CHAPTER

1 Introduction to Effective Treatment Planning

WHY IS DIAGNOSIS AND ASSESSMENT IMPORTANT?

I have heard students, colleagues, interns, and licensed professionals alike react to the diagnosis of mental disorders as a form of "labeling" clients, and insist that "Diagnosis is only for the insurance companies." For some reason, these comments seem to have increased since the publication of *DSM-5,* perhaps as resistance to or avoidance of learning about new and sometimes nuanced, diagnostic changes. Diagnosis can certainly be a challenge, but without an accurate diagnosis, how could we possibly know what treatments to recommend?

Consider for a moment the following scenarios:

Case Study 1.1

Jack A., a 64-year-old man, begins couples counseling with his wife because he has become irritable and difficult to be around. After 35 years of marriage he has begun to shout at his wife and becomes particularly hostile at the end of the day. She is considering leaving him. They attend weekly couples counseling but rather than getting better, the situation seems to be getting worse.

Case Study 1.2

Jillian is a 14-year-old girl who is being treated by a psychiatrist with SSRIs for her symptoms of OCD. She is fearful of eating food that has been touched or prepared by others, and now weighs less than 100 pounds. The psychiatrist refers the girl for individual therapy, but her new counselor decided she would fit perfectly into a weekly support group she runs for adolescent girls with anorexia. Instead of getting better, however, Jillian lost another 5 pounds in the first month.

Case Study 1.3

A 37-year-old married mother of three active boys has been diagnosed with fibromyalgia and rheumatoid arthritis. She is exhausted all the time, in pain, and recently resigned from her job so she could devote all of her time to taking care of herself and her family. At the recommendation of her doctor, she begins to attend weekly therapy sessions. Using the Gestalt empty-chair technique, her therapist encourages her to give her illness a name and express her anger to the chair.

Inaccurate (or no) diagnosis, inappropriate treatment, and poor clinical understanding on the part of the therapist contributed to the situations just described.

Months later, the first man went to the doctor for an annual physical examination. His wife mentioned his increasing irritability to the doctor, who recognized the end-of-day irritability as "sundowner's," a potential symptom of Alzheimer's disease. The patient was referred to a neurologist where he received an accurate diagnosis.

The young girl with OCD was referred by her psychiatrist for individual counseling, which could have been an appropriate companion therapy to medication management, if she had received individual sessions of CBT to help reduce her obsessions and compulsions. Unfortunately, putting her in a group with other girls with anorexia provided her an opportunity to learn new obsessive and compulsive eating behaviors that she had never thought of before. It also brought out her competitive nature. Within a month, her weight became dangerously low and she was hospitalized.

The young mother had a painful medical disorder that was exacerbated by stress. She was eventually referred to a mindfulness-based stress reduction group where she learned mindfulness meditation, acceptance, and relaxation techniques. She is now able to manage her pain without medication and has learned how to treat herself with compassion.

As these stories illustrate, the primary goal of diagnosis and treatment planning is to be able to make sound therapeutic decisions that will help clients feel better about themselves and their lives, return to better functioning, and achieve their goals. Just like other medical and mental health professionals, doctors, psychiatrists, psychologists, counselors, social workers, and addictions specialists must first do no harm. But in order to follow that edict, we must be knowledgeable about what helps and what has the potential for causing our clients to get worse.

For some well-researched disorders, such as generalized anxiety disorder, major depressive disorder, and some of the eating disorders, research has found specific evidence-based treatments that are more effective than placebo conditions or no treatment at all. When these interventions are used for specific disorders they result in improvement over relatively short periods of time, and the improvements are often of a dose-by-dose nature. More importantly, treatment gains are maintained after counseling has ended.

But many times, little or no research is available on a disorder, or despite a wealth of research, not one specific treatment modality stands out as the most effective. In other cases, as with conduct disorder, bipolar disorder, and borderline personality disorder, treatment will depend on the stage of the disorder, the most troublesome symptoms at that time, and a long-term approach.

Many of the diagnoses in *DSM-5* do not have evidence-based treatments. Some are too new to have an adequate research base, and some disorders are too rare to have garnered enough interest and funding for research. In those situations, case studies can often be found in the literature that can be culled from, and approaches that provide symptom relief can be recommended.

In these cases in particular, it helps to remember that psychotherapy *is* effective. So effective that nearly 40 years ago Smith, Glass, & Miller (1980) conducted a meta-analytic review on the effectiveness of psychotherapy. They concluded, "The average person who received therapy is better off at the end of it than 80% of those who do not" (p. 87).

AN INTEGRATED MODEL FOR TREATMENT PLANNING

Treatment planning generally moves from recognition of the symptoms of the disorder into consideration of the client's characteristics and on to the treatment approach. That sequence will be followed throughout most of this book with the help of an integrated treatment model called the Client Map.

All the elements necessary for effective treatment planning—diagnosis, objectives of treatment, and types of interventions—will be discussed here in terms of the DO A CLIENT MAP mneumonic. Readers who are familiar with the Client Map method of diagnosis and assessment already know how this simple acronym helps to make the process more thorough and effective by covering all the major elements of the treatment planning process. For those learning the system for the first time, each of the 12 letters in the DO A CLIENT MAP mneumonic helps to facilitate recall for each of the 12 parts of the assessment and treatment planning process:

- Diagnosis
- Objectives of treatment
- Assessment—tools to help clarify assessment may include structured clinical interviews, inventories, scales, neurological tests, or may be as simple as symptom check lists and self-reports
- Clinician characteristics
- Location of treatment
- Interventions to be used
- Emphasis of treatment—for example level of support needed, level of directiveness by the therapist, whether focus is cognitive, behavioral, emotional, or a combination of the three
- Numbers—who should participate in treatment? Is the most effective treatment individual therapy? Family therapy? Group?
- Timing—frequency, pace, and duration of treatment
- Medications needed, if any
- Adjunct services—community services, support groups, alternative treatments
- Prognosis

The clinician who gathers client information for each of the items in the Client Map will have completed the assessment and have the information necessary for a structured treatment plan that informs his or her work with that client. The acronym is used throughout this book to illustrate sample case studies relevant to the diagnoses in each chapter.

The format presented here for diagnosis and treatment has been used successfully by students, interns, therapists and other mental health professionals for at least two decades. It is comprehensive, provides a solid foundation on which evidence-based practice can be built, and has withstood the test of time. Now, with the elimination of the multi-axial system in *DSM-5,* the simple Client Map acronym provides students and experienced therapists alike with an easy-to-use diagnostic framework for their work with clients, if they choose to use it. Let's get started.

DIAGNOSIS

(**D**O A CLIENT MAP)

Effective treatment planning begins with the conceptualization of a diagnosis. Several different classification systems are available that reflect our current level of knowledge and the research

available. Although the best that we have available at this time, these classification systems must be considered to be fluid documents that evolve with new scientific knowledge. They must be updated and revised periodically to remain relevant with current medical knowledge and changing concepts of illness (Moriyama, Loy, & Robb-Smith, 2011).

The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*; American Psychiatric Association [APA], 2013) is the classification system used most frequently in the United States.

The *International Classification of Diseases and Related Health Problems (ICD)* was developed by the World Health Organization (WHO) and is used by 117 countries around the world to report national morbidity and mortality statistics. It is updated periodically and is currently in its tenth version, although an 11th edition is being developed. As of this writing, the United States is using *ICD-10-CM* (Clinical Modification) as the basis for medical coding and reporting. In the United States, the National Center for Health Statistics oversees this process. As of October, 1, 2015, all U.S. healthcare providers covered under the Health Insurance Portability and Accountability Act (HIPAA) were required to use the *ICD-10-CM* diagnostic codes for medical and mental health procedures. Both sets of codes (for *ICD 9* and *ICD 10*) are created by the World Health Organization. The codes are available for use free of charge from the WHO website (www.who.int/classifications/icd/en) and are also printed in *DSM-5* and in *DSM-5 Essentials: The Savvy Clinician's Guide to the Changes in Criteria* (Reichenberg, 2014).

Both the *DSM* and the *ICD* are updated periodically in keeping with the reality of new research, new statistics on prevalence rates, and new insights into the etiology and nosology of mental disorders. Both classification systems are primarily diagnostic, and do not venture into the area of treatment interventions.

Also, by their very nature, both systems are imprecise. Rather than being the final word on diagnosis, it is more helpful to consider *DSM-5* and *ICD-10* to be the best information that we have at the current time, with the understanding that classifications will change as our knowledge base changes. Mental health professionals must stay informed and keep pace with the changes in our profession.

Other, larger philosophical questions about the judgments that must be made to determine the boundaries of normalcy versus a disorder; the standards agreed to for guiding research; even questions related to causation, cultural differences, and what constitutes a medical illness versus a mental disorder are all fascinating topics for discussion, but they have all been covered elsewhere and are beyond the scope of this book.

Certainly care should be taken to distinguish between a true mental disorder and a normal reaction to stressful life events. More than 70% of disorders in *DSM-IV* included clinically significant distress or impairment as a required criterion for diagnosis. *DSM-5* provides a new definition of a mental disorder that is slightly different:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (APA, 2013, p. 20)

Until we reach a point when all mental disorders can be measured and the underlying

causative factors identified, clinical judgment will still be necessary to determine when a behavior or sequelae of behaviors has become dysfunctional or is associated with significant distress. Until then, *DSM-5* and *ICD* reflect the best currently available information we have for the diagnosis of mental disorders.

Another diagnostic challenge is the presence of co-occurring or comorbid disorders. The *DSM-5* allows for multiple diagnoses to be given at the same time, as long as the diagnostic criteria are met. Greater comorbidity means diagnosis will be more difficult, and treatment will be more complicated as issues of personality, behavior, substance use, and other influences will need to be factored into the treatment plan.

Provisional diagnoses may also be given, if there is a strong indication that the full criteria will ultimately be met. The provisional specifier is added following the diagnosis if not enough information is available. A provisional diagnosis can also be given if the duration criterion for a disorder has not been met.

Also important to diagnosis is an understanding of the client's developmental stage, and processes such as attachment, socialization, gender identity, and moral and emotional development. Understanding the client's stage of development is particularly important when treating children, adolescents, families, and older adults (Levant, 2005). Of equal importance is the developmental background of a disorder, when symptoms first began, and how it may have impacted the child developmentally. Some people with longstanding disorders may have failed to reach important developmental milestones, especially in the areas of self-direction and socialization.

DSM-5 incorporates years of research during which thousands of experts participated in more than 160 task forces and workgroups over a 12-year period to conduct research field trials of diagnostic criteria for mental disorders. At the end of the process, the Board of Trustees of the American Psychiatric Association approved the final changes that now constitute *DSM-5*. According to the APA, all the changes were intended to more accurately and clearly define the criteria for mental disorders to ensure diagnostic accuracy and consistency from one clinician to another (APA, 2013).

Following are some of the most significant changes in *DSM-5*. Readers can find a complete list of changes made from *DSM-IV* to *DSM-5* in *DSM-5 Essentials: The Savvy Clinician's Guide to the Changes in Criteria* (Reichenberg, 2014).

1. Movement to a nonaxial diagnostic system (similar to WHO's *International Classification of Diseases*) which combines all diagnoses together and lists as many diagnoses as necessary to provide the clinical picture.
2. Better clarification of the not-otherwise-specified (NOS) diagnostic categories from *DSM-IV*. Instead of the catchall NOS category, clinicians may now identify presentations that are clinically significant but do not meet the full criteria for a disorder and explain why the criteria have not been met. Or, as in emergency-room presentations, clinicians may report that insufficient information is available, and an "unspecified" diagnosis would be given. These two options are now available for all disorders in *DSM-5*.
3. Reclassification of disorders into a dimensional approach rather than the categorical approach used in *DSM-IV*. For example, OCD is a new classification and is located next to anxiety disorders. *DSM-5* provides dimensional and cross-cutting measures to help clarify diagnosis and increase the clinical utility of the manual.

4. Some categories have taken on a "spectrum" approach (as in schizophrenia spectrum and other psychotic disorders), and may be considered one disorder with a range of presentations.
5. The separation of some disorders, such as agoraphobia and panic, from each other. To provide further diagnostic clarification, panic attack is now also considered to be a specifier that can be applied to other disorders as well.

DSM-5 also adopts a developmental and lifespan approach and incorporates disorders that usually first begin in childhood into the chapters with adult diagnoses. For example, information on anxiety disorders in children and adolescents is now included with the anxiety disorders for adults. The book also begins with neurodevelopmental disorders, which frequently begin in childhood, and works through disorders as they occur across the lifespan up to the neurocognitive disorders that generally occur in older adults.

Many changes have been made in specific disorders in *DSM-5* as a result of these and other advances in our knowledge about mental disorders. A dimensional approach to diagnosis of substance use, for example, eliminates the categories of abuse and dependence which were used in *DSM-IV,* and now determines diagnosis based on severity levels. Adjustment disorders, some of the most frequently diagnosed disorders in *DSM-IV*, are now considered to be a severe reaction to a stressful life event and have been recategorized as a trauma- or stressor-related disorder along with PTSD and reactive attachment disorder. These, and other changes, will be discussed throughout this text as we follow the new *DSM-5* developmental and lifespan approach.

For simplicity, and ease of use, *Selecting Effective Treatments*, 5th ed. (*SET-5*) will be consistent with the format of *DSM-5* and can be divided into three parts:

Section I This section provides basic introductory material, how to use this book, and introduces the Client Map system of diagnosis and treatment planning.

Section II This section provides the 20 classifications of disorders in the same order as *DSM-5*.

Section III This section includes an appendix of material from the fourth edition of this text to help clinicians with suicide assessment. Extensive author and subject indexes are also included.

OBJECTIVES OF TREATMENT

(D**O** A CLIENT MAP)

Generally, determination of treatment objectives and goals should be a collaborative process between the therapist and client. Many variables must be taken into account including cost considerations, and individual client variables such as readiness for change, client motivation, and expectations for treatment. Other client qualities can strengthen or weaken treatment outcomes and should be taken into account when determining treatment goals and objectives, since they are likely to have an effect on treatment outcome. They include degree of participation in treatment, severity of the disorder, willingness and ability to take action, and personality characteristics of the client (Muran & Barber, 2010; Prochaska, Norcross, & DiClemente, 2013).

Clients with very low levels of readiness to change need therapists who can focus on consciousness raising, dramatic relief, and environmental evaluation.

Resistance to change is not directly confronted by the therapist; rather, it is reframed as

ambivalence and the therapist uses his or her skills at creating the Rogerian conditions for change (empathy, congruence, and unconditional positive regard), setting up the conditions in which the client can explore both sides of the dynamic (Seligman & Reichenberg, 2013). Carl Rogers noted, "significant positive personality change does not occur except in a relationship" (Rogers, 1967, p. 73). Supporting a client's readiness for change is the goal of motivational interviewing, a person-centered approach originally created by Miller and Rollnick (2013).

Motivational interviewing helps the therapist to establish the conditions in which the client can choose to change and is often used at the beginning of treatment for conditions that may be treatment refractory such as dually diagnosed disorders, eating disorders, substance use, and gambling. Therapists who incorporate motivational interviewing into their treatment interventions are more likely to achieve success with ambivalent clients than those who do not (Stasiewicz, Herrman, Nochajski, & Dermen, 2006).

It's a well-known fact that some people improve simply as a result of having special attention paid to them (Prochaska & Norcross, 2010). This so-called Hawthorne effect can improve self-esteem, reduce anxiety, and promote improvement.

The client's readiness to change unfolds over five distinct stages: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance (Prochaska & Norcross, 2010). Each stage represents a period of time during which certain attitudes, behaviors, and language occur. Aggregate data across studies and populations found that the client's readiness to change has a significant impact on whether they take action, based on the following:

Precontemplation People in this stage have no plan to change their behaviors, although they may think about it or wish they could. To move beyond this stage they must recognize and admit they have a problem. Coaching, on the part of the therapist can help, and roughly 40% to 45% of people will move on to the next stage.

Contemplation During this stage of change, the person readily admits they have a problem and would like to change. Fortunately 35% to 40% of them will take action toward significant behavioral changes. Therapists who use Socratic questioning are likely to encourage further action—even a small first step—toward behavioral change.

Preparation During this stage, behavior and intentions are aligned and 20% of people are prepared to take action.

Action During the action stage, people begin to modify their behaviors. This stage may last from 1 day to 6 months, during which the person is acquiring skills and strategies to prevent relapse. The therapists in the action and maintenance stages provide expert advice and support when needed (Prochaska et al., 2013).

Maintenance Maintaining behavioral change for longer than 6 months is the hallmark of the maintenance stage.

The next step in the Client Map process is an overview of assessment.

ASSESSMENT

(DO **A** CLIENT MAP)

Much has been written in the past 20 years about the importance of conducting a comprehensive, measurable, clinical assessment as a necessary first step in evidence-based practice.

Over the years, clinicians have come to rely less on projective tests (e.g., TAT, Rohrschach), and become increasingly reliant on assessment tests that are both psychometrically sound and clinically useful. In other words, they rely on tests that are standardized, reliable, have concurrent and predictive validity, and are either normed or have specific criterion-related cutoff scores that make them easier to use in individual settings (Hunsley, Lee, Wood, & Taylor, 2015). The development in recent years of brief, focused assessment instruments for specific symptoms and diagnoses has been helpful.

Ultimately, the goal of an assessment is the development of a comprehensive diagnosis and corresponding treatment plan that is specific to the client's needs, that is consistent with evidence-based practice, and that will be effective in the treatment of that particular diagnosis. For that to occur, the therapist must first begin with a thorough understanding of the person. The importance of the ability to truly listen to the client and to be genuine, supportive, and flexible cannot be overly emphasized. Many of these clinician traits have been found to be positively associated with the development of a strong alliance and successful treatment outcomes. One study found that even during the assessment process, a patient- and therapist-rated alliance developed and was stronger for those using a collaborative therapeutic model than for those receiving psychological testing as usual (Hilsenroth, Peters, & Ackerman, 2004). Therapists should keep this in mind during all stages of treatment, but especially during the initial assessment process.

Important aspects of the initial intake assessment with the client will include data on the following dimensions:

- Description of the presenting problem
- Demographic characteristics and cultural background of the client
- Assessment of mental status
- Physical and medical condition of the client
- Therapist's impression of cognitive functioning, behavior, affect, and mood
- Intelligence and executive functioning (e.g., goal setting, planning, organizational ability)
- Family background and support
- Other relevant history and experiences
- Daily functioning and quality of life (assessed through direct observation and self-report)
- History of relationships, any interpersonal problems
- Lifestyle
- Educational and occupational history
- Family history of psychiatric illness
- History of prior violent or suicidal behavior
- Any other relevant information (Seligman, 2004; Strub & Black, 2000).

Clinicians will want to gather and review any relevant records, previous assessments (i.e., psychological tests, medical evaluations), and arrange to obtain releases so they can contact current medical practitioners as part of continuity of care.

Increasingly, mental health professionals are making use of semi-structured diagnostic interviews, psychological inventories, and rating scales in the preliminary assessment of client functioning. No single instrument fits all situations, and clinicians must determine what best suits their needs, always leaving room, of course, to customize questions to the specific scenario, and leaving a certain amount of flexibility to accommodate the client. Therapists are reminded that fostering a positive therapeutic alliance is far more important to the development of a facilitative relationship with the client than the gathering of specific details. This is never more true than in the initial

sessions when a client may be nervous, fearful of being judged, or uncertain of what to expect in therapy.

Structured diagnostic interviews include:

- Structured Clinical Interview for the DSM-5 (SCID-5; First, Williams, Karg, & Spitzer; 2015)
- International Personality Disorder Examination (Loranger, Janca, & Sartorius, 1997) and the SCID-5-PD (First, Williams, Benjamin, & Spitzer) for personality disorders (In Press)
- Symptom Checklist-90 Revised (Derogatis, 1994)—a 90-item checklist covering 9 symptom clusters
- Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983)—a 53 item self-report based on the SCL-90-R; easily administered in less than 10 minutes)
- Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978)

General personality inventories include:

- Millon Clinical Multiaxial Inventory-III (Millon, Millon, Davis, & Grossman, 2009)
- Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Hathaway & McKinley, 1989)

Scales to assess suicidal ideation:

- Scale for Suicidal Ideation (SSI; Beck, Steer, & Ranieri, 1988)—a 21-item rating scale that assesses suicidality.
- Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991)—a 21-item self-report.

Disorder-specific inventories are often used for diagnosis to determine the severity and frequency of symptoms, and as a baseline for future measurement. Assessments specific to each diagnosis are listed in the appropriate chapters. Some of the most commonly used include:

- Beck Depression Inventory (Beck, Steer, & Brown, 1996)
- Beck Anxiety Inventory (Beck & Steer, 1990)
- Michigan Alcoholism Screening Test (Selzer, 1971)
- Conners 3rd ed. (Conners 3; Conners, 2015)
- Behavioral Assessment System for Children–2 (BASC-2; Reynolds & Kamphaus, 2002)
- Eating Disorder Examination, 16th ed. (EDE; Fairburn, 2008)
- Drug Abuse Screening Test (Skinner, 1982)

Some measures and scales are included in *DSM-5* to help with the information-gathering process. Emerging measures found in Section III of *DSM-5* (APA, 2013) can help to provide cross-cutting symptom measures to aid in diagnosis; disorder-specific severity measures to assess severity, frequency, intensity, and duration of symptoms for specific disorders (e.g., for depression, PTSD); ratings of home background and early childhood development; and cultural formulation interviews. These cross-cutting tools do not have enough scientific evidence for support but are designed to stimulate future research. Clinicians can link into the eHRS (electronic health records) for more complex assessments of symptoms (APA, 2013, p. 745).

The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) (Üstün, Kostanjsek, Chatterji, & Rehm, 2010) is a 36-item self-report that provides a useful assessment scale that can be helpful in tracking treatment progress. Other inventories and scales are also useful to assess different aspects of the person, including intelligence,

aptitude, achievement, interests, values, and career aspirations.

Assessment is an important component of treatment planning and should be undertaken with care. Effective treatment planning is unlikely unless the clinician has made an accurate and comprehensive diagnosis and has a good grasp of the client's needs and strengths. This can only be acquired by taking the time to conduct a thorough, careful diagnostic assessment.

Throughout this book assessment measures will be discussed for each disorder, when such measures are available.

CLINICIAN CHARACTERISTICS

(DO A **C**LIENT MAP)

The therapeutic alliance—the quality of the bond between the client and therapist and how well they are able to work together to bring about therapeutic change—is the best predictor of treatment outcome (Horvath & Symonds, 1991). Individual differences between therapists are strongly predictive of the alliance quality (Laska, Smith, Wislocki, Minami, & Wampold, 2013).

A meta-analysis that looked at the role of the therapeutic alliance found that it accounted for 8% of the variance in treatment outcomes (Horvath, Del Re, Flückiger, & Symonds, 2011). Another meta-analysis of nearly 70 studies confirms the effect of the therapist on the alliance is a significant predictor of treatment outcome (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012) and this correlation may be underestimated in the literature (Crits-Christoph, Connolly Gibbons, Hamilton et al., 2011). The establishment of a collaborative relationship between the therapist and client refers not only to the bond between them but also to their ability to establish and agree on the goals of treatment (Hatcher, Barends, Hansell, & Gutfreund, 1995; Hatcher & Barends, 1996, 2006; Horvath & Bedi, 2002).

More than 50 years of research has provided a good deal of evidence on the characteristics, attitudes, and approaches on the part of the therapist that are correlated with treatment outcomes. We have also learned which ones are not important. Gender, age, and cultural background, for instance, have little influence on treatment success. Therapists who rate higher on the Rogerian conditions of empathy, congruence, and unconditional positive regard tend to develop better therapeutic alliances and have more successful outcomes than those who rank lower. This is true regardless of the therapist's theoretical orientation (Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010).

The stability of the alliance is also important; therefore any ruptures that occur must be recognized and repaired by the therapist before they become breaks. Ruptures may include misunderstandings between the therapist and client or any feelings on the part of the client of being criticized, patronized, or unsupported; basically any feeling that raises concerns in the client's mind about the trustworthiness, sensitivity, or empathy on the part of the therapist can be considered to be a potential rupture. The therapist addresses such concerns as they arise and makes a concerted effort to reassure the client and restore the therapeutic alliance.

Of course, clients will vary in their ability to form a therapeutic alliance. Those with more severe mental disorders (e.g., schizophrenia spectrum, bipolar, severe personality disorders), those who cannot trust, and those with more severe childhood attachment wounds may need additional supportive therapy in order to be able to develop a positive alliance with the therapist. In either case—whether a rupture

occurs or when a client has difficulty establishing a trusting relationship—the therapist must slow the pace of therapy, respond with empathy, address what is going on in the room with genuine concern and unconditional positive regard—the foundation on which therapy is built.

It is only by actively working to maintain the therapeutic alliance that people with severe disorders or substance abuse problems will stay in treatment and get the help they need to overcome their problems.

Other therapist variables also affect outcomes. Therapists who are emotionally healthy themselves and who are active, hopeful, optimistic, nonjudgmental, straightforward and yet encouraging of responsibility on the part of the client are the most likely to achieve a positive outcome. Following are some of the research findings related to therapist attributes that help to create and maintain a positive therapeutic alliance:

- Communicating empathy and understanding
- Maintaining high ethical standards
- Having strong interpersonal skills; communicating support, warmth, caring respect, acceptance
- A reassuring and protecting attitude
- Affirming rather than blaming clients
- Being able to help the client access and tolerate emotion
- Empowering clients and supporting their autonomy
- Being open-minded and flexible
- Being nonjudgmental and tolerant of ambiguity and complexity
- Modeling mentally healthy qualities of self-actualization, self-fulfillment, self-development, and being able to cope with their own stress
- Being authentic, genuine, credible
- Expressing optimism and hope
- Being culturally competent
- Being actively engaged with and receptive to clients
- Giving some structure and focus to the treatment process, but not being overly directive
- Being authoritative but not authoritarian, and freeing rather than controlling of clients
- Being nondefensive; being aware of their own limitations, having a capacity for self-criticism, always looking for the best way to help clients
- Focusing on people and processes, not rules
- And most importantly, establishing a positive therapeutic alliance early on, and then attending to the alliance at every stage of treatment; addressing ruptures as they occur; and managing negative processes effectively (Bowman, Scogin, Floyd, & McKendree-Smith, 2001; Greenberg, Watson, Elliott, & Bohart, 2001; Lambert & Barley, 2001; Lambert & Cattani-Thompson, 1996; Meyer et al., 2002; Muran & Barber, 2010; Orlinsky, Grawe, & Parks, 1994; Rimondini et al., 2010)

It should go without saying that the relationship between therapist and client is a professional one. Boundaries are set that are not to be broken. Clients come to therapy vulnerable and in need of support, and therapists are responsible for maintaining high ethical standards.

Several meta-analyses confirm that a quality alliance is more predictive of positive outcomes than the type of intervention used (Karver, Handelsman, Fields, & Bickman, 2006; Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). Therapists can learn to improve their alliance-building behaviors through training,

supervision, and by increasing their responsiveness with their clients (Anderson, Lunnen, & Ogles, 2010; Stiles, 2009).

Careful handling of alliance ruptures also provides the client with the chance to learn in the here-and-now of the therapy session how to relate to others and address concerns in a productive manner. This can be used outside of therapy in their relationships with others (Stiles et al., 2004).

Little research is available on the relationship between therapist experience and treatment outcome. What research is available is inconclusive. Some research indicates that having more experience does not guarantee a better working alliance (Hersoug, Hoglend, Monsen, & Havlik, 2001), and two studies found expertise to be more important than theoretical orientation (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005). To date, other therapist variables, such as the amount of the therapist's training, the amount of professional expertise, or the therapist's professional discipline (e.g., psychologist, counselor, social worker) have not been found to be related to treatment outcomes. One early study (Berman & Norton, 1985) found that professionals and paraprofessionals were equally effective.

Therapist demographic variables such as gender, race, and religion, and clinical expertise have not been found to be related to therapeutic outcome (Bowman et al., 2001; Wampold & Brown, 2005). A meta-analytic review of more than 60 studies on therapist gender showed that gender had no effect on treatment outcomes (Bowman et al., 2001), or drop-out rates (Cottone, Drucker, & Javier, 2003). However, it should be noted that the gender of the therapist may be important to some clients. Even if gender matching does not lead to improved outcomes, it may enhance the therapeutic alliance to honor such requests and may be worth considering.

Therapist age, when linked to therapist's interpersonal skills, had a significant effect on treatment outcomes in one study by Anderson and colleagues (2009). Clients seem to prefer a therapist who is old enough to understand the client's age-related and developmental issues, and who is mature enough to have sufficient experience, but not so old as to have outmoded ideas or beliefs about treatment.

Therapists must also be aware of how their own worldviews and those of their clients shape their experiences and assumptions. Every person, therapist and client alike, will have a variety of dimensions in which they identify themselves (e.g., age, gender, race). Therapists must be culturally competent in their work with clients, recognizing that everyone is unique and will have experiences and backgrounds that differ from their own in one or more ways. The mnemonic ADDRESSING can be a good way to remember the wide range of social "locations" that we all come from. ADDRESSING stands for Age, Disability (acquired), Disability (developmental), Religion and spirituality, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, Gender/sex (Hays, 2001, 2008). Understanding a person's culture can be as important as knowing their family background and can make treatment more effective (Hays, 2009; Schnyder, 2009).

Therapists should also be aware of any personal traits, such as being too critical or demanding, that might detract from the development of a solid working alliance. Defensiveness, excessive use of techniques, and over- or understructuring sessions can all interfere with the development of a therapeutic alliance (Sharpless, Muran, & Barber, 2010).

LOCATION OF TREATMENT

(DO A C**L**IENT MAP)

In 2012, 34.1 million adults in the United States (14.5% of the population) reported having used some type of mental health treatment or counseling in the previous 12 months. Of those people, 12.4% used prescription medications, 6.6% sought counseling or other outpatient mental health services, and 0.8% used inpatient hospitalization (SAMHSA, 2013).

The setting in which mental health treatment is provided varies between inpatient and outpatient programs. In general, the treatment location will be determined by the following considerations:

1. The danger that the client poses to self or others
2. Diagnosis, and nature and severity of symptoms
3. Goals and objectives of treatment
4. Cost of treatment and consideration of insurance coverage and the client's financial resources
5. Client's current living situation and support systems
6. Nature and effectiveness of prior treatment
7. Client preferences (Seligman, 2004)

The least restrictive setting that provides optimal care for the person's needs and the disorder is often the best choice. If the setting lacks resources the person needs or is overly restrictive, it may not be therapeutic. Managed care may also require the use of the most cost-effective treatment, for example, requiring that outpatient treatment for substance abuse is considered before inpatient treatment will be considered.

Determining the best treatment placement for an adult, adolescent, or a child requires weighing a variety of complicated and interrelated factors. Often the decision is made based on insurance coverage and other financial considerations. Options typically include residential treatment, inpatient hospitalization, partial hospitalization program (PHP), or outpatient treatment. The research literature provides little guidance, so decisions must be made based on sound clinical judgment. A brief description of each follows.

Residential Treatment

Residential treatment programs are often considered for those with severe eating disorders (e.g., anorexia), chronic substance use disorders that have not responded to outpatient treatments, and those who require additional intensive treatment following inpatient psychiatric care. Children and adolescents with serious emotional and behavior problems may be placed in residential treatment so they can receive 24-hour supervision and monitoring by trained staff. Often, educational requirements will be maintained. Placement in a residential treatment program is usually for an extended period of time.

Inpatient Hospitalization

Hospitalization for treatment of mental health issues is usually required in crisis situations, when clients need to be closely monitored and when helping to adjust or stabilize the client's medications. Inpatient hospitalization is significantly shorter than residential treatment and may range from overnight to less than a few weeks in most cases. The average

length of an inpatient hospitalization for mental disorders was 7.2 days (Centers for Disease Control, 2010). Inpatient hospitalization may be appropriate for people who are a danger to themselves or others, as when suicidal or homicidal ideation is present. Treatment programs are usually highly structured. Patients are likely to be discharged from the hospital to a less restrictive setting such as a PHP or outpatient treatment as soon as practicable.

Partial Hospitalization Programs (PHPs)

PHPs and day-treatment programs are highly structured programs focused on the specific needs of the client (e.g., substance use, depression, dual diagnosis, eating disorders). These programs allow people to live at home while attending treatment during the day. PHPs often serve as transitional treatment from residential or hospitalization programs. Day treatment can be an effective and less costly option for people who do not need 24-hour care. "Stepped-down" half-day programs, or weekly group meetings that help to maintain treatment gains usually follow PHP programs. Limited research shows that day treatment is beneficial for the treatment of psychosis, mood disorders, anxiety disorders, and borderline personality disorder (Lariviere, Desrosiers, Tousignant, & Boyer, 2010). Preliminary research specific to adolescents with a mood disorder found the PHP program decreased symptom severity and was considered by the adolescents to be an acceptable form of treatment (Lenz, Del Conte, Lancaster et al., 2013). PHP treatment also reduces costs to third-party and private payers (Garfield et al., 2010).

Outpatient Treatment

The majority of treatment for mental health disorders takes place in outpatient settings that include private practice, community mental health centers, and agencies that focus on specific populations or problems (e.g., domestic violence, children, multicultural, suicide prevention). According to 2012 statistics, of those who sought outpatient treatment for a major depressive episode, the majority of people (58.5%) did so at their physician's office. More than 34% saw a psychiatrist or psychotherapist; 24.6% went to a counselor's office; 24.3% saw a psychologist, 19% sought religious or spiritual advice; 11.6 % saw another medical doctor, 11.4% went to a social worker, and 7% saw another mental health professional (SAMHSA, 2013).

INTERVENTIONS

(DO A CLIENT MAP)

The growing number of psychosocial options for the treatment of mental health disorders create new possibilities for millions of people. Currently, more than 400 different non-medication-related treatment interventions are known to exist, and many more are evolving. New technology-assisted treatment delivery methods are making it possible for more people than ever before to receive treatment, even those who cannot leave their own homes.

New mindfulness- and acceptance-based approaches are helping people to control rumination, anxiety, and depression, and many therapists are moving toward transdiagnostic treatment approaches that focus on related symptoms rather than theoretical orientation.

Each of these new modes of treatment provides additional options for more specialized treatment geared exclusively to the client experiencing a specific disorder.

More and more frequently, therapists are saying "I was trained in X, Y, or Z approach, but now I have expanded into CBT, mindfulness, existential, or interpersonal therapy." Many

prefer to work together with the client to establish a solid working relationship in which they can collaboratively determine what approach will work best.

In the 1980s, much was revealed about the importance of the therapeutic alliance in the creation of evidence-based treatments. Then came research on common factors that are found in all successful therapies, regardless of the diagnosis, such as the therapeutic alliance, client motivation, therapist skill, and the effect of the collaborative relationship on treatment success. It is becoming more and more difficult to advocate for one theoretical orientation or treatment modality, as the research begins to make clear that most treatments are effective, if certain conditions are met. One of the most widely studied common factors is the therapeutic alliance. That the strength of the alliance is related to treatment outcome has been verified over the years in numerous studies and meta-analyses (Del Re et al., 2012; Gaudiano, Dalrymple, Weinstock, & Lohr, 2015; Martin et al., 2000).

Today, the experienced therapist, knowledgeable in evidence-based practice, knows the following truths:

- The alliance is responsible for a large part of the success of therapy.
- The alliance consists of the therapist and the client, and the relationship that develops between them.
- Some treatments are evidence-based for use with certain disorders (e.g. exposure therapy for specific phobias; dialectical behavior therapy [DBT] for borderline personality disorder).

With case formulation providing the foundation, treatment recommendations should first consider evidence-based treatments that are available (Chorpita, Daleiden, & Weisz, 2005). A wealth of treatment intervention options are available, and setting goals and objectives for treatment should be a collaborative exercise with the therapist providing the expertise about treatment recommendations, while being flexible enough to tweak the recommendations to the needs of the client. In some cases, comorbid disorders will need to be addressed before treatment can begin in earnest. For others, relationship issues, emotional dysregulation, or symptoms of personality disorders may need to be addressed.

Empirically Supported Treatments

The American Psychological Association began tracking empirically supported treatments (ESTs) in 1993 through its Division of Clinical Psychology. In 1995, the first list of ESTs was created that met the criteria for different levels of support. "Well-established treatment" requires either of the following: (1) two randomized trials that demonstrated efficacy compared with a placebo or another established treatment or (2) a large series of single-case design experiments. "Probably efficacious treatment" has fewer restrictions.

American Psychological Association's Presidential Task Force on Evidence-Based Practice (2006) established a website listing the best available research evidence which, when combined with clinical expertise of the therapist, and client characteristics and values, provides the best evidence-based practices available. The list can be sorted by disorder or by 75 treatments that have met the criteria for empirically supported treatment. When the Division 12 Task Force published its first list of ESTs in 1995, only 18 treatments were identified as having empirical support; today there are over 75, many of them with well-established research support.

Many of the research-supported psychological treatments (e.g., social skills training for schizophrenia and stress inoculation

training), have become standards in most therapist's repertoire. Other ESTs are treatments recently added, such as acceptance and commitment therapy for chronic pain, CBT for social anxiety, and prolonged exposure for PTSD. Some of the other ESTs are listed here. The complete list is available online at www.div12.org, along with information on clinical trials, bonus material, and links to training manuals and interactive content.

- Acceptance and commitment therapy for chronic pain, depression, mixed anxiety, psychosis, and OCD
- Cognitive behavioral therapy for ADHD, eating disorders, generalized anxiety disorder (GAD), specific phobias, social anxiety, panic-disorder, schizophrenia, and PTSD
- Behavioral couples therapy for alcohol use disorders and depression
- Dialectical behavior therapy for borderline personality disorder
- Eye movement desensitization and reprocessing (EMDR) for PTSD
- Emotion-focused therapy for depression
- Family-focused therapy for bipolar disorder
- Family-based treatments for anorexia and bulimia nervosa
- Interpersonal therapy for binge-eating disorder, bulimia nervosa, and depression
- Exposure and response prevention (E/RP) for OCD
- Exposure therapies for specific phobias
- Schema-focused therapy for borderline personality disorder
- Social learning/token economy programs for schizophrenia
- Social skills training for schizophrenia
- Supported employment for schizophrenia

The American Psychological Association's Division 53 maintains a list of evidence-supported treatments for children and adolescents. The most well established are:

- CBT and interpersonal psychotherapy (IPT) for depression
- Behavior therapy for ADHD and autism spectrum disorders
- Family therapy for eating disorders
- Trauma-focused CBT for anxiety
- Parent management training for oppositional defiant disorder and conduct disorder

The website (effectivechildtherapy.org) contains other promising treatments and is updated on a regular basis as a community service to the public.

Other resources for evidence-based treatments include the National Institute for Health and Clinical Excellence (NICE) and the National Registry of Evidence-Based Programs and Practices (NREPP). Each of these organizations is listed in the resources section at the end of this chapter.

Although ESTs have been identified for many disorders, a comprehensive list of effective treatments for every disorder does not exist. In some cases, several different treatments have been found to be effective (as is the case with anxiety and mood disorders, schizophrenia, and borderline personality disorder). In other cases, no treatment approaches have received strong research support. In this text, the focus is primarily on what treatment interventions are efficacious and offer the best treatment options for clients. When that research is not available, case reports in the literature can help to provide some guidance, as can related treatments from similar disorders be used to extrapolate potential outcomes. The interventions section for each

disorder will describe evidence-based treatments if they are available for that disorder or it can provide other treatment recommendations that have some research support.

A "research–practice gap" seems to separate the time when a treatment intervention is determined to be efficacious and when the intervention becomes common practice. One study found that most therapists are not trained in evidence-based treatments (Schnyder, 2009). However, most clients do not look for a therapist based on their theoretical orientation. Many ESTs are manual-based, and some clients feel put off by treatment manuals. Whether manual-based or not, a later study by Schnyder found that 20% of clients dropped out of empirically supported therapies.

Clearly there are some modes of therapy that are harmful and should not be used. Some may have ambiguous research results or the research study itself may be flawed. Clinicians are responsible for choosing the treatment methodologies used in therapy and have a professional responsibility as part of the broader medical community to abide by the Hippocratic oath to "First, do no harm." The use of treatments that are not evidence-based should be done with caution. Treatments known to cause harm or to result in decrements in care should not be used at all.

A gray area exists, however, in treatments that have not been well researched but are being used extensively by therapists. This has been the subject of much controversy in the professional literature, and it must be noted that some of the so-called controversial treatments of a decade ago have become the newer evidence-based treatments of today. Readers are encouraged to conduct due diligence before implementing novel and unsupported therapies, especially when there is little or no underlying theoretical basis (Pignotti & Thyer, 2015). A compelling and comprehensive look at the overarching controversies in psychological treatment can be found in Lilienfeld, Lynn, and Lohr (2015).

Experienced therapists also know that there are many different ways to foster success in client outcomes. Beginning with the very first telephone call from a client, they work toward the creation of a collaborative, professional, and therapeutic relationship. It is this relationship on which most therapeutic change is grounded.

When to Recommend No Treatment

Research-based practice looks at all options for treatment, and the option of no intervention at all must be considered. The fact is, as many as 5% to 10% of people who receive treatment deteriorate during the process (Lambert & Ogles, 2004). Although little research is available on the negative effects of psychotherapy, it appears that no treatment at all might be the best recommendation in the following specific situations:

- Clients with an established history of multiple-treatment failures.
- Clients who are in the process of litigation (e.g., divorce, child custody dispute, court-ordered treatment). These clients may have an ulterior motive for seeking treatment and might, therefore, obfuscate or otherwise confound treatment.
- New clients who attend therapy for the expressed purpose of filing a disability claim and may have an investment in failing to make progress.
- People with malingering or factitious disorders who receive secondary gain from attending therapy sessions but have no motivation or intention to change.
- People who are at increased risk of having a negative response to treatment,

including those with ingrained personality disorders (e.g., narcissistic, borderline, obsessive compulsive, antisocial), those with oppositional or aggressive personality patterns, or people who are destructive to self or others.

Other causes of treatment deterioration include a mismatch between therapist and client on goals. Such lack of congruence often results in clients dropping out of treatment (Antony & Barlow, 2011). Assessing readiness for change, as discussed earlier, can often reduce such treatment failures. The recommendation of no treatment is designed to protect clients from harm, prevent negative therapy experiences, and delay treatment until the client is more receptive. In some cases, people may come to therapy merely out of curiosity and to see what it is all about. In the absence of an identifiable disorder or condition, they should be informed that they would most likely not benefit from therapy. Although the recommendation of no therapy may be the best choice, discouraging people from beginning therapy when it is difficult to know if they actually might benefit may be counterintuitive, and many therapists may be unwilling to use this option.

EMPHASIS

(DO A CLI**E**NT MAP)

Clinicians tend to adapt models of psychotherapy to fit their own personal styles and to fit the individualized needs of particular clients. Even within the same treatment modality, different therapists will apply the method differently. Clients will also have their own effect on treatment. It can even be said that the application of an approach to psychotherapy differs from one therapeutic relationship to another. The dimensions of therapy discussed in this section reflect some of the ways in which treatment is adapted to the individual through various areas of emphasis.

Directive Versus Evocative

Therapeutic approaches can be directive, evocative, or mixed. The directive approach has been correlated with a focus on goal attainment and lower-than-average levels of therapeutic alliance (Hersoug, Hoglend, Havik, von der Lippe, & Monsen, 2009; Malik, Beutler, Alimohamed, Gallagher-Thompson, & Thompson, 2003; Muran & Barber, 2010). Evocative approaches emphasize processes such as catharsis and abreaction; genuineness, empathy, and reflection of feeling; support; and unconditional positive regard. Even criticism or confrontation is supportive. Sometimes therapists mix approaches; initially being more evocative and supportive in assessment or symptom focus, and more directive in treatment in cognitive and behavioral goals.

Directive approaches generally seek to change behavior or cognitions. The therapist is in charge, determines treatment, and targets specific symptoms or goals. Any of the techniques in the cognitive behavioral spectrum will be drawn on to help the client experience real behavioral change. Systematic desensitization, flooding, positive reinforcement, token economies, Socratic dialogue, bibliotherapy, and other techniques within the session, reinforced between sessions with assignments, journaling, bibliotherapy, and behavior charts to reinforce learning. Albert Ellis, founder of rational emotive behavior therapy, encouraged clients to formulate experiments they could conduct between sessions and discuss the results in greater depth at the next session. In all directive approaches, the therapist assumes an

authoritative stance, defines target concerns, and oversees a specific program designed to change overt and covert symptoms.

Alternatively, an evocative approach seems more likely to be successful with people who are self-directed and more able to participate in a sound alliance between client and therapist (Malik et al., 2003; Sharpless et al., 2010). Approaches that are process-experiential, psychodynamic, and humanistic (e.g., Gestalt, person-centered, emotion-focused) models are generally low on direction and high on evocativeness, trusting the client to determine the focus of the session based on their own sense of priority. Evocative therapies are more process-experiential and view the person as the expert on his or her own life and, therefore, the one best able to solve the problem.

Exploration Versus Support

Another dimension that has been the subject of little focus in the literature but is an important aspect of treatment is the dimension of exploration versus support. Those that focus on exploration are typically analytical, probing, and interpretive. Recognition of past influences and patterns of behavior are stressed in an effort to promote insight. By contrast, approaches that emphasize support tend to focus on the present with a goal of symptom relief and behavioral change.

However, research has concluded that insight is not always necessary for change to occur (Wallerstein, 1986). In 45% of cases, changes seemed to go beyond the level of insight that was attained, whereas insight surpassed discerned change in only 7% of the cases. Overall, Wallerstein concluded that supportive therapy was more effective in these cases than had been expected, and it did not seem to be less effective than exploratory therapy. Indeed, Schnyder (2009) states that 70% of therapy is supportive therapy with or without medication, despite the lack of empirical support for this treatment modality.

Supportive psychotherapy provides empathy, encouragement, and reassurance and helps to enhance the client's self-esteem at a time when he or she is in crisis, is recovering from a diagnosis of a serious mental illness (i.e., bipolar, schizophrenia, dementia), or has decompensated to the point where unconditional acceptance, active listening, and empathy provided in a safe environment is necessary to provide containment, to build a therapeutic alliance, and to instill hope, so that, eventually, psychoeducation, cognitive restructuring, problem solving, or environmental change can take place.

Supportive therapy has been defined as an intervention designed to strengthen ego functioning, reality testing, and clarity of thought so that the person can resume, or continue on with the skills of daily living. Rockland (2003) outlined an approach to supportive therapy that provides both supportive and exploratory interventions. By finding the right mix of support and exploration, the therapist can tailor the interventions to best fit the client's needs in a particular situation.

Other Aspects of Emphasis

How much the treatment focuses on the past, the present, or the future is also an important dimension of treatment that will be influenced by the client's needs in conjunction with the therapist's predilections, among other considerations. Adapting a treatment approach to a specific person, as well as knowing when to focus on aspects of one theoretical orientation over another are often determined by therapeutic instincts.

Most therapists intuitively determine whether their clients need high or low levels

of support; which aspect of treatment to stress, whether they should focus on behavior, cognitions, or emotions; and how directive they should be. More research on these dimensions of treatment would facilitate better treatment planning and help students learn to frame treatment to better meet the client's individual needs. This may contribute to why some therapies work better than others for specific clients.

NUMBERS

(DO A CLIE**N**T MAP)

Numbers, in the DO A CLIENT MAP mnemonic, refers to who is in therapy. Deciding who should be treated is an important role of the therapist. Most disorders lend themselves to individual, one-on-one treatment between therapist and client. Disorders involving children, such as oppositional defiant disorder or conduct disorder, are best treated with a parental management component or family counseling. Group treatment is another consideration. Each of these will be discussed more fully.

Individual Therapy

People who are experiencing immediate problems, a crisis situation, or those whose problems might cause them shame or embarrassment in a group setting are best treated with individual therapy. At least in the beginning of treatment, individual therapy can help people who are feeling vulnerable, depressed, bereaved, low in self-esteem, or passive to receive the help they need. Individual therapy is usually a good choice, especially for those who are in treatment for the first time. But individual therapy does have some limitations since it encourages transference, reduces the amount of feedback provided to the therapist, and offers little opportunity to address family dynamics or other interpersonal issues that may be the root of the problem. Any new interpersonal behaviors that are learned must be tried outside the therapist's office, and reported back. Many people who start in individual therapy will later switch to group therapy where they will receive more instruction in group dynamics.

Group Therapy

Group therapy offers a therapeutic environment that is more similar to everyday life and provides an arena for interaction and learning. Group therapy can help to normalize problems, promote self-esteem, and reduce shame. It is generally the first choice for interpersonal problems involving withdrawal, competitiveness, shyness, aggression, and problems with authority (Fenster, 1993). Group therapy has been shown to be effective for multiple disorders and in multiple situations including substance abuse, eating disorders, and bereavement (Reichenberg, 2014).

Therapists who work in group situations must be familiar with group dynamics, and consider not only how the individual will benefit from group therapy but also how the group will be influenced by the individual. Ideal clients for group therapy seem to be those who are aware of their interpersonal difficulties and motivated to change. They must be able to give and accept feedback in an appropriate manner and willing to take some responsibility for their actions. Therefore, people who are fearful, self-centered, overly aggressive, or confused are generally not good candidates for group therapy. They might not benefit much from group therapy, or may even have a harmful impact on the group. For group therapy to be helpful with these clients, it should probably be deferred until more progress has been made in individual therapy.

Types of therapy groups vary. Some groups may be transdiagnostic—offering the same skills or training to a heterogeneous group of people (i.e., anger management skills for men and women; impulse control for people with a variety of behavior disorders; emotion regulation for all types of eating disorders). In group therapy, people with similar problems can often learn coping skills from one another, benefit from feedback and modeling, and receive support and validation. An important part of most groups is the focus on group interactions and building interpersonal skills.

Couples and Family Therapy

Interventions for couples and families are effective, in general, and those that are specific to some problems or disorders may be more effective than alternative treatments. Evidence-based research is available on couples therapy and suggests that empirically supported treatments include emotion-focused couples therapy (Greenberg & Johnson, 1988; Johnson, 2004), relationship enhancement therapy (Guerney, 1977, 1994), and behavioral couples therapy (BCT) for the treatment of substance abuse (Ruff, McComb, Coker, & Sprenkle, 2010).

Research on family systems has also found that specific types of family therapy receive empirical support when applied to specific disorders, including anorexia nervosa (Wilson & Fairburn, 2007) and depressive and schizophrenia spectrum disorders (Barlow & Durand, 2008). One in five children currently meet the diagnostic criteria for a mental disorder. Additionally, 50% of adult disorders were first manifested in childhood (Hunsley & Mash, 2012). Childhood disorders such as ADHD, oppositional defiant disorders, and conduct disorders will usually include family therapy as a component or adjunct treatment (Kazdin, 2008). People with bipolar disorders, substance-use disorders, eating disorders, OCD, and other disorders that have a genetic or familial component are also likely to benefit from family therapy (Finney, Wilbourne, & Moos, 2007; Miklowitz & Craighead, 2007). Earlier childhood assessment and treatment and the integration of family therapy into treatment planning for these disorders can be found in the relevant chapters of this book.

As with individual therapy, the therapeutic alliance in family therapy is established early on—generally in the first three or four sessions (Robbins, Turner, & Alexander, 2003).

When working with families, the therapeutic alliance involves establishing multiple alliances across a multigenerational system. The alliance created with each family member affects and is affected by the alliance with all other family members and cannot be considered in isolation (M. Beck, Friedlander, & Escudero, 2006).

Research on family therapy has found that alliances become stronger when:

- The therapist and family members collaborate on goals for treatment.
- The therapist created the necessary conditions for the development of a therapeutic alliance (empathy, warmth, and unconditional positive regard).
- The therapist was optimistic and able to instill hope.
- The therapist was active in sessions (M. Beck et al., 2006)

The client's perception of the alliance, not the therapist's, is the better predictor of treatment outcome. In addition, research found that in family therapy, the woman's perception of the alliance was more important than the man's perception in predicting treatment outcome

(Quinn, Dotson, & Jordan, 1997). A weak alliance in family systems therapy is predictive of a negative outcome.

TIMING

(DO A CLIEN**T** MAP)

Timing refers to treatment frequency and duration, both of which can vary. Most outpatient therapy occurs once a week in sessions 50- to 60-minutes in length.

Toward the end of therapy, sessions are often reduced to every other week as a way of easing the transition of termination. In contrast, classic psychoanalysis commonly involves five sessions a week.

Treatment duration also varies widely. Research on this varies, but most of the therapeutic effect of therapy is likely to occur within the first 10 to 20 sessions (Schnyder, 2009).

A meta-analysis that looked at the relationship between length of therapy and therapeutic outcome concluded that the total number of sessions and the duration of treatment are positively correlated to therapeutic benefit (Orlinsky & Howard, 1986). Not all studies showed the same outcome, but many indicated that short-term therapy can have a significant and lasting positive impact, but only for some disorders and some clients. For example, brief therapy is indicated in the aftermath of a crisis, such as a suicide attempt, trauma, or national disaster (Roberts, 2002).

If client problems are related to stress, dysfunctional behaviors, academic problems, or interpersonal difficulties and career concerns, then short-term cognitive therapy seems to work best (Littrell, Malia, & Vanderwood, 1995). Brief psychodynamic psychotherapy is suitable for depression (Luborsky et al., 1996). In general, short-term therapy seems to be effective for three quarters of clients. Because of its time-limited nature, many clients will feel encouraged to be more focused and get the most out of treatment.

MEDICATIONS NEEDED (IF ANY)

(DO A CLIENT **M**AP)

As mentioned earlier, this book is directed to clinicians who do not themselves prescribe medication; therefore, the focus of the medication section in each chapter will vary based on the diagnosis. For example, most people experiencing an adjustment disorder will not need medication. For others with more severe disorders such as bipolar disorder or schizophrenia, medication will usually be the main focus of treatment, and psychotherapy will provide adjunctive support.

Medications are used in combination with therapy to treat a variety of disorders including ADHD, major depressive disorder, anxiety disorders, and others. Severe mental disorders (e.g., schizophrenia spectrum disorders, bipolar disorders, neurocognitive disorders, and some neurodevelopmental disorders) are primarily managed through medications, with adjunct individual and family therapy. Still other disorders, if the situation warrants, may add the off-label use of a prescription drug to enhance the effectiveness of psychosocial treatment, or to reduce the severity of symptoms (as in borderline personality disorder, dissociative disorders, or adult ADHD). For those who are prescribed medications, ongoing assessment of medication compliance is often an important part of psychotherapy and reflects a holistic approach to treatment (Pratt & Mueser, 2002). In some situations, the combination of medication and psychotherapy has a synergistic effect, especially in the treatment of major depressive disorder. The medication acts first

to reduce vegetative symptoms, provide energy, and promote optimism. This enables the person to be able to make good use of psychotherapy, which in the beginning provides supportive and compassionate care to help instill hope and later helps the client move toward stability and recovery, which, due to the synergistic combination of both therapy and medication, is more likely to last longer.

Every clinician should have an up-to-date copy of a comprehensive medication manual to familiarize themselves with new medications, their interactions, and side effect profiles.

Nonmedical clinicians who have a good understanding of the role different medications can play in the treatment of mental disorders will be able to determine when a client's progress might be accelerated or improved by a referral for a medication evaluation. Therapists often collaborate with physicians and psychiatrists as part of collaborative care and will need clients' medication information readily available when developing treatment plans, when consulting with doctors and psychiatrists, and in the consideration of medication interactions or side effects.

The following brief list is provided to familiarize the reader with the psychotropic medications that are available. All readers should have their own comprehensive medication manual.

Five different groups of psychotropic medications are available—antipsychotics, antidepressants, mood stabilizers, anxiolytics, and other medication. Following is a brief overview of each:

Antipsychotic medications Antipsychotic medications are primarily prescribed for the treatment of schizophrenia spectrum disorders, bipolar disorders, and other disorders that involve delusions and hallucinations. Some people with other disorders (e.g., borderline personality disorder, Tourette's disorder, severe cognitive disorders) may also be prescribed antipsychotics "off label," for the relief of specific symptoms.

Older antipsychotics include:

- phenothiazines (e.g., Thorazine, Prolixin, Mellaril, and Stelazine)
- haloperidol (Haldol)

Newer atypical antipsychotics with better tolerability and fewer extrapyramidal side effects have been approved by the FDA. They include:

- Clozaril (clozapine)
- Geodon (ziprasidone)
- Risperdal (risperidone)
- Invega (paliperidone)
- Zyprexa (olanzapine)
- Zyprexa Relprevv (olanzapine pamoate, injectible)
- Seroquel (quetiapine)
- Abilify (aripiprazole)
- Saphris (asenapine maleate)
- Fanapt (iloperidone)
- Latuda (lurasidone)

Updates and adverse drug reactions are available from www.fda.gov/DrugSafetyCommunication.

Antidepressant medications The following categories of antidepressants are available:

- Tricyclic and heterocyclic antidepressants
  - Tofranil (imipramine)
  - Pamelor (nortriptyline)
  - Vivactil (protriptyline)
  - Surmontil (trimipramine)
  - Norpramin (desipramine)
  - Elavil (amitriptyline)
  - Asendin (amoxapine)

- Monoamine oxidase inhibitors (MAOIs):
  - Emsam Selegiline (skin patch)
  - Nardil (phenelzine)
  - Parnate (tranylcypromine)
  - Marplan (isocarboxazid)
- Selective serotonin reuptake inhibitors (SSRIs) are effective in the treatment of depression as well as disorders such as eating disorders and somatic symptom disorders. SSRIs can also help to reduce anxiety when it is associated with depression. All SSRIs include an FDA "black box" warning on the package insert, alerting users that SSRIs can increase suicidal thoughts and actions in children, adolescents, and young adults. SSRIs include:
  - Prozac, Sarafem, Symbyax (fluoxetine)
  - Zoloft (sertraline)
  - Celexa (citalopram)
  - Lexapro (escitalopram)
  - Paxil, Paxil CR, Pexeva (paroxetine)
  - Luvox (fluvoxamine)
  - Viibryd (vilazodone)
- Selective serotonin and norepinephrine reuptake inhibitors (SNRIs) affect levels of both serotonin and norepinephrine. SNRIs include:
  - Cymbalta (duloxetine)
  - Effexor (venlafaxine)
  - Remeron (mirtazapine)
  - Pristiq (desvenlafaxine)
- Atypical antidepressants:
  - Wellbutrin (bupropion)
  - Nefazodone
  - Desyrel (trazodone)
  - Ludiomil (maprotiline)

Mood Stabilizers The best-known mood stabilizer is lithium. It is effective in reducing symptoms of mania, depression, and mood instability associated with bipolar disorders, cyclothymia, and schizoaffective disorder. Other mood stabilizers include topiramate (Topamax), divalproex (Depakote), valproic acid (Depakene), and lamotrigine (Lamictal).

Anxiolytics Antianxiety drugs/benzodiazepines reduce anxiety, panic attacks, seizures, and insomnia. They are also used to facilitate withdrawal from drugs or alcohol, to control aggression related to drug use, and to enhance the impact of antipsychotic medications. Some of these drugs are very addicting and should be prescribed in low quantities or not at all in the case of people who develop addictions or who are depressed or suicidal—alprazolam (Xanax), lorazepam (Ativan), diazepam (Valium), and clonazepam (Klonopin).

Stimulants Stimulant medications can be prescribed to improve attention and impulse control for adults and children with ADHD. Following are the stimulants approved by the FDA. Age restrictions have been set for each medication, and some have not been approved for treatment of adult ADHD. The most common side effects of psychostimulants include decreased appetite and sleep problems.

- Ritalin, Concerta, Daytrana patch, Metadate, Methylin (methylphenidate)
- Adderall (amphetamine mixed salts)

- Dexedrine (dextroamphetamine)
- Vyvanse (lisdexamfetamine)

Nonstimulant Medications Strattera was the first nonstimulant medication approved for the treatment of ADHD in children, adolescents, and adults. Other nonstimulants approved by the FDA include Intuniv (guanfacine) for children ages 6 to 17, and Kapvay (clonidine) for use alone or in combination with a psychostimulant. As with all medications, the risks and side effects must be weighed against the benefit of taking the drug. These decisions should be made with the advice of a medical doctor.

Alcohol and Other Substance Withdrawal Several medications are helpful in reducing addictions including naltrexone (ReVia) and methadone. Benzodiazepines are also sometimes used to ease the symptoms of withdrawal from substance abuse. Antipsychotics may also be helpful if anxiety and agitation are accompanied by psychosis or paranoia.

Other Medications Some medications are prescribed "off label" for use in the treatment of psychiatric disorders. This means that the medication has been approved by the FDA, but not specifically for that purpose, even though some efficacy for its use does exist. Beta-blockers, for example, which are commonly prescribed for the treatment of high blood pressure, may also be prescribed to reduce symptoms of anxiety disorders (Preston, O'Neal, & Talaga, 2013).

Throughout this book, when medication has been determined to be an evidence-based practice for a specific disorder, it will be listed in the intervention strategies for that disorder.

ADJUNCT SERVICES

(DO A CLIENT M**A**P)

Referrals for adjunct services should be made when they reinforce the goals of therapy. Examples of appropriate adjunct services include an exercise program to reinforce weight loss, volunteer services to improve socialization, mindfulness to increase relaxation, and biofeedback to help clients recognize bodily sensations.

Nearly 50% of clients who have one *DSM-5* diagnosis are likely to have two. As treatment focuses on the main disorder, adjunct services may help with symptoms of the secondary disorder. This may occur while therapy is ongoing, or at the end of treatment, when a client may decide to seek treatment for secondary issues that have been raised in therapy but were not the main focus of attention. Referrals for couples counseling, family therapy, mindfulness-based stress reduction, or career counseling might be appropriate, depending on the person's goals. Therapists who stay abreast of community services offered in their area will be able to make appropriate referrals if the need arises in their clients. Most counties have a Community Services Board that helps provide information about mental health resources in the client's specific area.

The Internet can play an effective educational and therapeutic adjunct service to the therapist's treatment goals and objectives. A few examples of reputable online mental health sites include:

- www.nami.org
- www.mayoclinic.com/health/depression-and-exercise/MH00043
- www.webmd.com/depression/guide/understanding-depression-prevention
- http://mhrecovery.com/resouces.htm

- suicidology.org—provides grief support following loss due to suicide

Many people now have smartphones and use them to access information online about mental health. A percentage of them also download apps to help them remember to take their medications, exercise, meditate, track moods, biofeedback, or for other health-related concerns. Apps such as the Tactical Breather app help people use controlled breathing to thwart a panic attack. Another app for PTSD provides veterans with suggestions and hotline numbers they can use in situations in which they feel overwhelmed. Even social media such as Facebook can provide a community watch function, by providing information, monitoring, and follow up to Facebook users who express concerns about their own, or a friend's mental health.

PROGNOSIS

(DO A CLIENT MA**P**)

Nearly 50% of people in the United States will experience a mental health disorder at some point in their lifetime. With treatment, nearly 80% of them will recover. The prognosis for most disorders will depend on two variables—the nature and severity of the disorder and the client's motivation to make positive changes. More serious illnesses, such as schizophrenia or bipolar disorder, will take a more chronic life course.

TREATMENT RECOMMENDATIONS: THE CLIENT MAP

The CLIENT MAP method will be reinforced throughout this book. Each chapter will begin with a case study and end with two Client Maps—one that provides general information for all of the disorders listed in that category, and a second Client Map that is specific to the case study.

This chapter started with several case studies. Below is a sample Client Map for Jillian, a 14-year-old girl who has been diagnosed by her psychiatrist as having obsessive compulsive disorder.

Diagnosis

- Obsessive compulsive disorder

Objectives of Treatment

- Reduce obsessive thoughts and compulsive behaviors related to disorder
- Reduce levels of related anxiety and depression
- Treat any co-occurring disorders

Assessments

- Yale-Brown Obsessive Compulsive scale (Y-BOCS)
- Other scales for relevant symptoms (i.e., depression, anxiety)
- Assess for the presence of co-occurring disorders, specifically other disorders related to impulse control (e.g., eating disorders, gambling, substance abuse disorders)
- Assess for history of commonly co-occurring disorders first diagnosed in childhood: ADHD, tic disorder, Tourettes disorder

Clinician Characteristics

- Patient, supportive, and encouraging
- Able to be directive and firm, yet also collaborative

- Comfortable with a broad range of behavioral and cognitive interventions

Location of Treatment

- Outpatient setting

Interventions to Be Used

- Cognitive-behavioral and behavior therapy, especially recognition and modification of distorted cognitions
- Controlled exposure and ritual prevention (E/RP) to reduce anxiety

Emphasis of Treatment

- Present-oriented
- Moderately directive
- Supportive

Numbers

- Individual (group therapy is not advised for OCD)

Timing

- Usually weekly
- Moderate duration (8 to 10 sessions)
- Moderate pacing

Medications Needed

- SSRIs for remission of obsessions and compulsions

Adjunct Services

- Dietician to provide nutrition education and support
- Other approaches to stress management (meditation, yoga)
- Activity scheduling to reduce negative psychological states

Prognosis

- Generally good for amelioration of symptoms
- Less optimistic for complete elimination of the disorder, as stressful life events tend to exacerbate symptoms

RECOMMENDED READING

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