not limited to antidepressants, antipsychotics, anxiolytics/hypnotics, mood stabilizers, antihistamines, and antiparkinsonian drugs.
   b. Laboratory tests, medical therapeutics, diagnostic procedures, and treatment that are commonly performed in the assessment and treatment of psychiatric disorders.
2. Periodically, the APRN will randomly select cases for review with the collaborating physician. The purpose will be to review patient outcomes, including a review of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures that may be prescribed, dispensed, and administered by the APRN.
3. Schedule II and III drugs may be prescribed by the APRN. Patients receiving these medications will be reviewed in the same manner as in Section 2.
4. A registered nurse may take orders for medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures from an APRN under the supervision of a collaborating physician.
5. Consultation and referral shall be on a case-by-case basis as deemed appropriate by the APRN.
6. Coverage for patients during nonoffice hours and vacations will be arranged by the APRN.
7. There will be a method of disclosure to the patient of the MD–APRN collaboration.

_____ APRN Date: _____

_____ MD Date: _____

Connecticut Society of Nurse Psychotherapists (2000).

APPENDIX 15.3

Pharmacotherapy Consultation and Collaboration Request Form

Psychotherapist's request:

Date of consultation request: _____

Patient's name: _____

Date of birth: _____

Patient's phone number:_____

Psychotherapist/requester name: _____

Psychotherapist address: _____

Psychotherapist's phone number: _____

Symptoms of concern leading to consultation request:

Pertinent history:

Desired outcome of consultation:

- Assessment for appropriateness of pharmacotherapy?
- Second opinion on current pharmacotherapy? If so, how has current pharmacotherapist been involved in planning this consultation?
- Request for collaborative follow-up treatment?

Psychotherapist's signature and date:

Consultant's response:

Brief history of present illness (can include data such as target symptoms, pertinent negatives, current treatments):

Pertinent past psychiatric history (can include such data as past psychiatric hospitalizations, medication history, substance abuse history, past suicidal or violent behavior):

Medical history (can include such data as current medications, known illnesses, past operations, use of caffeine/tobacco/alcohol, diet, activity, allergies, PCP, and recent examinations or labs):

Family history of mental illness:

Current mental status examination (can include comments on appearance, alertness, language, affect, mood, thought process, and content, any specialized examinations or rating scale scores, assessment of dangerousness or of risk for suicidal behaviors):

Consultant's diagnostic assessment:

Consultant's recommendations regarding treatment:

Discussion of follow-up and medication instructions with the patient (can include data such as which side effects were discussed, whether consent was obtained for discussion with psychotherapist/PCP/others, any limitations on communications requested by the patient, and follow-up plans):

Signature of consultant: _____ Date: _____

Printed name of consultant: _____

Consultant's phone number: _____

From Ellison, J. (2005). Teaching collaboration between pharmacotherapist and psychotherapist. *Academic Psychiatry, 29*(2), 195–202.

16

Psychotherapeutic Approaches for Addictions and Related Disorders

TABLE 16.1 Worldwide Prevalence, Health Risks, and Economic Burden of Addictions

Use[1]		
■ Alcohol users		2 billion
■ Smokers		1.3 billion
■ Drug users		185 million
Alcohol Health-Related Risks and Disability[1]		
■ Eight leading risk for death		
■ Third leading risk for DALYs		
Alcohol Use Risk to Men vs. Risk to Women[1]		
■ 6% of deaths for men	vs.	1.1% of deaths for women
■ 7.4% of DALYs for men	vs.	1.4% of DALYs for women
Economic Burden[2]		
■ Health care costs		1.3% to 3.3%
■ Public order/safety costs		6.4% to 14.4%
■ GDP workplace costs		2.7% to 10.9%
■ Total global cost estimates		$210 to 665 billion

DALYs, disability-adjusted life years.

[1]World Health Organization (WHO). (2009). Global health risks: Mortality and burden of disease attributable to selected major risks. Retrieved from http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

[2]Institute of Alcohol Studies, UK Baumberg, B. (2006). The global economic burden of alcohol: A review and some suggestions. *Drug and Alcohol Review, 25*, 537–551.

TABLE 16.2 U.S. Prevalence, Health Risks, and Economic Burden of Addictions

Use (Age 12 Years and Older)[1]		
■ Current illicit substance use	8.7%	22.5 million
■ Current alcohol use	51.8%	133.4 million
■ Binge drinking*	22.6%	58.3 million
■ Heavy drinking**	6.2%	15.9 million
Lifetime Prevalence[2]		
■ Alcohol abuse	13.2%	
■ Alcohol dependence	5.6%	
■ Substance use disorder of any kind	14.6%	
Medical Comorbidity Risks[3]		
■ Drug abuse/dependence	1.5 to 2.6 times risk for	Coronary heart disease (CHD)
■ Drug abuse/dependence	1.3 to 1.7 times risk for	Hypertension (HTN)
■ Drug abuse/dependence	1.4 to 1.7 times risk for	Arteriosclerosis
■ Drug abuse/dependence	2.0 to 2.7 times risk for	Liver disease
■ Drug abuse/dependence	1.3 to 2.0 times risk for	Arthritis
■ Alcohol dependence	1.5 times risk for	CHD
■ Alcohol dependence	1.8 times risk for	Liver disease
Estimated Economic Cost[4,5]		
■ Illegal drugs	$181 billion/year	
■ Alcohol	$185 billion/year	
■ Tobacco	$193 billion/year	
■ Total	$559 billion/year	

*Binge drinking is defined as having five or more drinks on one occasion at least one time during the past month.
**Heavy drinking is defined as having five or more drinks a day with binge drinking during the past month.
[1]SAMHSA. (2012). Results from the 2011 National Survey on Drug Use and Health: Summary of national findings. Retrieved from http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf
[2]Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593–602. doi: 10.1001/archpsyc.62.6.593
[3]Chou, S. P., Huang, B. Goldstein, R., & Grant, B. F. (2013). Temporal associations between physical illnesses and mental disorders—Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Comprehensive psychiatry*. Retrieved from http://dx.doi.org.proxy.library.vanderbilt.edu/10.1016/j.comppsych.2012.12.020.
[4]U.S. Surgeon General. (2004). News release by U.S. Surgeon General Carmona: Face facts about drinking. Retrieved from http://alcoholism.about.com/cs/support/a/blnih040407.htm
[5]ONDCP (2004).

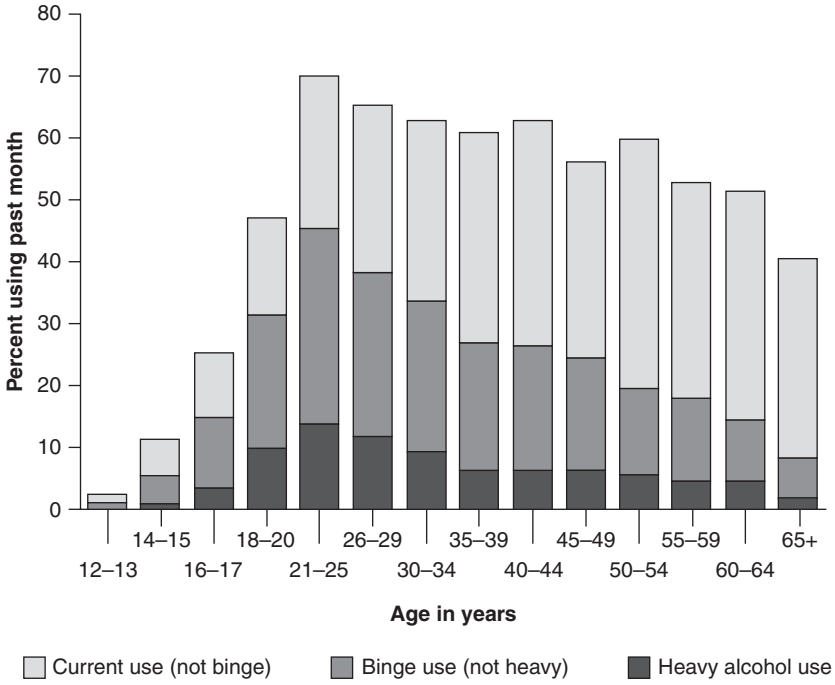

FIGURE 16.1 Current, binge, and heavy alcohol use among persons (age 12 years and older) by age group.
Adapted from Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Summary of national findings. Retrieved from http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf

TABLE 16.3 Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

Recovery is culturally based and influenced: Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are key to determining a person's journey and unique pathway to recovery.

Recovery is supported by addressing trauma: Services and supports should be trauma informed to foster safety (physical and emotional) and trust as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery.

For further detailed information about the new working recovery definition or the guiding principles of recovery, please visit www.samhsa.gov/recovery

TABLE 16.4 Principles of Effective Treatment for Addictions

1. Addiction is a complex but treatable disease that affects brain function and behavior
2. No single treatment is appropriate for everyone
3. Treatment needs to be readily available
4. Effective treatment attends to the multiple needs of the individual, not just his or her drug abuse (or behavior)
5. Remaining in treatment for an adequate period of time is critical
6. Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse (and behavioral addiction) treatment
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies
8. An individual's treatment and services must be assessed continually and modified as necessary to ensure that it meets his or her changing needs
9. Many drug-addicted individuals also have other mental disorders
10. Medically assisted detoxification is only the first stage of (drug) addiction treatment and by itself does little to change long-term drug abuse
11. Treatment does not need to be voluntary to be effective
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur
13. Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary

Source: NIDA. (2012). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). Bethesda, MD: National Institute of Health Publication 12–4180: U.S. Department of Health and Human Services. Retrieved from http://www.drugabuse.gov/sites/default/files/podat_1.pdf

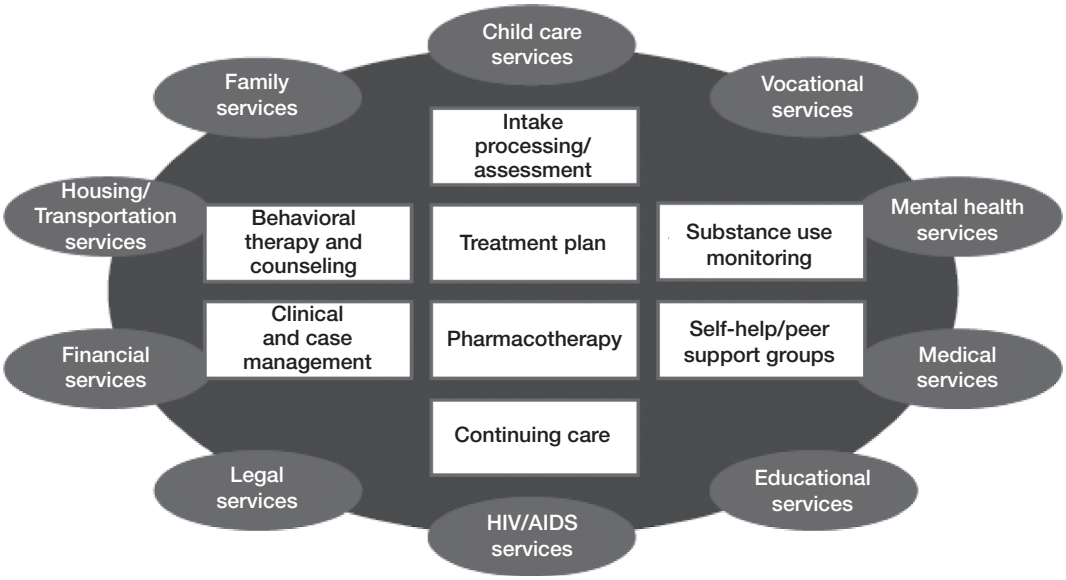

FIGURE 16.2 Components of comprehensive drug abuse treatment.
Adapted from NIDA. (2012). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). Bethesda, MD: National Institute of Health Publication 12–4180: U.S. Department of Health and Human Services. Retrieved from http://www.drugabuse.gov/sites/default/files/podat_1.pdf

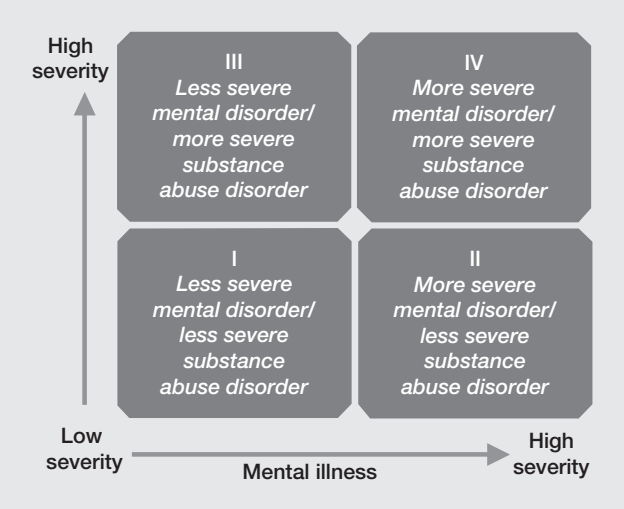

FIGURE 16.3 Co-occurring disorders by severity.
Adapted from NASMHPD and NASADAD (1998).

TABLE 16.5 Screening Tools for Alcohol and Drug Use

Screening Measure	Target Population	Groups Used With	Number of Items	Problem Screened	Cut-Off Score for Harmful Use	Time to Administer
CAGE*	Adults	Emergency rooms (ERs), hospitals, primary care providers	4	Alcohol dependence	1 (range 0–4)	Less than 1 minute
CAGE-AID*	Adults	ERs, hospitals, primary care providers	4	Alcohol and drug dependence	1 (range 0–4)	Less than 1 minute
Alcohol use disorders Identification test (AUDIT)	Adults	Primary care providers, ERs, driving while intoxicated (DWI) offenders Workplace screening	10 (three subscales)	Harmful or hazardous alcohol use	8 (range 0–40)	3 to 5 minutes
CRAFFT[1]	Adolescents	ERs, hospitals, primary care providers, psychiatric settings	6	Alcohol and drug abuse	2 (0–6)	Less than 1 minute
Drug abuse screening test (DAST-10)[2]	Adults Adapted for adolescents	Primary care providers Hospital, medical, and psychiatric settings	10	Drug abuse	Low: 1 to 2 Moderate: 3 to 5 Substantial: 6 to 10 (range 0–10)	1 to 2 minutes
TWEAK*	Pregnant women	OB/GYNs, midwives Labor and delivery settings	5	Alcohol abuse	2 (range 0–7)	Less than 2 minutes
UNCOPE*	Pregnant women	OB/GYNs, midwives Labor and delivery settings	6	Alcohol and drug abuse	2 (0–6)	Less than 1 minute

*Public domain.
[1]Copyright by Boston Children's Hospital; no cost, need approval of Center for Adolescent Substance Abuse Research (www.ceasar-boston.org).
[2]Copyright by Harvey Skinner, PhD; no cost, need approval through harvey.skinner@yorku.ca.

TABLE 16.6 Biopsychosocial Addiction Assessment

Chief Complaint

- Reason(s) for seeking treatment at this time
  Priority: assess level of patient safety
  (e.g., suicidality, homicidality)

History of Present Illness

- Antecedent events
- Pattern of presenting symptoms (depression, alcohol, drug use, and so on)
- Current and recent stressors
- Current coping skills/behaviors
- Include client and family's perception of alcohol or other drug consumption

Past Medical History

- Medical history/treatment and outcomes
- Recent and past hospitalizations, surgeries
- Include list of prior and any current medications, over-the-counter, herbal, or complementary treatments

Past Psychiatric History

- Psychiatric history/treatment and outcomes
- Recent and past psychiatric or substance abuse hospitalizations, residential, or outpatient treatments
- Include exposure to prescription opioids, psychotropic medications, side effects, treatment response

Comprehensive Review of Systems

- Current and chronic health problems by system
- Functional status
- Nutritional status

Biological Family History

- Family medical history (two generations)
- Family psychiatric and/or substance use history (two generations)

Sociocultural History

- Family and social history
- Work history/current employment
- Legal history—active and past
- Current support system
- Marital status, children

Development History (Especially for Children)

- Pregnancy/delivery/in utero exposure to alcohol/drugs
- Early developmental milestones
- Social and interpersonal development

Trauma History

- Trauma exposures
  - childhood abuse or neglect
  - rape or sexual assault
  - domestic violence
  - military/combat service
  - natural disasters
- History of head injury; loss of consciousness; and/or seizures

Substance Use History

- For each substance—identify type and details
- Duration/frequency/last use
- Blackouts
- Withdrawal seizures
- Drug-related psychosis
- Legal, psychosocial, physical, interpersonal, and occupational consequences

General and Neurological Examination: (Germane to Treatment Setting and Situation)

- General appearance, height, weight, BMI
- Current health status, last physical exam, allergies, dietary changes
- Physical exam
- Neurologic and mental status exam

Lab Work

- Serum, breath, or urine for substance used as indicated
- Chemistry profile, electrolytes, complete blood count
- Hemoglobin, hematocrit,
- Liver, renal, and thyroid function tests
- Comprehensive metabolic profile
- Pregnancy test (women of child-bearing age)
- HIV/AIDS, hepatitis C, tuberculosis
- Toxicology screens (if indicated)

Other Tests

- Electrocardiogram
- CAGE, AUDIT-C, TWEAK, CRAFFT (appropriate to age, gender, setting)

Differential Diagnoses

- Identify *DSM-5* psychiatric and substance use disorders

Proposed Treatment Plan

- Based on safety needs, severity of medical, psychiatric, and substance use disorders

TABLE 16.7 Feeling-State Addiction Protocol

1. Obtain history, frequency, and context of addictive behavior.
2. Evaluate the person for having the coping skills to manage feelings if he or she is no longer using the addictive behaviors to cope. If not, do resource development before continuing. Install future template if necessary.
3. Identify the specific aspect of the addictive behavior that has the most intensity associated with it. If the addiction is to a stimulant drug, then the rush/euphoria sensations are usually the first to be processed. However, if some other feeling is more intense, process that first. The starting memory may be the first time or the most recent—whatever is most potent.
4. Identify the specific positive feeling (sensation + emotion + cognition) linked with the addictive behavior and its Positive Feeling Score (PFS) level (0–10).
5. Locate and identify any physical sensations created by the positive feelings.
6. Have the client visualize performing the addictive behavior—feeling the positive feeling combined with the physical sensations.
7. Eye movement sets are performed until the PFS level drops to 0 or 1.
8. Install future templates of how the person will live without having that feeling.
9. Between sessions, homework is given to evaluate the progress of therapy and to elicit any other feelings related to the addictive behavior.
10. In the next session, the addictive behavior is reevaluated for both the feeling identified in the last session as well as identifying other positive feelings associated with the behavior.
11. Steps 3 to 9 are performed again as necessary.
12. Once the FSs associated with the addictive behavior have been processed, the negative beliefs underlying the FSs are determined, and the desired positive beliefs are chosen.

Source: Miller, R. (2012). Treatment of behavioral addictions utilizing the feeling-state addiction protocol: A multiple baseline study. *Journal of EMDR Practice and Research, 6*(4), 159–169.

17

Psychotherapy With Children

TABLE 17.1 Key Events and Principles in Family-Centered Care Approach

- **CASSP Established (Children and Adolescent Service System Program).** The overarching goals of CASSP were to coordinate community services for children with serious emotional needs. CASSP principles also emphasized that parents should be empowered, treated as partners in care, and participate fully in treatment planning (Day & Roberts, 1991).
- **Systems of Care Approach Is Defined.** These principles moved into a broader systems of care approach to treatment (Stroul & Friedman, 1996) with the creation of agencies and funding that ensured comprehensive community-based services would be available for families of children with serious emotional illness. Here the emphasis shifted to establishing networks for delivering individualized service plans embedded in comprehensive, culturally competent, coordinated service networks.
- **Comprehensive Community System of Care Ideology Is Developed.** With these grants, systems of care were developed that held parents as key players determining how services would be developed, delivered, managed, and evaluated to match the needs of the child.

18

Psychotherapy With Older Adults

TABLE 18.1 Treatment Options for Common Psychiatric Disorders in Older Adults

Goals of Therapy	Foci/Themes of Therapy	Evidence-Based Psychotherapy Modalities	Evidence-Based CAM Modalities**
Depression Symptom reduction to remission, adherence to health care regimen, relapse recognition and prevention	Isolation, grief, caretaker's burden, finding meaning in life, balancing resources, how to improve quality of life	CBT, RT, interpersonal therapy, group therapy, family therapy	St. John's wort, SAMe, exercise, bright light exposure
Anxiety Symptom reduction to remission, adherence to health care regimen, reduction in inappropriate use of primary care, relapse prevention	Specific worries of older adults such as about death, health, and becoming dependent, concrete suggestions for managing acute anxiety	Behavioral therapy, relaxation training, biofeedback, CBT, IPT, psychoeducation	Kava, yoga, mindfulness-based stress reduction (MBSR), guided imagery, biofeedback, rosemary and lavender essential oils, music therapy
Schizophrenia Health care management, enhancing quality of life, optimizing adherence with medications, achieving remission	Skills for daily living, maintaining meaningful relationships, health status, substance use, coping skills	Psychoeducation, psychosocial skills training, CBT, family therapy	No CAM therapies have been substantiated for the treatment of psychosis
Bipolar Disorder Health care management, enhancing quality of life, optimizing adherence with medications, achieving remission	Skills for daily living, maintaining meaningful relationships, health status, substance use, coping skills	Psychoeducation, psychosocial skills training, CBT, family therapy	No CAM therapies have been substantiated for treatment of cyclic mood changes
Dementia Health care management, enhancing quality of life, optimizing adherence with medications, achieving remission	Skills for daily living, maintaining meaningful relationships, health status, substance use, coping skills	Psychoeducation, psychosocial skills training, CBT, family therapy	Ginkgo biloba, B vitamins, Snoezelen sensory stimulation, music therapy

**Lake. J. (2007). *Textbook of Integrative mental health care*. New York, NY: Thieme Medical Publishers, Inc.

TABLE 18.2 Modification of CBT for Older Adults

CBT Issue	CBT Modifications
Difficulty in increasing pleasant events due to social isolation and physical limitations	Adapt the pleasant event list to activities that are realistic. Ask patient to identify only 5 to 10 pleasant events. Consider appropriate nonphysical pleasant events. Remind patient of events to engage in.
Multiple physical, social, and cognitive problems identified each week	Set agenda each week. Set priorities for work and skill building each week. Refocus on abilities as well as disabilities. Use "faces" chart to identify feelings.
Confuses thoughts and feelings Worries about writing things down because of hand tremors or embarrassment about ability to express thoughts and feelings	Adapt worksheets to provide adequate space; consider lined paper for guide to writing. Ask patient to use audiotape or voice mail as option to writing or use keyboard and computer. Reassure patient that writing is a memory and learning tool; penmanship is not evaluated. Encourage patient to use a writing prosthesis.
Forgets to complete weekly activity schedules and dysfunctional thought records	Ask patient to use audiotape recorder or voice mail. Develop reminders (calendar, voice mail, friend, or family) for patient.

TABLE 18.3 Modificationn of Interpersonal Psychotherapy for Older Adults

IPT Issues	IPT Modifications
Initial Sessions	
Many problems are presented by patient, and there is too much life history to cover.	Link presenting problems to one or two focus areas, and have patient prioritize these.
Patient does not understand he or she has depression.	Quantify depression with standardized scales; use these scales to educate the patient and family or support system about depression.
Patient wants the therapist to "cure" depression.	Take an active role to structure therapy sessions using the IPT manual. Give the patient permission to temporarily take on the sick role so that energy can be focused on getting healthier rather than external demands.
Intermediate Sessions	
Patient is reluctant to talk about conflictual, negative feelings.	Educate the patient about basic communication principles and identification of feelings.
Patient does not understand he or she has depression.	Quantify depression with standardized scales; use these scales to educate the patient and family or support system about depression.
Patient has difficulty staying focused on problem areas.	Address the patient's difficulty staying focused on the topic; look for patterns of distraction, and correlate feelings with distraction.
Patient is reluctant to identify changes needed in his or her behavior.	Take an active role in therapy, but do not provide advice about therapy dilemmas presented by the patient; encourage the patient to state what can be done about the problem.
Patient wants to include family and other support in sessions.	Include joint meetings if appropriate, and IPT issues can be addressed.
Termination Sessions	
Patient experiences ongoing physical problems or stressors and wants to continue IPT.	Every few sessions, remind the patient of the number of sessions left. Remind the patient about the contract, and address sadness due to loss or change in the interpersonal relationship.

TABLE 18.4 Distinguishing Reminiscence and Life Review

Criteria	Reminiscence	Life Review
Attributes	Verbal interaction between two or more people who are eliciting memories Involves "flash bulb" recall and spontaneous interaction or theme-focused group discussion No evaluation of life; focus is on pleasurable memories Focused on past events or experiences, not current events	Done between a therapeutic listener and reviewer on 1:1 basis Recall process covers entire life span, usually chronologically Recall must contain an evaluative or analytical component to prepare for the future Recall past or recent events and experiences
Recalled events Timeframe goals	Both happy and sad times No specific time allotted Decreased isolation Increased socialization, connectedness, and friendships Increased self-esteem Increased life satisfaction	Both happy and sad times Usually takes 4 to 6 weeks Integrity Increased self-esteem Decreased depression Increased life satisfaction Peace
Patient characteristics	Cognitively intact and mild to moderately impaired older adults Able to focus on self and others in the group May be difficult in group setting to reminisce if patient has many traumatic events or is guarded	Cognitively intact to mildly impaired Self-focused Usually experiencing a life event trigger

19

Reimbursement and Documentation

TABLE 19.1 Revised Psychotherapy Codes All CPT Codes are Registered Exclusively to the American Medical Association

Before 2013	After 2013
90801—Diagnostic interview	90791 (no medical) 90792 (with medical) (report with interactive complexity add-on [+90785] when appropriate)
90802—Interactive diagnostic interview	Work now captured by interactive complexity add-on
90804, 90816—Individual psychotherapy, 20 to 30 minutes	90832—Psychotherapy, 30 (16–37) minutes (report with interactive complexity add-on [+90785] when appropriate)
90810, 90823—Interactive individual psychotherapy, 20 to 30 minutes	Work now captured by interactive complexity add-on
90806, 90818—Individual psychotherapy, 45 to 50 minutes	90834—Psychotherapy, 45 (38–52) minutes (report with interactive complexity add-on [+90785] when appropriate)
90812, 90826—Interactive individual psychotherapy, 45 to 50 minutes	Work now captured by interactive complexity add-on
90808, 90821—Individual psychotherapy, 75 to 80 minutes	90837—Psychotherapy, 60 (53+) minutes (report with interactive complexity add-on [+90785] when appropriate)
90814, 90828—Interactive psychotherapy, 75 to 80 minutes	Work now captured by interactive complexity add-on
90805, 90817—Individual psychotherapy with E/M, 20 to 30 minutes	+90833—Psychotherapy, 30 (16–37) minutes, use only add-on code to selected E/M code (report with interactive complexity add-on [+90785] when appropriate)
90811, 90824—Interactive individual psychotherapy with E/M, 20 to 30 minutes	Work now captured by interactive complexity add-on
90807, 90819—Individual psychotherapy with E/M, 45 to 50 minutes	Eliminated, use only as add-on code to selected E/M code +90836—Psychotherapy, 45 (38–52) minutes (report with interactive complexity add-on [+90785] when appropriate)
90813, 90827—Interactive individual psychotherapy with E/M, 45 to 50 minutes	Work now captured by interactive complexity add-on
90809, 90822—Individual psychotherapy with E/M, 75 to 80 minutes	Eliminated, use only as add-on code to selected E/M code +90838—Psychotherapy, 60 (53+) minutes (report with interactive complexity add-on [+90785] when appropriate)
90815, 90829—Interactive individual psychotherapy with E/M, 75 to 80 minutes	Eliminated
90857—Interactive group psychotherapy	Eliminated, now use 90853, group psychotherapy (reported with interactive complexity add-on [+90785] when appropriate)
90862—Pharmacologic management	Eliminated

Adapted from American Psychiatric Association materials available at www.psych.org/practice/managing-a-practice/cpt-changes-2013

TABLE 19.2 Commonly Used CPT Codes

Office/Outpatient Visit New CPT	Office/Outpatient Visit Established CPT	Office/Outpatient Consultation CPT	Initial Hospital Care CPT
99201	99211	99241	99221
99202	99212	99242	99222
99203	99213	99243	99223
99204	99214	99244	
99205	99215	99245	

TABLE 19.3 Language Associated With E/M Codes

History HPI*	History PFSH**	History ROS***	# Diagnoses # Data	Risk	Medical Decision Making	Level of Service
Brief	Pertinent	Problem pertinent	Minimal	Minimal	Straightforward	Problem focused (PF)
Extended	Complete	Extend	Limited	Low	Low complexity	Expanded problem focused (EPF)
		Complete	Multiple	Moderate	Moderate complexity	Detailed (DET)
			Extensive	High	High complexity	Comprehensive (COMP)

Source: Department of Health and Human Services. (2010). *Evaluation and management services guide*. Retrieved from the Medicare learning network: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

*History of present illness.

**Past, family, and social history.

***Review of systems.

TABLE 19.4 CPT Requirements: History

HPI	PFSH	ROS	Level of Service
Brief: one to three elements or one to two chronic conditions	N/A	N/A	Problem focused 99202/99212
Brief: one to three elements or one to two chronic conditions	N/A	Problem pertinent: 1 system	Expanded problem focused 99203/99213
Extended: one to three elements or one to two chronic conditions	Pertinent One element*	Extended: 2 to 9 systems	Detailed 99204/99214
Extended: four elements or three chronic conditions	Complete Three elements**	Complete: 10 to 14 systems	Comprehensive 99205/99215

Source: Department of Health and Human Services. (2010). *Evaluation and management services guide*. Retrieved from the Medicare learning network: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

*No PFSH required for subsequent hospital visits.

**Only two elements required for established patient.

TABLE 19.5 CPT Physical Exam Requirements for Psychiatry

Elements of Examination	Level
One to five bulleted elements from psychiatric exam	Problem focused 99202, 99212
At least six bulleted elements from psychiatric exam	Expanded problem focused 99203, 99213
At least nine bulleted elements from psychiatric exam	Detailed 99204, 99214
– All bulleted elements from psychiatric exam – Three of seven components of vital signs and general appearance (two bullets) from constitutional – One bullet element from unshaded border from musculoskeletal	Comprehensive 99205, 99215

Source: Department of Health and Human Services. (2010). *Evaluation and management services guide*. Retrieved from the Medicare learning network: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

TABLE 19.6 Tabulation of MDM Elements (Marshfield Criteria) Score Based on Highest 2 out of 3 in the Office or Other Outpatient Settings

No. of Diagnoses or Management Options	Points	Amount and Complexity of Data	Points	Risk Factors of Presenting Problems
Self-limiting	1	Review and/or order lab data	1	One self-limited or minor problem (e.g., dysthymia well managed) Management options include minimal risk
Established problem to examining provider—stable or improved	1	Review and/or order radiology tests	1	Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated illness Management options include low risk such as OTC medications
Established problem to examining provider—worsening	2	Review and/or order tests in the medical section of CPT	1	One or more chronic illnesses with mild exacerbation, progression, or side effects Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Management options include any prescription medication—this elevates risk to moderate
New problem to examining provider—no additional workup or diagnostic procedures ordered (Max 2)	3	Discussion of test results with performing provider	1	One or more chronic illnesses with severe exacerbation, progression, or side effects Acute or chronic illnesses that pose a threat to life or bodily function Management options are elevated to extensive risk because the pharmacological prescription requires intensive management
New problem to examining provider—additional workup planned	4	Review and summarization of old records and/or obtaining history from someone other than the patient Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another provider Independent visualization of image tracing, or specimen itself (not simply review report)	1 2 2	
Minimal	Less than 1	Minimal	Less than 1	Minimal
Limited	2	Limited	2	Low
Multiple	3	Multiple	3	Moderate
Extensive	4	Extensive	4	Extensive

Source: Department of Health and Human Services. (2010). *Evaluation and management services guide*. Retrieved from the Medicare learning network: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

TABLE 19.7 Determination of Level of MDM

No. of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity/Mortality	Designated Level of Medical Decision Making
Minimal (0–1 problem points)	Minimal or none (0–1 data points)	Minimal	Straightforward 99202–99212
Limited (2 problem points)	Limited (2 data points)	Low	Low complexity 99203–99213
Multiple (3 problem points)	Multiple (3 data points)	Moderate	Moderate complexity 99204–99214
High complexity (4 problem points)	Extensive (4 data points)	Extensive	High complexity 99205–99215

Source: Department of Health and Human Services. (2010). *Evaluation and management services guide*. Retrieved from the Medicare learning network: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

TABLE 19.8 All Required E/M Elements

New/Established Office or Other Outpatient Services				
	99202/99212 Problem focused	99203/99213 Expanded problem focused	99204/99214 Detailed	99205/99215 Comprehensive
History				
CC	Required	Required	Required	Required
HPI	One to three elements	One to three elements	Greater than four elements	Greater than four elements
ROS	One system	One system	Two to nine systems	10 to 14 systems
PFSH	N/A	N/A	1/3 elements	2/3 elements (3/3 new patient)
Physical Exam				
1997	One to five bullets from psychiatric exam	At least six bullets from psychiatric exam	At least nine bullets from psychiatric exam	All bullets from constitutional and psychiatric, one from musculoskeletal
Medical Complexity Decision Making				
	Straightforward	Low complexity	Moderate complexity	High complexity
Counseling/Coordination of Care				
Face to face	10 minutes	15 minutes	25 minutes	40 minutes

Source: Department of Health and Human Services. (2010). *Evaluation and management services guide*. Retrieved from the Medicare learning network: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

APPENDIX 19.1

Evaluation and Management Established Patient Office Progress Note

Client Name: _____

Date of Service: _____

Provider Name: _____

Time In: _____ am/pm Time Out: _____ am/pm

Total Time Spent (minutes): _____

Level of Service: 99212_____ 99213_____ 99214_____ 99215_____

Counseling/Coordination > 50% of time (explain) _____

_____

_____

_____

Tabulation of Medical Decision-Making Elements—Highest 2 Out of 3 for Overall MDM

No. of Diagnoses or Management Options	Points	Amount and Complexity of Data	Points	Risk Factors of Presenting Problems	Number of Management Options
Self-limiting	1	Review and/or order lab data	1	• One self-limited or minor problem, e.g., dysthymia well-managed	Rest Minimal risk
Established problem to examining provider-stable or improved	1	Review and/or order radiology tests	1	• Two or more self-limited or minor problems; • One stable chronic illness; • Acute uncomplicated illness	OTC Meds Low risk
Established problem to examining provider-worsening	2	Review and/or order tests in the medical section of CPT	1	• One or more chronic illnesses with mild exacerbation, progression, or side effects; • Two or more stable chronic illnesses; • Undiagnosed new problem with uncertain prognosis; • Acute illness with systemic symptoms	Prescription RX Moderate risk
New problem to examining provider-no additional workup or diagnostic procedures ordered (Max 2)	3	Discussion of test results with performing provider	1	• One or more chronic illnesses with severe exacerbation, progression, or side effects; • Acute or chronic illnesses that pose a threat to life or bodily function	RX requiring intensive management High risk
New problem to examining provider-additional workup planned	4	Review and summarization of old records and/or obtaining history from someone other than the patient Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another provider Independent visualization of image tracing, or specimen itself (not simply review report)	1 2 2		
Straightforward	<1	**Straightforward**	<1	**Straightforward**	Minimal
Low complexity	2	**Low complexity**	2	**Low complexity**	Low
Moderate complexity	3	**Moderate complexity**	3	**Moderate complexity**	Moderate
High complexity	4	**High complexity**	4	**High complexity**	High
Notes:					

HPI Location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms *OR* status of 3 or more chronic diseases.	
Elements Documented: 99212-Problem Focused = 1–3 99214-Detailed = 4 Or >3 Chronic Conditions	99213-Expanded Problem Focused = 1–3 99215 Comprehensive = 4 Hpi Or >3 Chronic Conditions

ROS	**NL**	**NOTE**
Const	☐	☐
Musculo	☐	☐
Psych	☐	☐
CV	☐	☐
Resp	☐	☐
GI	☐	☐
Skin/Breasts	☐	☐
Neuro	☐	☐
Genitourinary	☐	☐
ENT/Mouth	☐	☐
Endocrine	☐	☐
Hem/Lymph	☐	☐
Allerg/Immun	☐	☐
Eyes	☐	☐

99212-Problem Focused = None 99214-Detailed = 2–9 Systems	99213-Expanded Problem Focused = 1 System 99215-Comprehensive =>10 Systems

PFSH	No Chng	See Note
Past	☐	☐
Family	☐	☐
Social	☐	☐
99212-Problem Focused = None 99214-Detailed = At Least 1 Item From 1 Category		99213-Expanded Problem Focused = None 99215-Comprehensive Specifics Of At Least Two Items

Exam-Single System 2 Bullets	NL	See Note
• **3 out of 7 Constitutional**	☐	☐
Blood Pressure:		
Pulse:		
Temperature:		
Respiration:		
Height:		
Weight:		
• **General appearance of patient**	☐	☐
(e.g., development, nutrition, body habits, deformities)		
☐ Well Groomed ☐ Disheveled ☐ Bizarre ☐ Inappropriate		

Exam–Single System 2 Bullets	NL	See Note
Musculoskeletal	☐	☐
• Gait and station	☐	☐
• Muscle strength or tone, atrophy, abnormal movements (e.g., flaccid, cog wheel)	☐	☐
Note:		

Notes:

Psychiatric Single System Exam—11 Bullets
Attitude: ☐ Cooperative ☐ Guarded ☐ Suspicious ☐ Uncooperative
• Speech: ☐ Normal ☐ Delayed ☐ Excessive ☐ Pressured ☐ Articulation clear ☐ Soft ☐ Loud ☐ Perseverating ☐ Spontaneous ☐ Paucity
• Thought Process: ☐ Intact ☐ Circumstantial ☐ LOA ☐ Flight of Ideas ☐ Illogical ☐ Logical/Coherent ☐ Abstract reasoning ☐ Computations
• Associations ☐ Tangential ☐ Loosel ☐ Intactl ☐ Tangential ☐ Tangential
• Thought Content: ☐ Delusions ☐ Phobias ☐ Poverty of Content ☐ Obsessions ☐ Compulsions ☐ Paranoid Ideation ☐ Ideas of Reference ☐ Preoccupation with violence ☐ Homicidal ideation ☐ Suicidal ideation
• Judgment: ☐ Intact ☐ Impaired: ☐ Minimal ☐ Moderate ☐ Severe
• Insight: ☐ Intact ☐ Impaired: ☐ Minimal ☐ Moderate ☐ Severe
Complete mental status examination including
• Orientation: ☐ Fully Orientated ☐ Disorientated: ☐ Time ☐ Person ☐ Place
• Memory: Recent = ☐ Intact ☐ Impaired: ☐ Minimal ☐ Moderate ☐ Severe Remote = ☐ Intact ☐ Impaired: ☐ Minimal ☐ Moderate ☐ Severe
• Attention span and concentration
• Language (naming objects, repeating phrases)
• Fund of knowledge (awareness of current events, past history, vocabulary
• Mood: ☐ Euthymic ☐ Depressed ☐ Anxious ☐ Euphoric ☐ Agitation Affect: ☐ Appropriate ☐ Labile ☐ Blunted ☐ Flat ☐ Expansive ☐ Constricted

Level of Exam	**Content and Documentation Requirements**
99212-Problem Focused	**One to five elements identified by a bullet**
99213-Expanded Problem Focused	**At least six elements identified by a bullet**
99214-Detailed	**At least nine elements identified by a bullet**
99215-Comprehensive	**Perform ALL elements identified by a bullet; document every Element in Psychiatric and Constitutional Exam and at least one element in Musculoskeletal**

DESCRIPTION OF SESSION (must include effects of meds, modifications, psychosocial issues and HPI if applicable):

Service Provided: ☐ Individual ☐ Family/Couple ☐ Group

Treatment Implemented: ☐ Cognitive Behavioral ☐ Supportive ☐ Insight Oriented ☐ Pharmacological ☐ Lab work ordered, Rationale: _____

Does AIMS test need to be completed? _____ ☐ Yes _____ ☐ No _____ ☐ N/A _____

Substance Abuse: _____

Records/Progress Notes Reviewed/Collateral Contacts: _____

Medications (Dosage, S/E): _____

ASSESSMENT (Response to treatment)

REMINDERS: Is the medication sheet updated after each visit? ☐ Yes ☐ No
If you prescribed medication, did the patient sign an informed consent? ☐ Yes ☐ No
Does patient/family understand the treatment plan? ☐ Yes ☐ No
Was patient referred for preventive/ancillary services? ☐ Yes ☐ No

Diagnosis Imp. _____ / _____ / _____ /_____

MDM Plan, Estimated Discharge Date and Next Appointment:_____

Signature _____ Date of Signature: _____

20

Termination and Outcome Evaluation

TABLE 20.1 Selected Holistic Outcome Measures

Outcome	Instrument	Type of Tool and How to Obtain
Hope	Herth Hope Scale (Herth, 1992)	12-item self-report on a 1 to 4 Likert scale Contact kaye.herth@mnsu.edu
Resilience	Brief Resilient Coping Scale (Sinclair & Wallston, 2004)	4-item self-report rated on a 1 to 5 Likert scale Contact vaughn.sinclair@Vanderbilt.Edu for tool
Connection to others	Sense of Belonging Instrument (Hagerty & Patusky, 1995)	18-item self-report questionnaire, respondents rate their sense of connection to others on a 1 to 4 Likert scale Contact bmkh@umich.edu for tool
Relationships with others	Interpersonal Relationship Inventory (IPRI) (Tilden, Nelson, & May, 1990)	30-item self-report on a 1 to 5 Likert scale that asks the respondent how they feel about personal relationships Contact vtilden@unmc.edu for tool
Quality of life	Quality of Life Scale (Flanagan, 1982)	See Chapter 3
Spiritual well-being	WHO Spirituality, Religiousness and Personal Beliefs (SRPS) (WHO, 2002)	See Chapter 3

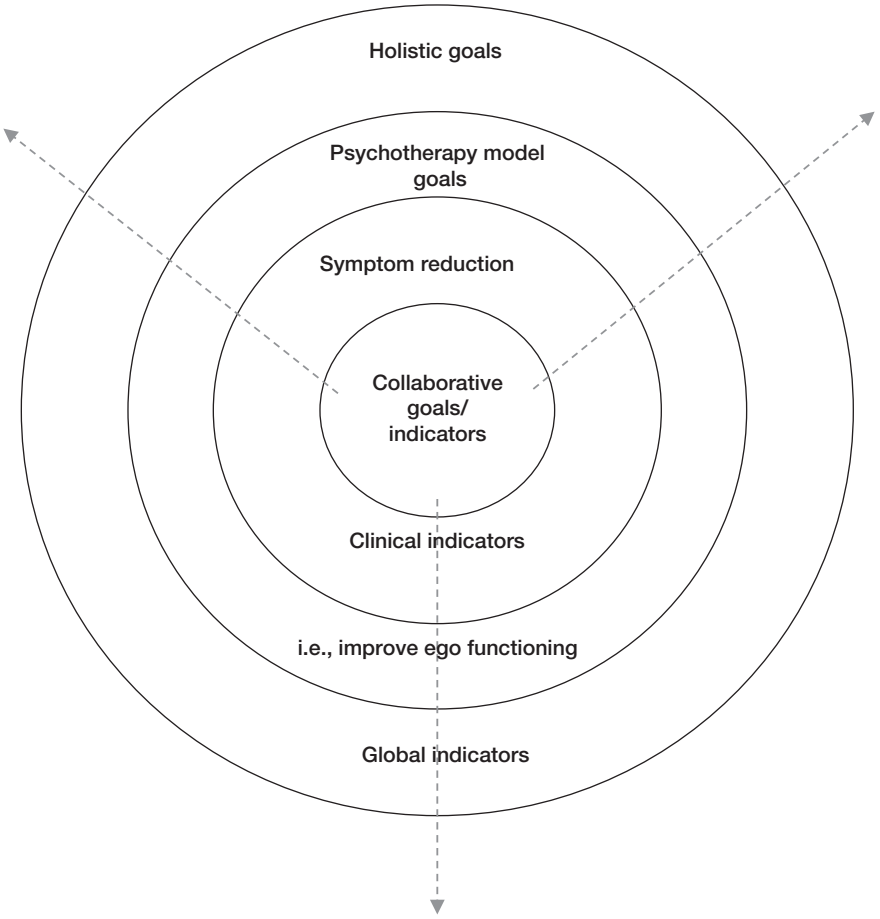

FIGURE 20.1 Level of outcome measurement in psychotherapy.

APPENDIX 20.1

Selected Instruments for Psychotherapy Outcome Measurement

The table below is a selected list of instruments that may be used in psychotherapy research. This is not a comprehensive list but does include many instruments that have been used in EMDR research. Sources of other instruments include journals, publishing houses, as well as the following publications:

American Psychiatric Association. (2000). *Handbook of psychiatric measures*. Washington DC: APA.

Antony, M., Orsillo, S., & Roemer, L. (2001). *Practitioner's guide to empirically based measures of anxiety*. New York, NY: Kluwer Academic/Plenum Pub.

Conoley, J. D., & Kramer, J. J. (1995). *The twelfth mental measurements yearbook*. Lincoln, NB: Buros Institute of Mental Measurement.

Fischer, J., & Corcoran, K. (2007). *Measures for clinical practice & research* (Vol. 1 & 2) New York, NY: Oxford University Press.

Stanford School of Medicine, Research Instruments Developed, Adapted or Used by the Stanford Patient Education Research Center accessed July 21, 2009, http://patienteducation.stanford.edu/research

Tool	Description	Reliability/Validity	Reference	Available
Beck Depression Inventory (BDI-II)	21-item self-report measure of depressive symptoms	Content, construct and factorial validity; reliability 0.86–0.93	Beck, Steer, and Garbin (1988)	Purchase from: Harcourt Assessment Customer Service P.O. 599700, San Antonio, TX 78259
Brief Depression Rating Scale (BDRS)	8-item therapist-rated observation measure of depressive symptoms	Concurrent validity 0.83; reliability 0.91–0.94	Kellner (1986)	Dr. Robert Kellner Department of Psychiatry University of Mexico 2400 Tucker, NE, NM 87131
Brief Resilience Coping Scale (BRCS)	4-item self-report scale on a 5-point Likert scale measuring perception of resilient coping	Construct and criterion validity; new tool with minimal reliability 0.7	Sinclair and Wallston (2004)	In public domain but contact Vaughn Sinclair, PhD Professor of Nursing Vanderbilt University vaughn.sinclair@vanderbilt.edu
Client Satisfaction Questionnaire	18-item 4-point Likert scale to measure client satisfaction with treatment	Good concurrent validity; reliability 0.86–0.94	Larsen, Attkisson, Hargreaves, and Nguyen (1979)	Dr. C. Attkisson Professor of Medical Psychology Department of Psychiatry Box 33-C University of California, San Francisco San Francisco, CA 94143
Combat Exposure Scale	7-item measure of wartime stressors experienced by combatants	Good discriminate validity; reliability 0.85–0.97	Keane and Caddell (1989)	Dr. Terrence Keane PTSD Center (116B) Veteran Affairs Medical Center 150 South Huntington Avenue Boston, MA 02130
Depression Scale (CES-D)	20-item Likert self-report scale screening test for depression	Validity construct based on *DSM-IV*; reliability 0.85 internal consistency	Radloff (1977)	In public domain
Dissociative Experiences Scale (DES)	28-item self-report to measure dissociation	Construct validity; reliability 0.79–0.86	Bernstein and Putnam (1986)	In public domain
Geriatric Depression Scale (GDS)	30 yes/no items self-report to rate depression in the elderly	Concurrent validity 0.83; reliability 0.94	Yesavage, Brink, Rose, and Leirer (1983)	In public domain
Hamilton Rating Scale for Depression (HAM-D)	Clinician-rated 17-item checklist of depressive symptoms	Concurrent validity 0.8–0.9; inter-rater reliability 0.9 and alpha 0.80–0.92	Williams (1988)	In public domain
Health Resource Utilization	4 items asking numerical information about frequency of health care visits/use over the past 6 months	Test-retest reliability 0.76–0.97	Lorig, Stewart, Ritter, González, Laurent, and Lynch (1996)	In public domain http://patienteducation.stanford.edu/research/utilization.html

(*continued*)

Tool	Description	Reliability/Validity	Reference	Available
Health Survey Short Forms (SF-36 & SF-12)	2 self-report forms, one 36 items and the other 12 items, that measure perceived physical and mental health	Excellent concurrent, construct and discriminate validity; reliability 0.76–0.93 with longer form higher	Ware, Kosinski, and Keller (1994)	Medical Outcomes Trust 20 Park Plaza Suite 1014 Boston, MA 021116 www.outcomes-trust.org
Hope Index	16-item self-report measure of hope	Construct and discriminative validity; reliability 0.78–0.85	Staats and Partlo (1992)	In public domain Dr. Staats staats1@osu.edu
Impact of Events Scale (IES)	15-item self-report Likert scale assessing current subjective distress related to a specific event	Good criterion, content, and construct validity; reliability 0.79–0.92	Horowitz, Wilner, and Alvarez (1979)	In public domain Mardi Horowitz, MS University of California, San Francisco 401 Parnassus Avenue San Francisco, CA 94143
Inventory of Interpersonal Problems (IIP)	32-item self-report Likert scale assessing interpersonal problems	Validity for longer version 127 items adequate; convergent validity with longer scale 0.90; reliability 0.88–0.89	Alden, Wiggins, and Pincus (1990)	Purchase from: The Psychological Corporation 555 Academic Court San Antonio, TX 78204-2498
Interpersonal Relationship Inventory (IPRI)	30 item self-report 5-point Likert scale that asks respondents how they feel about personal relationships	Content and construct validity; reliability >0.80	Tilden, Nelson, and May (1990)	Contact vtilden@unmc.edu
PTSD Checklist (PCL)	17-item self-report Likert scale assessing symptoms of PTSD. There is a civilian, military, and specific version with the latter focusing on a particular event	Convergent and concurrent validity; reliability 0.96–0.97	Weathers, Litz, Herman, Huska, and Keane (1993)	In public domain http://www.ncptsd.va.gov/ncmain/assessment/assessmt_request_form.html
Sense of Belonging Instrument	18-item self-report questionnaire with respondents rating sense of connection to others on a likert scale	Content and construct validity; reliability test-retest 0.88	Hagerty and Patusky (1995)	Contact bmkh@umich.edu
Symptom Checklist-90-Revised (SLC-90-R)	90-item single-page self-report Likert screening tool designed to measure symptoms of psychopathology	Convergent validity 0.89 with MMPI; internal consistency reliability 0.89	Derogatis (1994)	Purchase from: National Computer Systems P.O. Box 416 Minneapolis, MN 55440 www.ncs.com
State-Trait Anxiety Inventory (STAI)	20-item self-report with a 4-point Likert scale; 2 forms with STAI-1 for state anxiety and STAI-2 for trait anxiety	Good convergent validity; reliability	Spielberger (1977)	Purchase from: Mind Garden 855 Oak Grove Avenue Suite 215 Menlo Park, CA 94025