

Profile of a Treatment Plan:

Early Stage

Rapport
Unit of Treatment
Collaborative Goals
Symptom Reduction
Collateral Resources
(Symptomatic)

Middle Stage

Active Stage of Change
Deal with Underlying
Themes and Dynamics
Collateral Resources
(Thematic)

Late Stage

Goals Met?
Loss of Therapy
Anticipate Future Problems
Resources
Open Door Policy

Psychodynamic Therapy (Freud, Jung, Erikson, Framo, Sager):

Acronym:

D – Deficiencies in the Holding Environment
U₂ – Unresolved Past Issues / Unconscious
R – Recapitulation of Past Issues in Present
P – Projection and Projective Identification
I – Introjection
S – Splitting

General Concepts:

- **Focus:** Past's influence on present, unconscious past dynamics and the effect on present
- Emphasis on intrapsychic structure formed as a result of relationships with primary caregivers (e.g. attachment)
- External holding environment becomes internalized by client
- Improve holding capacity and ability to self-soothe
- Develop ability to distinguish past/present/fantasy/reality

Early Stage Goals:

- Provide a safe holding environment
- Establish therapeutic relationship
- Explore presenting problems and establish goals
- Symptom reduction and reframe role of identified patient

Role of the Therapist:

- Neutral, non-reactive participant
- "Blank slate" – allows client to project transferences onto us
- Therapist serves as a container for strong feelings

Timeframe:

Past and the Present

Duration:

Long Term

Unit of Treatment:

Individuals, Couples, Families

How Change Occurs: Insight and working through transference

Termination Criteria:

- Symptoms have been connected with a cause
- Original conflicts have been worked through
- Object relations have been improved
- Family's holding capacity allows members' needs to be met satisfactorily. (Separation – Individuation)

Early Stage Interventions:

- Establish and model boundaries
- Use Empathic Listening
- Ask questions that clarify and amplify issues / begin to put language to feelings
- Psychoeducate and normalize to promote symptom reduction

Middle Stage Goals:

- Identify and interrupt dysfunctional patterns (e.g. projective identification)
- Make unconscious dynamics conscious
- Explore and reframe defense mechanisms (e.g. splits, repression, etc)
- Promote insight
- Promote and emotionally corrective experience
- Help clients recognize and integrate split-off aspects of the personality
- Develop ability to distinguish between the past and present
- Increase the level of individuation and promote the development of a cohesive self

Late Stage Goals:

- Symptoms have been connected with a cause
- Client has become conscious of defense mechanism
- Transference of past issues to present relationships has been brought to awareness
- Restructuring of object relations for each family member
- Family members act in an authentic and adaptive manner
- Work through termination issues – loss of the therapeutic relationship

Middle Stage Interventions:

- Continued use of clarification and amplification
- Interpretation and linking the past to the present
- Reframe the adaptive purpose of defense mechanisms
- Identify and educate about defenses
- Explore and interrupt the projective identification process
- Interpret and explore transferences and projections
- Identify and increase tolerance of split-off parts
- Continue psychoeducation when relevant
- Use of objective countertransference (therapist aware of own feelings to aid in therapy)

Late Stage Interventions:

- Interpret and explore recapitulated issues / loss of therapeutic relationship
- Review and consolidate self-soothing and other coping mechanisms

Existential Theory: (Gestalt – Client Centered) (Yalom, Frankl, May)

General Concepts:

- A person is free to choose behavior
- Life has no meaning other than what each person ascribes to it
- Importance of awareness, genuine encounters
- Client must assume responsibility of one's life
- "Neurotic anxiety" occurs when individual doesn't accept responsibility
- Human beings are whole and united entities. All parts of self are available and present for interacting if one chooses
- Denial and repression are viewed as a choice not to know a truth (bad faith)
- Intentionality: the ways in which people create meaning for themselves
- Project: one's basic goals and aims in life
- Existential conflicts causing anxiety: death, isolation, freedom and meaninglessness
- Goals are defined by client, not therapist
- Satisfaction of needs is central

- Creating treatment stages objectifies the client by determining how the therapy "should" progress
- Assessment is viewed as quantifying human existence

Role of the Therapist:

- Non-directive
- A Separate and Free Being
- Uses Self with Client to Model Authentic Relating
- Not an Expert

Timeframe: Here and Now (in the room)

Duration: Client determined

Unit of Treatment: Individuals, Couples Families

How Change Occurs: Through Client's Awareness

Termination Criteria:

- The Client is aware of his/her choices
- The Client is living "in the moment"
- The Client accepts anxiety as a basic human characteristic

Early / Middle / Late Stage Goals:

- Develop therapeutic relationship as microcosm of other healthy relationships
- Facilitate awareness of:
 - o One's parts that are out of awareness
 - o One's unique, subjective experience
- Facilitate client's search for personal meaning and life goals
- No stages
- Therapist's role as Facilitator
- Affirm personal choices and responsibilities
- Acceptance of anxiety as a basic human characteristic
- Acceptance of responsibility
- Increase personal choice
- Assume responsibility for and ownership of one's life
 - o From "Victim" to "Chooser"

Treatment Interventions:

- Therapist's Use of Self as person in response to the client
- Clarifying
- Identifying
- Guiding
- Exploration of client's internal world
- Noting metacommunication (body language)
- Experimenting

Reviewing Family Systems Concepts:

Nonsummativity – A system cannot be analyzed by isolated segments. The whole is greater than the sum of the parts.

Wholeness – There is interdependence between the parts of a system. Change in one person results in change in the system.

Circular Causality – Each person is organizing and being organized by others in repeating feedback loops

Equifinality – Same results may spring from different origins

Triangulation – Two people under stress recruit a third person to lower anxiety

Homeostasis – A system's balance point

Positive Feedback – Occurs when the system experiences a change of homeostasis

Negative Feedback – Occurs when the system reverts to homeostasis; there is no change in the system

Boundaries – Invisible barriers regulating contact with others

Subsystems – Alignments between family members based on generation, developmental tasks, etc

Unit of Treatment: Whole Family

- Take focus off of IP; symptoms belong to the system
- Focus is on the process; not the content
- No belief in linear causality
- Content not the concern
- Sequence of transactions = process "conflict detour mechanism"

Experiential (Satir) Theory:

Acronym:

- E** - Feelings
- R** - Rules and Roles
- G** - Growth
- S** - Self Esteem
- C** - Communication

General Concepts:

- Free choice and Conscious Self Determination
- Self-awareness leads to the ability to make decisions and take responsibility ("self actualizing")
- Based on "Seed Model" – Innate self-actuating tendencies need to be nourished for people to flourish
- Premise: Faulty communication and/or inappropriate roles and/or inappropriate rules and/or unrealistic expectations = Dysfunctional relationships
- Low self-esteem and defensive behavior result from dysfunctional family systems
- Growth is facilitated by intervening at the level of process rather than content
- (Content is superficial)

Role of the Therapist:

- Directive
- Active/Educator
- Provides for new experiences by being a foreign element in the system

Early Stage Goals:

- Make contact
- Create alliance with part(s) that want to change
- Shift focus from IP to family system
- Facilitate awareness
- Creation of systemic hypothesis (what do we see going in)

Middle Stage Goals:

- Unblock defenses
- Promote congruent communication, openness and flexibility in the family
- Enhance self-esteem, acceptance of self and others
- Reflection is always good

Timeframe: Here and Now; Honors past influences

Duration: Varies, more brief than psychodynamic

Dysfunctional Communication Stances:

- Placator
- Computer
- Blamer
- Distractor

Functional Communication Stance: Leveler

Unit of Treatment: Entire family system preferred; will work with individuals and couples

How Change Occurs:

- Individuals in the family become aware of feelings, faulty communication patterns, inappropriate roles, restrictive rules and/or unrealistic expectations and take responsibility to make new choices that maintain healthy relationships

Termination Criteria:

- Clients are aware of their choices / can express feelings
- Partners operate as separate individuals
- Children are not drawn into the parents' pain
- Family adapts more easily to change
- Balance between sharing and autonomy
- Family can communicate clearly and congruently
- Personality parts are integrated into a whole

Early Stage Interventions:

- Use congruent behavior and authenticity to establish contact with each family member
- Use circular questioning to facilitate a supportive environment
- Ask the family about their therapeutic goals
- Ask questions to explore expectations, beliefs, yearnings, and meanings
- (Yearning = experience of self actuating tendencies)
- Construct self-mandate to assess areas of strength and challenge
- Note communication patterns, roles, rules, survival stances, levels of self esteem
- Reframe / relabel the problem
- Family Life Chronology
- Family Sculpting (Person's view)
- Self Mandalas – difference parts of self

Middle Stage Interventions:

- Model congruent (level) communication by using "I" statements, active listening
- Discuss significant events in the family life chronology
- Direct family members to speak for themselves
- Use a feelings chart and sentence stems
- Use a "temperature" reading to allow family members to express feelings and aspirations
- Point out positive intentions (even when perceived bad or is bad, the intention is good)
- Role play / Empty Chair
- "Parts Party" – to help family members see how their parts interact with each other

Late Stage Goals:

- Anchor self-worth, maturation (separation, individuation, differentiation), and gains client has made
- Affirm strengths
- Increase personal integrity and decrease dependence
- Facility termination – closure

Late Stage Interventions:

- Coach the practice of new behaviors
- Sculpt new behavioral patterns and compare to old sculptures
- Recount the new family life story (by therapist or family)
- Discuss and compliment growth and change
- Identify new metaphors and names to describe new rules and roles
- Imagery rehearsal of new relational dynamics

Multigenerational Family Systems (Bowen):

Acronym:

- A** - Anxiety
- S** - Solid self / pseudo self
- T** - Triangles
- O** - Over / under functioning (relationship load uneven)
- P** - Projection
- F** - Fusion (interpersonal / intrapsychic – merging thoughts and feelings)
- E** - Emotional Reactivity / Cut off / Knee-jerk
- D** - Differentiation
- M** - Multigenerational Patterns (history of family issues)

General Concepts:

Differentiation: intrapsychic (separate thoughts from feelings) and interpersonal (self and other; ability to hold beliefs and values regardless of other’s emotional pressure)

Anxiety: the tension between the competing pulls of togetherness and individuality creates emotional arousal and reactivity which overwhelms the cognition system and leads to automatic, thoughtless behavior

Pathology: seen as developing through generational patterns

Insight: into present relationship dynamics, relationship to family-of-origin and intergenerational processes = key to change and required for differentiation

Role of the Therapist:

- A coach, researcher of family functioning; neutral
- Healthy point of triangle / reduces emotional reactivity

Timeframe:

Past’s influence on present functioning

Duration:

Long Term

Unit of Treatment:

Initially the family, but will frequently see just the couple. Will also work with the most differentiated family member on an individual basis.

How Change Occurs:

- Through insight into how the client’s current relationship dynamics are impacted by family-of-origin intergenerational processes

Termination Criteria:

- Emotional reactivity has been reduced
- Family members respond rather than react
- Conflicts are resolved without projection / triangulation
- Solid self (differentiated self) has been developed
- Person-to-person relationships are established
- Multi-generational transmission process is disrupted

Early Stage Goals:

- Form the therapeutic relationship
- Assess levels of differentiation and anxiety
- Reduce emotional reactivity and fusion
- Remove IP label
- Define nature of problem and set goals

Middle Stage Goals:

- Decrease anxiety
- De-triangulate
- Increase differentiation – development of Solid Self

Late Stage Goals:

- Resolve family-of-origin relationships
- Highlight newly established differentiation and ability to balance individuality and togetherness
- Work through loss of therapy – related issues
- (First order change – In the system)
- (Second order change – OF the system)

Early Stage Interventions:

- Maintain therapeutic neutrality
- Direct clients to talk to the therapist, not each other
- Educate about triangles
- Educate regarding family life cycle tasks
- Use of Bibliotherapy and Cinema Therapy (displacement techniques)
- Introduction to “I” statements and journaling
- Introduction to Genogram
- Identify sibling positions and their impact on current family relationships

Middle Stage Interventions:

- Ask process questions about the dynamics of the marital dyad
- Ask process questions about the extended family dynamics
- Use the Genogram to explore toxic patterns
- Teach anxiety management techniques such as deep breathing techniques
- Coach regarding 1:1 relationships; detriangulation
- Role-Play differentiated positions (e.g. Empty Chair)
- Explain about the difference between thoughts and feelings
- Promote autonomy with “I” statements
- Continuation of Bibliotherapy, Cinema Therapy, and Journaling
- Discuss how family members see their role in family conflict
- Homework to explore and establish ties with community
- Letter writing / Phone calls to Extended Family

Late Stage Interventions:

- Assign visits to family of origin
- Coach members to maintain differentiated stance, a non-anxious presence, and to avoid triangles and change-back maneuvers
- Identify and discuss learning about Triangles, the family Projection Process, and Anxiety
- Discuss and anticipate reactions to the loss of therapy
- Discuss and anticipate reactions to family life cycle transitions

Strategic Family Systems (Haley):

Acronym:

- P** - Power
- C** - Communication
- P** - Paradoxical Interventions
- P** - Presenting Problem
- D** - Directives

- All about Power Dynamics

General Concepts:

- Symptoms represent a power struggle in the relationship
- Therapy focuses on communication and interactions that perpetuate problems
- One cannot NOT communicate and all communications are multi-layered
- Difficulties occur when stressors converge and overwhelm family's coping mechanism
- Family systems resist change and fight to maintain homeostasis
 - o Developmental Stressor
 - o Situational Stressor

Early Stage Goals:

- Join the family
- Identify the problem
- Reframe symptom as belonging to the system
- Explore interpersonal payoff of problem behavior
- Plan strategy for solving the presenting problem
- Explore solutions previously tried

Middle Stage Goals:

- Produce change within the family system
- Prevent repetition of dysfunctional patterns so the presenting problem no longer serves a function
- Move the family to a more adaptive homeostatic level
- Facilitate improved family communication
- Help family to next stage of family life cycle

Late Stage Goals:

- Once problem is resolved, treatment is terminated
- Power struggle among family members no longer needed

- Symptoms serve a function in the homeostasis of the family system
- Goals are not collaborative; set by therapist to manipulate change
- Change occurs by carrying out therapist's directives, not by insight
- Interventions shift the family organization so presenting problems no longer serve a function
- Therapy is concluded when presenting problem is resolved
- Symptoms keep a family in balance

Role of the Therapist:

- Adaptive, Active, Directive
- Determines the Direction of Treatment

Timeframe: Present – No History Taking

Unit of Treatment: Whole Family

How Change Occurs:

- By family carrying out therapist's directives

Termination Criteria:

- Presenting problem has been resolved
- Power struggle among family members no longer serves a purpose

Early Stage Interventions:

- Observe family dynamics and communication patterns
- Assume a leadership role with the family
- Use circular questioning to get a specific behavioral picture of the problem
- Reframe / Relabel dysfunctional behavior

Middle Stage Interventions:

- Comment on family's attempt to control therapist and each other
- Move between coalitions
- Emphasize the positives (Relabel dysfunctional behavior)
- Use directives, both compliance-based and paradoxical: Positioning Strategy, Pretend Technique, Restraining Strategy, Metaphorical Tasks, Prescribing Ordeals
- Create a new problem and have the family solve it in a way that will lead to the solution of the presenting problem
- Teach communication skills, e.g. "I" statements; speak to, not about each other

Late Stage Interventions:

- Emphasize gains
- Identify system changes; anticipate problems

Structural Family Systems (Minuchin):

General Concepts:

- Symptoms are the result of dysfunctional role assignments and overly rigid or overly diffuse boundaries
- The focus is change in the family structure, not the presenting problem
- Dysfunctional families lack alternatives resulting from inflexible family structure
- Action-oriented, not insight-oriented
- Healthy subsystems are free of interference from other subsystems
- Attention paid to cultural considerations and family metaphors
- Focuses on family life cycle adjustments

Early Stage Goals:

- Form therapeutic subsystem (Joining)
- Assess boundaries, alliances, coalitions
- Symptom reduction
- Relabel the presenting problem and reframe the family's view of it
- Remove the IP label
- Set goals

Middle Stage Goals:

- Change underlying family structure and patterns that maintain symptoms
- Strengthen boundaries between subsystems
- Restructure: boundaries, hierarchy, alignments
- Create a cohesive executive subsystem
- Educate about development issues

Late Stage Goals:

- Consolidate Gains

Role of the Therapist:

- Stage director; observer; educator
- Active in making interventions to uncover & modify underlying structure of family

Timeframe: Here and now

Duration: Short term

Unit of Treatment: Whole Family

How Change Occurs:

- Through Restructuring and Realigning the Hierarchy

Termination Criteria:

- Presenting problem is resolved
- Family system restructured to allow problem-solving
- Family has skills to resolve future conflicts

Early Stage Interventions:

- Joining, accommodating, mimesis
- Confirmation and empathy
- Reframe Problem as family problem
- Enactments: e.g. draw picture of family – shows power distribution
- Tracking
- Family Mapping: look for alliances and splits

Middle Stage Interventions:

- Re-enactment
- Manipulate intensity – e.g. repetition of themes, blocking or encouraging interactions, modulating voice
- Boundary making – e.g. changing the placement of people in the room
- Paradoxical interventions – if clients aren't compliant – do more of what doesn't
- Unbalance the system – e.g. support "one down" person
- Teach conflict resolution skills (communication skills, parenting skills)
- Psychoeducation – regarding family patterns and developmental issues
- Shaping competence – by highlighting strengths and progress

Late Stage Interventions:

- Highlight therapeutic progress
- Mark structural alterations
- Emphasize strengths
- Discontinue sessions digressively

Cognitive Theory (Beck, Meichenbaum, Ellis):

Acronym:

- S** - **Systematic bias** (error in processing information, lenses distorted, selective attending to negative, discounting the positive)
- U** - **Underlying assumptions**
- C** - **Cognitive distortions** (errors in evaluating information, overgeneralization, black/white thinking)
- S** - **Schema** (belief of world) (refers to the Cognitive Triad of self, world, future)

General Concepts:

- Self-defeating ideas are learned and can be unlearned
- Thoughts and beliefs determine affect and behavior
- Dysfunctional beliefs about events – not the events – are the basis of emotionally charged consequences
- Cognitive triad – beliefs about self, world, future
- Systematic bias – error in information processing

Role of the Therapist: Active collaborator; trainer/educator; directive

Timeframe: Present and Future

Duration: 12 – 16 week model with Booster session

Unit of Treatment: Individuals, Couples, Families

How Change Occurs: By altering dysfunctional thought patterns

Early Stage Goals:

- Form a collaborative therapeutic relationship
- Set collaborative goals
- Symptom reduction
- Socialize to the cognitive model

Middle Stage Goals:

- Establish more balanced ways of thinking
- Correct faulty cognitions
- Improve communication skills
- Evaluate underlying assumptions and schemas

- Automatic thoughts – immediate, situation-specific cognitions (instant reaction)
 - Underlying assumption – cross-situational belief
 - Schemas (core beliefs) – beliefs formed early in childhood

Cognitive Distortions:

- **Cognitive Distortions** are errors in information evaluation
- **Selective Abstraction:** taking a detail out of context, missing the significance of the total situation
- **Catastrophizing:** anticipation of unfavorable outcomes
- **Arbitrary Inference:** jumping to a conclusion without evidence to support it
- **Labeling:** extreme form of overgeneralization
- **Polarized Thinking:** thinking in extremes with events labeled as “good” or “bad”
- **Disqualifying the Positive:** rejecting positive experiences
- **Overgeneralizations:** an unjustified generalization based on a single incident
- **Personalization:** a person seeing him or herself as the cause of a negative external event when this isn't so

Termination Criteria:

- Dysfunctional thought patterns impacting emotional/behavioral disturbances have been recognized and corrected
- New cognitive and behavioral patterns which are more adaptive have been established
- Clients demonstrate flexibility, self-acceptance, and responsibility for own life

Early Stage Interventions:

- Conduct a structured interview to clarify problem
- Create a problem list
- Develop a therapeutic contract of goals and responsibilities
- Ask clients to chart and track problem behavior
- Teach relaxation; develop action plan, e.g. activity schedule
- Activate collateral resources
- Explain theoretical model, teach automatic thought record

Middle Stage Interventions:

- Use automatic thought record and downward arrow technique to facilitate the guided discovery of underlying assumptions and schema
- Teach thought stopping and other diversion techniques
- Teach communication skills (“I” statements, role playing)
- Assign homework, e.g. journaling, automatic thought records, Bibliotherapy, etc
- Shape desired behavior by identifying positive and negative behavioral reinforcers in the family
- Systematic desensitization
- Negotiate quid pro quo and contingency contracts
- Specific discernable acts
- Downward arrow – auto thoughts to schema

Late Stage Goals:

- Evaluate therapeutic progress
- Strategize to prevent symptom reoccurrence

Late Stage Interventions:

- Review the problem list
- Highlight therapeutic gains
- Cognitive rehearsal: anticipate future obstacles and rehearse ways to cope with them
- Identify behavioral reinforcers likely to maintain changes
- Establish booster session schedule

Narrative Therapy (White, Epston):

Acronym:

- I** - Invitations of the problem
- S** - Separate the person from the problem
- E** - Externalizing the problem
- E** - Exceptions to the problem
- D** - Deconstruction of the problem
- U** - Unique outcomes
- R** - Re-Authoring
- C** - Circulation of the new story

General Concepts:

- Realities are socially constructed
- Experience is shaped by language
- Reality lends itself to multiple interpretations (e.g. stage fright vs. anticipation)
- There are no absolute truths or one universally accurate description of people or problems
- Focus is on client resources and not on problem saturated stories

Early Stage Goals:

- Establish collaborative relationship and goals
- Create openings for the client's story to be told
- Map the effects and history of the problem
- Map family members' influence on the problem
- Identify factors that support the problem
- Begin separating the client from the problem

Role of the Therapist:

- Takes a NOT KNOWING stance
- The therapist is NOT the expert
- Therapist asks questions to elicit client resources

Timeframe: Present

Duration: Therapy is usually short term

Unit of Treatment: Individuals, Couples, Families

How Change Occurs:

- Through externalization and deconstruction, the client is empowered to develop alternative stories that include new options/strategies for living

Termination Criteria:

- The problem is no longer a problem
- The client has re-authored a preferred story
- Client has accessed resources, allowing him/her to reinforce the new story

Early Stage Interventions:

- Ask permission to pursue sensitive lines of questioning
- Ask questions that personify the problem
- Ask questions to learn about client apart from the problem
- Ask how the problem invites the client's participation
- Utilize externalizing language

Middle Stage Goals:

- Deconstruct context in which problem occurs
- Help clients develop a new relationship to the problem
- Locate and thicken alternative story or narrative
- Help client to uncover competencies and self-knowledge

Late Stage Goals:

- Reinforce the client's new story
- Circulate client's new, alternate, or preferred story
- Extend the new story into the future
- Process the end of therapy

Middle Stage Interventions:

- Note unique outcomes and exceptions to the problem
- Explore the client's internal resources and strengths
- Ask questions to elicit preferred selves and stories
- Ask externalizing questions
- Ask deconstruction questions
- Facilitate re-authoring of the client's new narrative
- Assess client's week to week progress

Late Stage Interventions:

- Recruit problem fighters and a community of concern
- Encourage letter writing to circulate the new story
- Ask questions to extend the story into the future
- Identify rituals and traditions that support the new story
- Celebrations and certificates to thicken the alternative story

Solution-Focused Therapy (DeShazer, Berg):

Acronym:

- R** - Resources Within
- E** - Expert
- S** - Solution Talk
- S** - Small Steps Lead to Bigger Steps
- D** - Different Interventions

General Concepts:

- Cause of the problem is not important to dissolving the problem
- Client is the expert on his or her own life
- Client has already existing strengths and abilities; strength-based
- "There are no resistant clients, only inflexible therapists"
- Small changes leads to larger changes (snowball effect)
- Central Philosophy:
 - o If it's not broken, don't fix it
 - o If it's working, do more of it
 - o If it's not working, do something different

Role of the Therapist:

- Collaborative, cheerleader of the belief that the client has the wisdom, power and agency

Timeframe: Present and Future

Duration: Usually Brief

Unit of Treatment: Whoever attends the therapy session is the "customer"

How Change Occurs:

- Client learns to access inner resources
- Only small change is necessary

Termination Criteria:

- Client is effectively accessing his or her resources

Early Stage Goals:

- Determine if the client is a customer
- Elicit client goals / description of complaint
- Introduction and explanation of the therapy process
- Formation of a solution
- Establish therapist's role as helper, cheerleader

Middle Stage Goals:

- Elicit client strengths
- Facilitate and encourage solution talk
- Encourage what is working
- Promote ideas to replace what isn't working

Late Stage Goals:

- Notice and reinforce accomplishments and new skills

Early Stage Interventions:

- Ask "What's changed since you made the appointment?"
- Miracle Question to set goals and establish future orientation
- Describe the philosophy and procedures of the model

Middle Stage Interventions:

- Coping questions to elicit strengths
- Scaling questions to notice what's working
- Scaling questions to facilitate solution talk
- Relationship questions to promote "something different"
- Compliments
- Assign noticing tasks
- Assign homework to do more of same or to do something different

Late Stage Interventions:

- Compliments and encouragement
- Questions about how client would know when to come back to therapy
- Questions about how client would know how to solve future problems

ISSUE	GOAL	INTERVENTION LANGUAGE
Grief and Loss	Facilitate Grieving Process	Educate re DABDA Process Listen; Letter to Deceased
Acting Out Child	Increase Effective Parenting	Educate Teach Parenting Skills Review Natural and Logical
Substance Abuse	Promote Sobriety	Link Past to Present Explore Triggers Teach Alternative Coping Skills
Divorce	Clarify Post-Divorce Relationship	Explore Rules and Roles Reverse Role Play Explore Areas of Commonality
Differing Expectations and/or Conflicted Values (Be Specific)	Negotiate Differences	Explore Rules and Roles Family of Origin Patterns Teach Communication Skills Move from Blame to Problem Solving
Poorly Integrated Blended Family	Promote Integration	Explore Rules and Roles Teach Communication Discuss Conflicting Loyalties

ISSUE	GOAL	INTERVENTION LANGUAGE
Discrimination	Rally Internal Strength and External Support	Process Assumptions Affirmations
Abusive Family System	Increase Impulse Control Bolster Self-Esteem	Teach Cycle of Violence Explore Triggers Abused: Teach Boundary Setting Abuser: Timeouts
Difficulty with Life Cycle Transition (Be Specific) (e.g. Intimacy vs. Isolation)	Facilitate Development Transition	Depends on the Development Stage
Current Trauma Re-Activating Past Trauma	Promote Insight	Link Past to Present Reflective Listening Clarification
Coping with Issues of Being Gay or Lesbian	Facilitate Self Acceptance and Acceptance with Family	Explore Internalized Homophobia Identify Positive Role Models Discuss "Coming Out" Process Gay and Lesbian Support Groups

ISSUE	GOAL	INTERVENTION LANGUAGE
Acculturation Difficulties	Achieve a Desired Balance Between the New Culture and the Culture of Origin	Educate about Acculturation Process Referral in (TYPE) Community Identify Cultural Values
Generational Role Reversal (Surrogate Spouse)	Establish Appropriate Hierarchy	Educate About Family Roles Educate About Developmental Needs Role-playing Exercise
Survival Guilt	Facilitate Grieving Process	Explain About Survivor Guilt Normalize Feelings Responsibility Pie Bereavement Group
Distorted Body Image	Promote Healthy Relationship With Body; Increase Self-Esteem	Emphasize Other Aspects of Identity Explore Legitimate Express of Power Mirroring
Weak Parental Subsystem	Strength Parental Subsystem	Teach and Model Parenting Skills

ISSUE	GOAL	INTERVENTION LANGUAGE
Low Self-Esteem	Bolster Self-Esteem	Identify Strengths Reflective Listening Empathy
Family Dealing with Chronic or Terminal Medical Condition, Or Mental Illness	Promote Healthy Adjustment	Family Meeting Process Expectations of Self and Others Educate About Changing Roles and Process Losses Support Group for Caregiver and Those Affected
Coping with Special Needs Child	Promote Adjustment	Educate Teach Skills Explore Expectations Referral: Regional Center
Trauma (e.g. Rape)	Promote Adjustment	Educate about Trauma Reactions Teach Explore Process

ISSUE	GOAL	INTERVENTION LANGUAGE
Denial	Increase Awareness and Insight	Encourage Personal Responsibility Cost / Benefit Analysis Confrontation
Loss of Autonomy	Promote Self-Acceptance	Identify Existing Independence Process Issues of Loss (DABDA) Model Positive Statements Explore Changing Identity
Overwhelmed Single Parent	Effectively Manage Parental Responsibilities	Teach Parental Skills Activate Support System Explore How They Were Parented
Convergence of a Situational Stressor (e.g. - Job Loss) On Top of a Development Transition (e.g. Launching)	Promote Healthy Coping	Teach Stress Management Educate (re: Development) Situational Stressors Support Group

ISSUE	GOAL	INTERVENTION LANGUAGE
Family Secrecy	Promote Clear and Distinct Communication	Teach "I" Statements Active Listening Block Conflict Avoidance Explore Underlying Process Normalize Feelings
Betrayal of Trust	Process the Betrayal	Validate Experience "I" Statements Letter Writing Empty Chair Technique
Inappropriate Sexual Boundaries within Family	Establish Clear Boundaries	Teach Appropriate Touch Developmental Education Raise Parental Supervision Set Clear Boundaries
Family Proximity Issues: Estrangement / Disengagement	Increase Contact	Create Caring Lists Block Conflict Avoidance
Family Proximity Issues: Over-involvement / Enmeshment	Set Clear Boundaries	"I" Statements Stop Interruptions Process Past Control Issues

Crisis Issues

- Crisis issues are those which impact the safety, functioning and/or well-being of the client.
- They must be addressed first either because:
 - o Treatment cannot reasonably proceed until safety is assured or the crisis issue has been stabilized
 - o Treatment cannot proceed until legal duties (mandates) have been discharged

- M** - Mandates
 - Child Abuse
 - Dependent Adult / Elder Abuse
- D** - Duty to Warn (Tarasoff) and Danger to Others
- S** - Spousal Abuse / Domestic Violence
- P** - Physical Crises
- A** - Alcohol or Substance Abuse / Dependence
- A** - Anxiety
- D** - Depression
- S** - Suicide

Mandates:

- **Child Abuse**
 - o **PU₂NS**
 - Physical Abuse
 - Unlawful Corporal Punishment
 - Unjustified punishment or willful cruelty
 - Neglect
 - Sexual Abuse
- **Elder / Dependence Adult Abuse**
 - o **PAINFA**
 - Physical Abuse
 - Abandonment
 - Isolation
 - Neglect
 - Financial abuse
 - Abduction

Tarasoff: Duty to Warn

- You have a Tarasoff Duty to Warn when:
 - o Your client (or another person in relationship to this client)
 - o Communicates to you
 - o Your client's serious, imminent intent
 - o To do physical violence
 - o To a reasonably identifiable other
- If you believe that your client is dangerous to another, regardless of whether your client has communicated to you an intent to physically harm the person, you have a Tarasoff Duty to Warn

Danger to Others:

- If a client is dangerous to others in general, you have the right to break confidentiality to prevent harm to the other in accordance with Evidence Code 1024

Spousal Abuse / Domestic Violence:

Indicators:

- Marks and bruises
- Anger and hostility, high level of conflict
- Startle response around spouse
- Cycle of violence
- Power imbalance in the relationship
- Substance use increases the risk
- D.V. families are often isolated

Physical Factors:

- Untreated physical symptoms, ailments or conditions
- May be a presenting problem or otherwise obvious issue:
 - o Headaches, bruises, cuts, welts, or other injuries
 - o Feeling faint, dizzy, glassy-eyed, stomach ache, etc
- May be inferred or underlying:
 - o Effects of substance abuse, ailments related to an eating disorder, STDs or HIV

Alcohol or Substance Abuse / Dependence:

Drug or alcohol use resulting in:

- Slurred speech, lack of coordination
- Hand tremors, unsteady gait
- Sweating
- Impairment in attention or memory
- Relationship or legal problems
- Impaired social or occupational functioning

Signs of Anxiety:

- T** - Tension
 - J** - Jitteriness
 - S** - Sweaty palms, sleep disturbance
 - D** - Difficulty breathing
 - L** - Light headedness
 - I** - Increased heart rate (tachycardia)
 - F** - Flushed cheeks
-
- Impaired social or occupational functioning
 - Fear of leaving the house (agoraphobia)

Depression:

- L** - Libido (low)
- A** - Appetite
- A** - Ahedonia (lack of pleasure)
- C** - Concentration
- E** - Energy
- S** - Sleep
- S** - Self-worthlessness
- S** - Suicidal thoughts
- S** - Social / occupational functioning

(Vegetative signs of depression)

Suicidal Indicators:

- Feelings of hopelessness, helplessness, despair
- Suicidal ideation, plan, means
- Loss of a relationship
- Anniversary of a traumatic event
- Putting affairs in order
- Giving away prized possessions
- Shift in behavior or mood
- Period of potential increased risk when depression lifts

Psychosocial Stressors and Environmental Problems:

- "A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed." (DSM-IV-TR)
- "In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. The clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become the focus of treatment." (DSM-IV-TR)

Psychosocial Stressors:

- F** - Problems with primary support group (Family)
- S** - Problems related to Social environment
- O** - Occupational / Educational
- \$** - Economic Problems
- H₂** - Health care access / Housing problems
- L** - Problems related to Legal system / crime
- O** - Other psychosocial problems

Family Stressors include:

- Death of a family member
- Health problems
- Separation, divorce, estrangement
- Removal from the home
- Remarriage of parent
- Neglect, sexual or physical abuse
- Parental overprotection
- Inadequate discipline
- Discord with siblings
- Birth of sibling

Health care problems include:

- Inadequate health care services
- Lack of transportation to health facilities
- Inadequate health insurance

Social Stressors include:

- Death or loss of friend
- Inadequate social support
- Living alone
- Difficulty with Acculturation
- Discrimination
- Adjustment to life-cycle transition (such as retirement)

Occupational problems include:

- Unemployment
- Threat of job loss
- Stressful work schedule
- Difficult work conditions
- Job dissatisfaction
- Job change
- Discord with boss or co-workers

Educational problems include:

- Illiteracy
- Academic problems
- Discord with teachers or classmates
- Inadequate school environment

Economic problems include:

- Extreme poverty
- Inadequate finances
- Insufficient welfare support

Housing problems include:

- Homelessness
- Inadequate housing
- Unsafe neighborhood
- Discord with neighbors or landlord

Legal / Crime problems include:

- Arrest
- Incarceration
- Litigation
- Victim of crime
- Parole or probation

Other psychosocial / environmental problems include:

- Exposure to disasters, war or other hostilities
- Exposure to traumatic events
- Discord with non-family caregivers such as counselor, social worker, or physician
- Unavailability of social service agencies

ASSESSMENT:

- Q** - Questions
- R** - Releases
- M** - Mental Status Exam
- O** - Observation
- T** - Tests
- H** - History
- S** - Strengths

(Beck Depression Inventory)
(Burns Anxiety Scale)

Managing a Stressor:

- N** - Normalize, contextualize, reframe
- F** - Process Feelings
- S** - Elicit Strengths
- S** - Teach Skills
- C** - Collateral resources / referrals / support group
- A** - Develop (collaborate on) an Action plan
- M** - Break the action plan down into Manageable parts (clearly defined objectives)

Human Diversity Issues:

- S** - Socioeconomic, class, education
 - C** - Culture, race, ethnicity, national origin
 - A** - Age, developmental stage
 - G** - Gender, sexual orientation
 - S** - Spirituality, religion
 - O** - Other (disability or physical difference, circumstantial – the lived experience, occupational, etc)
- How might behaviors and symptoms in the vignette translate into diagnoses?
 - Look for words that point to DSM-IV-TR disorder categories (mood disorders, anxiety disorders, eating disorders, etc) or specific diagnoses

ASPERGER'S DISORDER:

Impairment in social interactions, and repetitive, stereotyped behaviors and interests

ATTENTION-DEFICIT / HYPERACTIVITY DISORDER:

Symptoms of inattention and/or hyperactivity before age 7, for at least 6 months, in 2 or more settings

CONDUCT DISORDER:

3 or more anti-social acts (lying, fire setting, stealing, truancy) within 1 year; 1 of those acts occurs within the last 6 months

OPPOSITIONAL DEFIANT DISORDER:

Negativistic, hostile and defiant behavior, lasts at least 6 months, becomes evident before age 8, and not later than early adolescence

ENCOPRESIS:

Repeated passage of feces in clothing or on floor, involuntary or intentional, at least once a month for at least 3 months.

Onset: 4 years or a mental age of 4 years.

- Primary: never had control of bowels
- Secondary: develops after a period of fecal continence

DELIRIUM:

Disturbance of consciousness, change in cognition, impaired recent memory, disorientation, language disturbance, presence of illusions and hallucinations. Occurs usually in the elderly or very young children. May resolve in hours or persist for weeks.

DEMENTIA:

Multiple cognitive deficits, coded based on etiology (e.g. Alzheimer's Type, Due to Head Injury, HIV, TB, Cancer, etc). Usually occurs among the elderly. Onset is gradual. Course can be progressive, static or remitting.

SUBSTANCE DEPENDENCE:

3 or more of the following symptoms within a 12 month period:

- Tolerance
- Withdrawal
- Use of larger amounts or over a longer time than intended
- Persistent desire but unsuccessful attempts to quit
- Much time spent in obtaining the substance or recovering from its use
- Social, occupational, or recreational activities are given up

ENURESIS:

Voiding of urine into bed or clothes, involuntary or intentional, at least 2 times a week for at least 3 month OR causing clinically significant distress. Onset: 5 years or mental age of 5 years

- Primary: never had control of bladder
- Secondary: develops after period of urinary continence

SEPARATION ANXIETY DISORDER:

Persistent and excessive worry about being separated from major attachment figures. Must persist for at least 4 weeks. ("Failure to thrive")

REACTIVE ATTACHMENT DISORDER OF INFANCY OR CHILDHOOD:

Bonding failure often associated with multiple early caregivers or disruption in caretaking. Onset: Begins before age 5

- Disinhibited Type: Diffuse and indiscriminate sociability and attachments with a lack of selectivity
- Inhibited Type: Failure to initiate or respond to social interactions

SUBSTANCE ABUSE:

Only requires 1 symptom – does not meet the criteria for Substance Dependence; no tolerance or withdrawal; no desire to quit (a DUI can occur)

PSYCHOTIC DISORDERS:

Psychotic refers to loss of boundaries or gross impairment in reality testing Involves bizarre delusions or hallucinations Involves disorganized speech, thought and behavior

SCHIZOPHRENIA:

Two or more of the following symptoms: Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, affect flattening, alogia, avolition. If delusions are bizarre or auditory hallucinations are chronic, the diagnosis is met.

- Brief Psychotic Disorder: 1 day to 1 month (only 1 symptom necessary)
- Schizophreniform Disorder: 1 month to 6 months
- Schizophrenia: more than 6 months

SCHIZOAFFECTIVE DISORDER:

Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior PLUS a Major Depressive, Manic or Mixed Episode. Delusions or hallucinations are present for at least 2 weeks in the absence of prominent mood symptoms

DELUSIONAL DISORDER:

Non-bizarre delusions. No history of bizarre delusions, hallucinations, disorganized speech and behavior. Apart from delusions, functioning and behavior are not impaired. At least 1 month duration.

MAJOR DEPRESSIVE DISORDER:

5 or more depressive symptoms for at least 2 weeks, (in children and adolescents, the mood can be irritable)

DYSTHYMIC DISORDER:

Less severe depressive symptoms than in Major Depressive Disorder, which have been present for at least 2 years (adults) or 1 year (children, adolescents)

BIPOLAR I DISORDER:

At least 1 manic or mixed episode (lasting at least 1 week); with or without a history of depressive episodes

GENERALIZED ANXIETY DISORDER:

At least 6 months of excessive anxiety and worry about a number of events. 3 or more symptoms for Adults, 1 or more for Children

ANOREXIA NERVOSA:

Body weight less than 85% of what is expected; Amenorrhea – absence of at least 3 consecutive periods
 - Restricted Type: no bingeing or purging
 - Binge-Eating / Purging Type

BULIMIA NERVOSA:

Recurrent episodes of Binge Eating (2 times / week for 3 months) coupled with inappropriate compensatory behavior to prevent weight gain

ADJUSTMENT DISORDERS:

Development of symptoms in excess of what would be expected in response to a stressor. Occurs within 3 months of the stressor; once stressor has terminated, the symptoms do not persist for more than 6 additional months. (May be diagnosed “Chronic” if symptoms occur in response to a chronic stressor)

BIPOLAR II DISORDER:

At least 1 Hypomanic Episode (lasting at least 4 days) PLUS the presence or history of 1 or more Major Depressive Episodes

PANIC DISORDER WITHOUT AGORAPHOBIA:

Recurrent, unexpected Panic Attacks

PANIC DISORDER WITH AGORAPHOBIA:

Recurrent, unexpected Panic Attacks AND the presence of Agoraphobia

OBSESSIVE-COMPULSIVE DISORDER:

For at least 1 hour per day a person experiences Obsessions (intrusive thoughts) and/or Compulsions (ritualistic behaviors)

PTSD / ACUTE STRESS DISORDER:

Following exposure to a traumatic / life threatening event, person experiences intrusive recollections, startle response, hypervigilance, nightmares
 - **Acute Stress Disorder** = 2 days to 4 weeks
 - **PTSD** = 1 month or longer (can be years after the events)

PERSONALITY DISORDERS (AXIS II):

-All involve an enduring, persisting pattern of disturbance or inner experience and behavior that deviates markedly from cultural expectations

Antisocial Personality Disorder:

A pervasive pattern of disregard for and violations of the rights of others, occurring since the age of 15. Lying, aggressiveness, fights, assaults and a lack of remorse. Person must be at least 18.

Borderline Personality Disorder:

Unstable and intense relationships with alternation between extremes of idealization and devaluation; fear of abandonment; unstable sense of self with feelings of abandonment; unstable sense of self with feelings of emptiness; inappropriate, intense anger or difficulty controlling anger; suicide threats.

Histrionic Personality Disorder:

Interaction characterized by inappropriate, sexually seductive behavior; exaggerated expression of shallow emotions; attention attracting behavior and appearance.

Schizoid Personality Disorder:

Detachment from social relationships and a restricted range of expression of emotions in interpersonal settings; chooses solitary activities; little if any interest in sexual experiences with another person; appears indifferent to praise or criticism from others. (Ego-syntonic)

Dependent Personality Disorder:

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation; difficulty making everyday decisions; difficulty expressing disagreement; passivity in relationships

Obsessive-Compulsive Personality Disorder:

Preoccupation with orderliness, perfectionism, and control; prone to repetition, and excessive attention to detail and checking for mistakes; oblivious to the impact of their behavior on others. (Ego-syntonic)

Narcissistic Personality Disorder:

A pervasive and pattern of grandiosity, need for admiration, and lack of empathy; boastful and pretentious

Avoidant Personality Disorder:

Pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation; avoidance of activities that involve significant interpersonal contact for fear of criticism, disapproval, or rejection. (Ego dystonic)

V-CODES: RELATIONAL PROBLEMS:

Patterns of interaction associated with clinically significant impairment in functioning If they are not the focus of clinical attention, they should be listed on Axis IV

- **Relational Problem Related to a General Medical Condition or Mental Disorder**
- **Parent-Child Relational Problem**
- **Partner Relational Problem**
- **Sibling Relational Problem**
- **Relational Problem NOS**

V-Code applies if the FOCUS of attention is on the PERPETRATOR or the abuse or neglect or on the relational unit in which it occurs The VICTIM of abuse or neglect is coded 995.5 if a Child, 995.81 if an Adult
Problems Related to Abuse or Neglect:

- **Physical Abuse of Child**
- **Sexual Abuse of Child**
- **Neglect of Child**
- **Physical Abuse of Adult**
- **Sexual Abuse of Adult**

Additional conditions - focus of clinical attention:

- **Noncompliance with Treatment**
- **Malingering (making oneself sick for money)**
- **Adult Antisocial Behavior**
- **Child or Adolescent Antisocial Behavior**
- **Age-Related Cognitive Decline**
- **Bereavement**
- **Academic Problem**
- **Occupational Problem**
- **Identity Problem**
- **Acculturation Problem**
- **Phase of Life Problem**

DSM-IV

MULTI-AXIAL SYSTEM:

Axis I:

- Clinical Disorders
- Other conditions that may be the focus of clinical attention (V-Codes)

Axis II:

- Personality Disorders
- Mental Retardation
- Borderline Intellectual Functioning
 - o This is the only V-Code to be coded on Axis II

Axis III:

- General Medical Conditions
 - o Medical conditions potentially relevant to the understanding or management of an individual's mental disorder
 - o A general medical condition directly causing a mental disorder is coded on Axis I (e.g. "Mood Disorder Due to Hypothyroidism, With Depressive Features") and Axis III ("Hypothyroidism")

Axis IV:

- Psychosocial and Environmental Problems
 - o As many psychosocial stressors as are present should be noted on Axis IV
 - o When a psychosocial stressor is the primary focus of clinical attention, it should be recorded on Axis I

Axis V:

- Global Assessment of Functioning (GAF Scale)
 - o 51-100: Ranging from moderate symptoms to superior functioning
 - o 1 – 50: Ranging from persistent danger to self or others to serious symptoms

ASPERGER'S DISORDER:

Criteria: Impairment in social interactions, and repetitive, stereotyped behaviors and interests

Key Descriptive Words:

- Obsession with certain topics (trains, cars, games)
- Engages in repetitive behaviors – lines objects and knocks them down
- Flaps hands
- Bangs head
- Difficulty socializing with peers
- Lack age-appropriate social skills

Differential diagnosis: In Asperger's, there is no impairment in the development of language and cognition. In Autistic Disorder, there is impairment in both.

ATTENTION-DEFICIT / HYPERACTIVITY DISORDER:

Criteria: Symptoms of inattention and/or hyperactivity before age 7, for at least 6 months, in 2 or more settings

Key Descriptive Words:

- Restless
- Fidgety
- Easily distracted
- Talks a lot
- Interrupts
- Can't sit still
- Doesn't finish things

Differential diagnosis: Environmental, ODD, social skills deficit related to Autistic Disorder / Asperger's

CONDUCT DISORDER:

Criteria: 3 or more anti-social acts (lying, fire setting, stealing, truancy) within 1 year; 1 of those acts occurs within the last 6 months

Key Descriptive Words:

- Sets fires
- Hurts animals
- Doesn't care about consequences
- In trouble with the law
- Gets in fights
- Lacks empathy
- Bullies
- Truant

Differential Diagnosis: ODD, Substance Abuse

OPPOSITIONAL DEFIANT DISORDER:

Criteria: Negativistic, hostile and defiant behavior, lasts at least 6 months, becomes evident before age 8, and not later than early adolescence

Key Descriptive Words:

- Argues with authority
- Pestering
- Defiant
- Talks back
- Flies off the handle
- Annoying
- Bratty

Differential Diagnosis: Parent-Child Relational Problem, Conduct Disorder, AD/HD, Learning Disability, Autistic Disorder, Asperger's

ENCOPRESIS:

Criteria: Repeated passage of feces in clothing or on floor, involuntary or intentional, at least once a month for at least 3 months. Onset: 4 years or a mental age of 4 years.

- Primary: never had control of bowels
- Secondary: develops after a period of fecal continence

SEPARATION ANXIETY DISORDER:

Criteria: Persistent and excessive worry about being separated from major attachment figures. Must persist for at least 4 weeks. ("Failure to thrive")

Key Descriptive Words:

- Refuses to go to school
- Afraid to go to bed alone
- Cries when separated from primary caregiver
- Complains of illness in order to avoid having to leave primary caregiver
- Recent life stressor (death, illness, moving)
- Afraid of losing primary caregiver

Differential diagnosis: Generalized Anxiety Disorder, Social Phobia, Adjustment Disorder

REACTIVE ATTACHMENT DISORDER OF INFANCY OR CHILDHOOD:

Criteria: Bonding failure often associated with multiple early caregivers or disruption in caretaking. Onset: Begins before age 5

- Disinhibited Type: Diffuse and indiscriminate sociability and attachments with a lack of selectivity
- Inhibited Type: Failure to initiate or respond to social interactions

Key Descriptive Words:

- Frequent accidents
- Parents thought child had grown out of this
- Embarrassment / shame
- Avoids sleepovers

Differential Diagnosis: Organic Cause (refer to physician), highly correlated with sexual abuse and marital discord, Oppositional Defiant Disorder traits

ENURESIS:

Criteria: Voiding of urine into bed or clothes, involuntary or intentional, at least 2 times a week for at least 3 months OR causing clinically significant distress. Onset: 5 years or mental age of 5 years

- Primary: never had control of bladder
- Secondary: develops after period of urinary continence

Key Descriptive Words:

- Frequent accidents
- New baby in the house
- Parents thought child had grown out of this
- Embarrassment / shame
- Avoids sleepovers

Differential diagnosis: Organic Cause (refer to physician), highly correlated with sexual abuse and marital discord

Key Descriptive Words:

- **Inhibited:**
 - o Apathetic / Distrustful / Hypervigilant
 - o Does not respond to comforting
 - o No desire to connect
- **Disinhibited:**
 - o Asks, "Can I come home with you?"
 - o Attaches easily to most anyone

Differential Diagnosis: Autistic Disorder / Asperger's, Social Phobia, ODD, Conduct Disorder

DELIRIUM:

Criteria: Disturbance of consciousness, change in cognition, impaired recent memory, disorientation, language disturbance, presence of illusions and hallucinations. Occurs usually in the elderly or very young children. May resolve in hours or persist for weeks.

Key Descriptive Words:

- Sudden onset
- Hallucinations / Delusions
- Disorganized Thinking
- Suffered from a high fever
- Loss of RECENT memory
- Disoriented
- Taking medications / drugs

Differential diagnosis: Dementia, Substance Intoxication / Withdrawal

DEMENTIA:

Criteria: Multiple cognitive deficits, coded based on etiology (e.g. Alzheimer's Type, Due to Head Injury, HIV, TB, Cancer, etc). Usually occurs among the elderly. Onset is gradual. Course can be progressive, static or remitting.

Key Descriptive Words:

- Impaired long AND short term memory
- Change in personality
- Impaired thinking / judgment
- Problems with language / motor skills / recognition

Differential Diagnosis: Delirium, Substance Intoxication / Withdrawal

SUBSTANCE DEPENDENCE:

Criteria: 3 or more of the following symptoms within a 12 month period:

- Tolerance
- Withdrawal
- Use of larger amounts or over a longer time than intended
- Persistent desire but unsuccessful attempts to quit
- Much time spent in obtaining the substance or recovering from its use
- Social, occupational, or recreational activities are given up

PSYCHOTIC DISORDERS:

- Psychotic refers to loss of boundaries or gross impairment in reality testing
- Involves bizarre delusions or hallucinations
- Involves disorganized speech, thought and behavior

SCHIZOPHRENIA:

Criteria: Two or more of the following symptoms: Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, affect flattening, alogia, avolition. If delusions are bizarre or auditory hallucinations are chronic, the diagnosis is met.

- Brief Psychotic Disorder: 1 day to 1 month (only 1 symptom necessary)
- Schizophreniform Disorder: 1 month to 6 months
- Schizophrenia: more than 6 months

Key Descriptive Words:

- Slurred speech
- Poor coordination / Shaking
- Dilated pupils
- Lost jobs / relationships
- Says they have tried to quit in the past
- Claim that they no longer derive pleasure from it – using the substance to avoid withdrawals
- Need to use more to get same effect

Differential Diagnosis: General Medical Condition, Bipolar Disorder, Substance Abuse

SUBSTANCE ABUSE:

Criteria: Only requires 1 symptom – does not meet the criteria for Substance Dependence; no tolerance or withdrawal; no desire to quit (a DUI can occur)

Key Descriptive Words:

- Occupational / educational / legal / social problems
- Correlated with Domestic Violence
- Symptoms of intoxication (slurred speech, poor coordination, dry mouth, etc)
- Do not want to quit / do not believe they have a problem
- Acting out behaviors in youth

Differential Diagnosis: General Medical Condition, Bipolar Disorder, Substance Dependence, Conduct Disorder (in youth)

Key Descriptive Words:

- Hallucinations (auditory, olfactory, kinesthetic)
- Delusions
- Poor hygiene
- Paranoia
- Onset often occurs in young, college age men

Differential Diagnosis: Substance-Induced Psychotic Disorder, Mood Disorder with Psychotic Features, Delusional Disorder, Psychotic Disorder due to a General Medical Condition

SCHIZOAFFECTIVE DISORDER:

Criteria: Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior PLUS a Major Depressive, Manic or Mixed Episode. Delusions or hallucinations are present for at least 2 weeks in the absence of prominent mood symptoms

Key Descriptive Words:

- Hallucinations (auditory, olfactory, kinesthetic)
- Delusions
- Mania (spending sprees, impulsivity, grandiosity, etc)
- Depression (tearful, hopeless, anhedonia, etc)

Differential Diagnosis: Schizophrenia, Mood Disorder with Psychotic Features

DELUSIONAL DISORDER:

Criteria: Non-bizarre delusions. No history of bizarre delusions, hallucinations, disorganized speech and behavior. Apart from delusions, functioning and behavior are not impaired. At least 1 month duration.

Key Descriptive Words:

- Delusions are the primary symptom
- The client may appear normal otherwise (employed, good hygiene)
- Client's claim may be conceivable, therapist may have difficulty determining validity of claim

Differential Diagnosis: Same differentials as Schizophrenia, as well as: Body Dysmorphic Disorder, OCD, and Paranoid Personality Disorder

MAJOR DEPRESSIVE DISORDER:

Criteria: 5 or more depressive symptoms for at least 2 weeks, (in children and adolescents, the mood can be irritable)

Key Descriptive Words:

- Crying / tearful
- Unable to get out of bed
- Poor hygiene

BIPOLAR I DISORDER:

Criteria: At least 1 manic or mixed episode (lasting at least 1 week); with or without a history of depressive episodes

Key Descriptive Words:

- Out of control
- Grandiosity
- Pressured Speech
- Hyper-sexual
- Not sleeping
- Huge spending sprees
- Calling friends in the middle of the night
- Note the timeframe

Differential Diagnosis: Substance Abuse, Substance Intoxication, Bipolar II, Cyclothymic Disorder

BIPOLAR II DISORDER:

Criteria: At least 1 Hypomanic Episode (lasting at least 4 days) PLUS the presence or history of 1 or more Major Depressive Episodes

- Loss of appetite
- Missing work
- Loss of interest in friends, staying home
- Hopelessness / suicidality

Differential Diagnosis: Dysthymic Disorder, Depressive Disorder NOS, Mood Disorder due to a Medical Condition, Substance-Induced Mood Disorder, Bipolar Disorder

DYSTHYMIC DISORDER:

Criteria: Less severe depressive symptoms than in Major Depressive Disorder, which have been present for at least 2 years (adults) or 1 year (children, adolescents)

Key Descriptive Words:

- Lack of motivation
- Irritability (in children)
- Feeling "blah"
- Poor appetite
- Trouble concentrating
- Down in the dumps
- "I'm not myself"
- Lack of energy

Differential Diagnosis: Major Depressive Disorder, Depressive Disorder NOS, Cyclothymic Disorder

Key Descriptive Words:

- Inflated Self-Esteem
- Decreased need for sleep
- Pressured speech
- Increased involvement in activities
- Note the timeframe
- Not severe enough to require hospitalization

Differential Diagnosis: Substance Abuse, Substance Intoxication, Bipolar I, Cyclothymic Disorder

PANIC DISORDER WITHOUT AGORAPHOBIA:

Criteria: Recurrent, unexpected Panic Attacks

Key Descriptive Words:

- Intense feelings of fear, terror or impending doom
- Shortness of breath
- Heart palpitations
- Sweating
- Fear of losing control
- Fear of going crazy
- Fear of dying

Differential Diagnosis: PTSD / Acute Stress Disorder, Generalized Anxiety Disorder, Substance-Induced Anxiety Disorder, OCD

PANIC DISORDER WITH AGORAPHOBIA:

Criteria: Recurrent, unexpected Panic Attacks AND the presence of Agoraphobia

Key Descriptive Words:

- Intense feelings of fear, terror or impending doom
- Shortness of breath
- Heart palpitations
- Sweating
- Fear of losing control
- Fear of going crazy
- Fear of dying
- Fear or anxiety about or avoidance of places or situations in which escape might be difficult: airplanes, buses, cars, movie theaters, elevators, tunnels, bridges

Differential Diagnosis: Social Phobia, Specific Phobia, PTSD / Acute Stress Disorder, Generalized Anxiety Disorder, Substance-Induced Anxiety Disorder, OCD

OBSESSIVE-COMPULSIVE DISORDER:

Criteria: For at least 1 hour per day a person experiences Obsessions (intrusive thoughts) and/or Compulsions (ritualistic behaviors)

Key Descriptive Words:

- Persistent, distressing, intrusive ideas or thoughts
- Feelings of loss of control

GENERALIZED ANXIETY DISORDER:

Criteria: At least 6 months of excessive anxiety and worry about a number of events. 3 or more symptoms for Adults, 1 or more for Children

Key Descriptive Words:

- Restlessness, feeling keyed up, or on edge
- Easily fatigued
- Unrealistic worries
- Difficulty concentrating, mind going blank
- Irritability
- Muscle tension
- Sleep disturbance

Differential Diagnosis: Panic Disorder, OCD, Somatization Disorder, Adjustment Disorder

ANOREXIA NERVOSA:

Criteria: Body weight less than 85% of what is expected; Amenorrhea – absence of at least 3 consecutive periods

- Restricted Type: no bingeing or purging
- Binge-Eating / Purging Type

- Repeated doubts or thoughts about contamination
- Engages in rituals (hand washing, showering, cleaning, counting)
- Feel they must follow certain rules
- Dislikes the intrusive thoughts / compulsive behaviors (Ego-Dystonic)

Differential Diagnosis: Obsessive Compulsive Personality Disorder, Generalized Anxiety Disorder

PTSD / ACUTE STRESS DISORDER:

Criteria: Following exposure to a traumatic / life threatening event, person experiences intrusive recollections, startle response, hypervigilance, nightmares

- **Acute Stress Disorder** = 2 days to 4 weeks
- **PTSD** = 1 month or longer (can be years after the events)

Key Descriptive Words:

- Identifiable trauma (rape, combat, severe accident)
- Event is persistently re-experienced
- Symptoms of arousal
- Difficulty falling asleep
- Hypervigilance, exaggerated startle response
- Avoidance of stimuli associated with the trauma
- Dissociative symptoms

Differential Diagnosis: Brief Psychotic Disorder, Adjustment Disorder, Major Depressive Disorder

Key Descriptive Words:

- Thinks that they're fat
- Fear of gaining weight
- Food rituals
- Throwing up / Excessive exercise
- Poor self-esteem
- Extremely thin
- Missed periods

Differential Diagnosis: Organic cause-refer to physician, OCD, Mood Disorder, Body Dysmorphic Disorder, Borderline Personality Disorder

BULIMIA NERVOSA:

Criteria: Recurrent episodes of Binge Eating (2 times / week for 3 months) coupled with inappropriate compensatory behavior to prevent weight gain

Key Descriptive Words:

- Thinks that they are fat
- Fear of gaining weight
- Food rituals
- Throwing up / Excessive exercise
- Poor self-esteem
- May appear to be of normal weight
- No missed periods

Differential Diagnosis: OCD, Mood Disorder, Body Dysmorphic Disorder, Borderline Personality Disorder

ADJUSTMENT DISORDERS:

Criteria: Development of symptoms in excess of what would be expected in response to a stressor. Occurs within 3 months of the stressor; once stressor has terminated, the symptoms do not persist for more than 6 additional months. (May be diagnosed "Chronic" if symptoms occur in response to a chronic stressor)

Key Descriptive Words:

- Identifiable stressor: divorce, minor car accident, recent move, lawsuit
- Resulting symptoms: depressions, anxiety, behavior problem

Differential Diagnosis: PTSD / Acute Stress Disorder, Major Depressive Disorder, Conduct Disorder

Adjustment Disorders Timeline:

- Stressor
 - Symptoms Begin (must occur within 3 months of stressor)
 - Symptoms Stop (6 months after stressor has terminated)

Dependent Personality Disorder:

- A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation; difficulty making everyday decisions; difficulty expressing disagreement; passivity in relationships

Obsessive-Compulsive Personality Disorder:

- Preoccupation with orderliness, perfectionism, and control; prone to repetition, and excessive attention to detail and checking for mistakes; oblivious to the impact of their behavior on others. (Ego-syntonic)

Narcissistic Personality Disorder:

- A pervasive and pattern of grandiosity, need for admiration, and lack of empathy; boastful and pretentious

Avoidant Personality Disorder:

- Pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation; avoidance of activities that involve significant interpersonal contact for fear of criticism, disapproval, or rejection. (Ego dystonic)

V-CODES: RELATIONAL PROBLEMS:

- Patterns of interaction associated with clinically significant impairment in functioning
- **If they are not the focus of clinical attention, they should be listed on Axis IV**

PERSONALITY DISORDERS (AXIS II):

All involve an enduring, persisting pattern of disturbance or inner experience and behavior that deviates markedly from cultural expectations

Antisocial Personality Disorder:

- A pervasive pattern of disregard for and violations of the rights of others, occurring since the age of 15. Lying, aggressiveness, fights, assaults and a lack of remorse. Person must be at least 18.

Borderline Personality Disorder:

- Unstable and intense relationships with alternation between extremes of idealization and devaluation; fear of abandonment; unstable sense of self with feelings of abandonment; unstable sense of self with feelings of emptiness; inappropriate, intense anger or difficulty controlling anger; suicide threats.

Histrionic Personality Disorder:

- Interactions characterized by inappropriate, sexually seductive behavior; exaggerated expression of shallow emotions; attention attracting behavior and appearance.

Schizoid Personality Disorder:

Detachment from social relationships and a restricted range of expression of emotions in interpersonal settings; chooses solitary activities; little if any interest in sexual experiences with another person; appears indifferent to praise or criticism from others. (Ego-syntonic)

- **Relational Problem Related to a General Medical Condition or Mental Disorder**
- **Parent-Child Relational Problem**
- **Partner Relational Problem**
- **Sibling Relational Problem**
- **Relational Problem NOS**

- **V-Code applies if the FOCUS of attention is on the PERPETRATOR or the abuse or neglect or on the relational unit in which it occurs**

- The **VICTIM** of abuse or neglect is coded 995.5 if a Child, 995.81 if an Adult

- **Problems Related to Abuse or Neglect:**

- Physical Abuse of Child
- Sexual Abuse of Child
- Neglect of Child
- Physical Abuse of Adult
- Sexual Abuse of Adult

- **Additional conditions - focus of clinical attention:**

- Noncompliance with Treatment
- Malingering (making oneself sick for money)
- Adult Antisocial Behavior
- Child or Adolescent Antisocial Behavior
- Age-Related Cognitive Decline
- Bereavement
- Academic Problem
- Occupational Problem
- Identity Problem
- Acculturation Problem
- Phase of Life Problem

Law and Ethics:

Ethics:

- C** - Countertransference
- I** - Informed Consent
- L** - Limits of Confidentiality
- E** - Expectations of Therapy
- B** - Boundaries

Countertransference:

The BBS Handbook says MFT Candidates must demonstrate the ability to:

- “Manage countertransference to maintain integrity of the therapeutic relationship” and demonstrate the knowledge of “strategies to manage countertransference issues.”

Informed Consent:

- The BBS Handbook says that candidates must be able to address client expectations about therapy to promote understanding of the therapeutic process and discuss fees and office policies to promote understanding of the treatment process
- Clients have the right to consent or refuse consent to treatment, and must have the information on which to base such decisions
- Informed consent assists clients and therapists in avoiding misunderstandings
- **Legal Requirements:**
 - o Fee for treatment must be disclosed prior to treatment
 - o (California Business and Professional Code 4982)
 - o Therapists must disclose the name of the owner of any fictitiously named business
- Fee is Legal.
- Discussing Fee is Ethical.

Ethical Aspects of Informed Consent:

- Potential risks and benefits of therapy
- Therapist’s availability for emergencies and between sessions

CAMFT Ethical Standard 3.4 States:

- “Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that impair work performance or clinical judgment.”

Managing Countertransference:

- Journal to gain clarity on personal reactions to a particular issue or client that interfere with the integrity of the therapeutic relationship
- Seek professional supervision or consultation with colleagues or mentors
- Use one’s own personal therapy
- If unable to maintain the integrity of the therapeutic relationship, make reasonable arrangement for continuation of necessary treatment with another therapist

- Therapist’s responsibility to allow clients to make their own decision on the status of relationships
- The limits of confidentiality
- The fee and any fee arrangements before therapy
- Therapist’s experience, education, specialties, theoretical and professional orientation

Limits of Confidentiality:

The BBS Handbook says candidates must demonstrate the ability to manage confidentiality issues to maintain the integrity of the therapeutic contract, and knowledge of confidentiality issues in therapy. It also stresses knowledge of approaches to address expectations of therapy, which includes where confidentiality does and does not apply

Clients should be advised that:

“The information disclosed by you during the course of your therapy is generally confidential. However, there are exceptions to confidentiality including, but not limited to, reporting child, dependent adult, and elder abuse, expressed threats of violence towards an ascertainable (intended) victim, and where you make your mental or emotional state an issue in a legal proceeding.” (CAMFT Legal and Ethical Practices, 2004)

Expectations about Therapy:

- The BBS Handbook lists tasks and knowledge that should be demonstrated by MFT candidates
- Task one = Address client's expectations about therapy to promote understanding of the therapeutic process
- Knowledge task = Approaches to address expectations of the therapeutic process

- Clarifying misconceptions of therapeutic process or goals
- Clarifying misconceptions of the therapist's role
- Dual relationships
- Risks and benefits of therapy
- We do NOT make decisions for our clients
- Limits of confidentiality
- No-secrets policy
- Records are kept and client has right to inspect
- Accurate representation of therapist competence, education, training, and experience

Boundaries:

- The BBS Handbook states that candidates should demonstrate a knowledge of:
 - o Strategies to manage countertransference issues
 - o The impact of gift giving and receiving on the therapeutic relationship
 - o Business, personal, professional, and social relationships that create a conflict of interest within the therapeutic relationship

Legal Obligations about Child Abuse:

Upon knowledge or reasonable suspicion, a therapist must:

- Notify a child protective services agency within the state of California as soon as possible
- Follow up with a written report within 36 hours
- Maintain confidentiality if the client reporting his or her own abuse is 18 or older UNLESS the therapist has knowledge or reasonable suspicion that the perpetrator has abused others who are currently under the age of 18

What is a Dependent Adult? An Elder?

- A dependent adult is anyone residing in California between the ages of 18 and 64 who has a physical, mental, or financial limitation which restricts the ability to carry out normal activities of living, or is unable to protect his or her rights

- An elder is anyone age 65 or older, residing in the state of California

- o The implications of sexual feeling / contact within the context of therapy
- o Strategies to maintain therapeutic boundaries

Managing Boundaries:

- Obtain informed consent to prevent misunderstandings
- Sessions start and stop on time
- Brief, limited phone contact between sessions
- Sessions held at therapist's place of business
- Regular and consistent payment of fees
- No bartering fees
- No dual relationships or extra-therapeutic contact with clients outside of sessions
- No sexualized behavior on therapist's part

MDS₂SC₂P₂R₂ – LAW:

- M** - Mandates
- D** - Duty to warn / Danger to Others
- S₁** - Suicide (Bellah vs. Greenson)
- S₂** - Scope of practice
- \$** - Fees
- C₁** - Confidentiality
- C₂** - Consent to treat a minor
- P₁** - Privilege
- P₂** - Professional Therapy Never Includes Sex
- R₁** - Releases
- R₂** - Records

Legal Obligations about Dependent Adult and Elder Abuse:

Upon knowledge or reasonable suspicion of dependent adult or elder abuse, a therapist must:

- Report by phone to Adult Protect Services within the state of California as soon as practicably possible
- Follow up with a written report within 2 working days

Tarasoff Statute 43.92:

If your client communicates to you a serious, imminent threat of physical violence to a reasonably identifiable other, you must make reasonable efforts to contact law enforcement and the intended victim, and document in your notes the reason you believe the threat to be credible and your attempts at notification.

Tarasoff "Duty to Warn" Pursuant to "Ewing vs. Goldstein":

If you believe your client is dangerous to another, regardless of whether your client has communicated to you an intent to physically harm the person, you must take reasonable steps to protect the safety of the person

Reasonable precautions include:

- **Notifying the police**
- **Notifying the intended victim**
- Notifying someone likely to warn the intended victim
- Arranging for your client to be hospitalized
- Anything else you deem reasonable under the circumstances

Hedlund Decision:

- Therapists who do not carry out their duty under Tarasoff are liable for damages or injuries to bystanders harmed by their client

What is the therapist's legal responsibility under the Hedlund decision?

- o None. If the therapist has a Tarasoff situation, the therapist must simply make reasonable efforts to notify the police and warn the intended victim
- o Hedlund imposes no additional responsibilities, but rather increases the liability for therapists who don't carry out their Tarasoff duty to warn

Suicide – Bellah vs. Greenson:

- Establishes the legal precedent that therapists must take reasonable steps to prevent clients from committing suicide
- Reasonable steps are clinical interventions a reasonably prudent therapist would use under similar circumstances
- **Interventions that do not break Confidentiality:**
 - o No suicide contract
 - Suicide prevention hotline number
 - Promises to call friends, family
 - o Increased contact with client
 - Extra sessions

Confidentiality:

- Confidentiality is both a legal and an ethical requirement placed on the therapist restricting the volunteering of information received in the context of the therapeutic relationship

Consent to Treat a Minor:

- Generally speaking, therapists must obtain the consent of a parent or guardian to treat a minor
- Legally, either parent in an intact marriage may consent to treatment, but it is advisable to have the consent of both parents
- In families where there is a divorce or separation, either parent with joint custody can consent to treatment, unless the custody agreement indicates otherwise. Ask to see the custody agreement before proceeding with treatment
- Minors age 12 and older who are victims of abuse or a danger to self or others without treatment may qualify to consent for their own treatment

Records:

- California Business and Professional Code 4982(v) states that it is unprofessional for a therapist to
 - o Fail to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered

- Increased phone contact
- o Have client dispose of means
- o Have client voluntarily hospitalize self

- **Interventions that BREAK Confidentiality:**

- o Evidence Code 1024:
 - Gives therapist the right to make disclosures deemed appropriate by the therapist to prevent threatened danger, e.g. warning parent, spouse, etc
 - Therapist must have solid reasons to break confidentiality under E.C. 1024
- o Warning parent, spouse, etc
- o Help family and friends organize a 24-hour watch
- o Have client voluntarily hospitalized by initiating a 5150
 - Call 911
 - Or Call the county Psychiatric Emergency Team (the PET team)

Fees:

- California Business and Professional Code 4982(n) says that it is unprofessional conduct for a therapist to:
 - o Prior to the commencement of treatment, fail to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed

Privilege:

- Privilege is a client's right to refuse to disclose and to prevent others from disclosing a confidential communication between patient and psychotherapist in a legal proceeding
- Psychotherapists have the right and duty to claim (or assert) the privilege whenever the communication is sought to be disclosed
- Subpoena = assert privilege

Professional Therapy Never Includes Sex:

- Upon learning of a client's sexual contact with a former therapist or current therapist, the therapist receiving this information is required by law to give the client the Department of Consumer Affairs' brochure "Professional Therapy Never Includes Sex"
- The BBS will NOT accept complaints from one therapist about another therapist's alleged sexual contact with a client

Releases:

- California Civil Code 56.11 generally prohibits the release of confidential information without a valid authorization
- All members of the treatment unit competent to do so must sign the release in order for confidential information about any one member of the treatment unit to be disclosed

General Exceptions to Privilege:

- The client waives privilege
- The client introduces his/her emotional condition into a legal proceeding
- The client treated confidential information as if it were not confidential
- The client signed a health insurance claim or other waiver
- The client has sought psychotherapy to commit or escape punishment for a crime

Who is the Holder of Privilege?

- The client, regardless of age (unless there is a guardian or conservator)
- The guardian or conservator when there is a guardian or conservator
- The personal representative of the patient (if the patient has died)
- Parents do NOT hold privilege for their children UNLESS they have been accorded "guardian ad litem" status by the court

Who can Exercise a Minor's Privilege?

- Minors who have (or who could have) consented to their own treatment
- The state when the minor client is a ward of the state (an attorney is usually appointed to determine whether privilege should be waived)
- A Guardian Ad Litem appointed by the court (could be the parents or could be an attorney)

What are the Legal Obligations regarding Spousal Abuse?

- There are NO legal obligations or mandate
- The therapist does not "report" spousal abuse unless the spouse is in a protected class of individuals
- The therapist would take steps to advance the welfare of the client

What is a 5150?

- California Welfare and Institutions Code 5150, allowing for a 72 hour hold (involuntary confined) for treatment and evaluation of a person who is gravely disabled or is a serious threat of physical or mental harm to self or others

What are the Mandatory Exceptions to Confidentiality?

- Child Abuse
- Elder Abuse
- Dependent Adult Abuse
- Tarasoff (Duty to Warn)
- Patriot Act

What are the Permitted Exceptions to Confidentiality?

- Evidence Code 1024
- Release Authorizations
- Certain Professional Consultations
- Breaches of Duty
 - o Client sues therapist
 - o Client commits a crime against therapist
 - o Client fails to pay the therapist

When can a Minor be treated without Parental Consent?

- A minor must be 12 years of age or older
- Therapy must be on an outpatient basis
- The minor must be mature enough to participate meaningfully in the therapeutic process
- There must be documented in the records a good reason why parental involvement is not advisable
- Minor IS responsible for payment of fees
- The minor is:
 - o A serious danger of physical or mental harm to self or others without treatment
 - o Or, an alleged victim of child abuse (which includes rape and incest)

What is the Therapist's Role in a 5150?

- To initiate a 5150 by calling 911 or PET
- A 5150 may be INVOLVED by the police, an evaluation team member, or by someone designated by the county

Legal Responsibility if Minor Client is engaged in Consensual Sexual Activity?

- Sexual activity involving minors is generally not reportable with four (4) exceptions:
 1. The minor is under the age of 16 and the adult is 21 years or older
 2. The minor is 14 or 15 and the adult is at least 10 years older
 3. Any sexual activity between a minor under the age of 14 and a person of disparate age
 4. All oral and anal sex involving any minor is reportable

COUNTERTRANSFERENCE:

The BBS Handbook says MFT Candidates must demonstrate the ability to: “Manage countertransference to maintain integrity of the therapeutic relationship” and demonstrate the knowledge of “strategies to manage countertransference issues.”

CAMFT Ethical Standard 3.4 States:

“Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that impair work performance or clinical judgment.”

INFORMED CONSENT:

The BBS Handbook says that candidates must be able to address client expectations about therapy to promote understanding of the therapeutic process and discuss fees and office policies to promote understanding of the treatment process. Clients have the right to consent or refuse consent to treatment, and must have the information on which to base such decisions. Informed consent assists clients and therapists in avoiding misunderstandings

CONSENT TO TREAT A MINOR:

- Generally speaking, therapists must obtain the consent of a parent or guardian to treat a minor
- Legally, either parent in an intact marriage may consent to treatment, but it is advisable to have the consent of both parents
- In families where there is a divorce or separation, either parent with joint custody can consent to treatment, unless the custody agreement indicates otherwise. Ask to see the custody agreement before proceeding with treatment
- Minors age 12 and older who are victims of abuse or a danger to self or others without treatment may qualify to consent for their own treatment

LIMITS OF CONFIDENTIALITY:

The BBS Handbook says candidates must demonstrate the ability to manage confidentiality issues to maintain the integrity of the therapeutic contract, and knowledge of confidentiality issues in therapy. It also stresses knowledge of approaches to address expectations of therapy, which includes where confidentiality does and does not apply.

Managing Countertransference:

1. Journal to gain clarity on personal reactions to a particular issue or client that interfere with the integrity of the therapeutic relationship
2. Seek professional supervision or consultation with colleagues or mentors
3. Use one’s own personal therapy
4. If unable to maintain the integrity of the therapeutic relationship, make reasonable arrangement for continuation of necessary treatment with another therapist

Legal Requirements of Informed Consent:

- Fee for treatment must be disclosed prior to treatment (California Business and Professional Code 4982)
- Therapists must disclose the name of the owner of any fictitiously named business
- Fee is Legal.
- Discussing Fee is Ethical.

Ethical Aspects of Informed Consent:

- Potential risks and benefits of therapy
- Therapist’s availability for emergencies and between sessions
- Therapist’s responsibility to allow clients to make their own decision on the status of relationships
- The limits of confidentiality
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EXPECTATIONS ABOUT THERAPY:

The BBS Handbook lists tasks and knowledge that should be demonstrated by MFT candidates

Task one = Address client's expectations about therapy to promote understanding of the therapeutic process

Knowledge task = Approaches to address expectations of the therapeutic process

BOUNDARIES:

The BBS Handbook states that candidates should demonstrate a knowledge of:

- Strategies to manage countertransference issues
- The impact of gift giving and receiving on the therapeutic relationship
- Business, personal, professional, and social relationships that create a conflict of interest within the therapeutic relationship
- The implications of sexual feeling / contact within the context of therapy
- Strategies to maintain therapeutic boundaries

- Clarifying misconceptions of therapeutic process or goals
- Clarifying misconceptions of the therapist's role
- Dual relationships
- Risks and benefits of therapy
- We do NOT make decisions for our clients
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Managing Boundaries:

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- No dual relationships or extra-therapeutic contact with clients outside of sessions
- No sexualized behavior on therapist's part

LEGAL OBLIGATIONS ABOUT CHILD ABUSE:

Upon knowledge or reasonable suspicion, a therapist must:

- Notify a child protective services agency within the state of California as soon as possible
- Follow up with a written report within 36 hours
- Maintain confidentiality if the client reporting his or her own abuse is 18 or older UNLESS the therapist has knowledge or reasonable suspicion that the perpetrator has abused others who are currently under the age of 18

WHAT IS A DEPENDENT ADULT? AN ELDER?

- A dependent adult is anyone residing in California between the ages of 18 and 64 who has a physical, mental, or financial limitation which restricts the ability to carry out normal activities of living, or is unable to protect his or her rights
- An elder is anyone age 65 or older, residing in the state of California

LEGAL OBLIGATIONS ABOUT DEPENDENT ADULT AND ELDER ABUSE:

Upon knowledge or reasonable suspicion of dependent adult or elder abuse, a therapist must:

- Report by phone to Adult Protect Services within the state of California as soon as practicably possible
- Follow up with a written report within 2 working days

TARASOFF STATUTE 43.92:

If your client communicates to you a serious, imminent threat of physical violence to a reasonably identifiable other, you must make reasonable efforts to contact law enforcement and the intended victim, and document in your notes the reason you believe the threat to be credible and your attempts at notification.

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SUICIDE – BELLAH VS. GREENSON:

Establishes the legal precedent that therapists must take reasonable steps to prevent clients from committing suicide
Reasonable steps are clinical interventions a reasonably prudent therapist would use under similar circumstances

Interventions that do not break Confidentiality:

- No suicide contract
- Suicide prevention hotline number
- Promises to call friends, family
- Increased contact with client
- Extra sessions
- Increased phone contact
- Have client dispose of means
- Have client voluntarily hospitalize self

FEES:

California Business and Professional Code 4982(n) says that it is unprofessional conduct for a therapist to:

CONFIDENTIALITY: Confidentiality is both a legal and an ethical requirement placed on the therapist restricting the volunteering of information received in the context of the therapeutic relationship

What are the Mandatory Exceptions to Confidentiality?

- Child Abuse
- Elder Abuse
- Dependent Adult Abuse
- Tarasoff (Duty to Warn)
- Patriot Act

RECORDS:

California Business and Professional Code 4982(v) states that it is unprofessional for a therapist to Fail to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered

PRIVILEGE:

Privilege is a client's right to refuse to disclose and to prevent others from disclosing a confidential communication between patient and psychotherapist in a legal proceeding
Psychotherapists have the right and duty to claim (or assert) the privilege whenever the communication is sought to be disclosed
Subpoena = assert privilege

General Exceptions to Privilege:

- The client waives privilege
- The client introduces his/her emotional condition into a legal proceeding
- The client treated confidential information as if it were not confidential
- The client signed a health insurance claim or other waiver
- The client has sought psychotherapy to commit or escape punishment for a crime

PROFESSIONAL THERAPY NEVER INCLUDES SEX:

Upon learning of a client's sexual contact with a former therapist or current therapist, the therapist receiving this information is required by law to give the client the Department of Consumer Affairs' brochure "Professional Therapy Never Includes Sex"
The BBS will NOT accept complaints from one therapist about another therapist's alleged sexual contact with a client

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- Warning parent, spouse, etc
- Help family and friends organize a 24-hour watch
- Have client voluntarily hospitalized by initiating a 5150
- Call 911 Or Call the county Psychiatric Emergency Team (the PET team)

Prior to the commencement of treatment, fail to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed

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- A Guardian Ad Litem appointed by the court (could be the parents or could be an attorney)

RELEASES:

California Civil Code 56.11 generally prohibits the release of confidential information without a valid authorization

All members of the treatment unit competent to do so must sign the release in order for confidential information about any one member of the treatment unit to be disclosed

WHAT ARE THE LEGAL OBLIGATIONS REGARDING SPOUSAL ABUSE?

- There are NO legal obligations or mandate
- The therapist does not “report” spousal abuse unless the spouse is in a protected class of individuals
- The therapist would take steps to advance the welfare of the client

WHAT IS A 5150?

California Welfare and Institutions Code 5150, allowing for a 72 hour hold (involuntary confined) for treatment and evaluation of a person who is gravely disabled or is a serious threat of physical or mental harm to self or others

WHAT IS THE THERAPIST’S ROLE IN A 5150?

- To initiate a 5150 by calling 911 or PET
- A 5150 may be INVOLKED by the police, an evaluation team member, or by someone designated by the county

LEGAL RESPONSIBILITY IF MINOR CLIENT IS ENGAGED IN CONSENSUAL SEXUAL ACTIVITY?

- Sexual activity involving minors is generally not reportable with four (4) exceptions:
- The minor is under the age of 16 and the adult is 21 years or older
- The minor is 14 or 15 and the adult is at least 10 years older
- Any sexual activity between a minor under the age of 14 and a person of disparate age
- All oral and anal sex involving any minor is reportable

Human Diversity in a Treatment Plan:

- E** - Empathy
- R** - Respect
- R** - Rapport
- C** - Curiosity
- E₂** - Educate Yourself and Educate the Client
- P** - Personal Bias
- T** - Treatment Plan

Empathy is particularly important when dealing with human diversity issues and clients whose difference often causes them to feel alienated

Mirroring, and careful, **reflective listening** to stories of difference, otherness, and alienation builds empathy and is in itself therapeutic and healing

Demonstrating **respect** means being aware of your cultural values and taking care not to impose them on others who may have different but equally valid cultural values

Demonstrating **respect** means openly addressing differences as they arise in the room and incorporating them into treatment

Educate yourself:

- Ethical standards require therapists to actively strive to understand the diverse cultural backgrounds of their patients by:
 - o Consulting with other therapists who have experience or expertise in the particular human diversity issue you are working with
 - o Reading books about the diversity issue
 - o Reading peer review literature about research in working with the diversity issue

Educate The Client:

- Share relevant information from self-education about diversity issue about which client may be unaware
- Provide relevant resources
- Must be done with sensitivity so as not to presume or imply an expert stance with someone who has genuine expertise by virtue of the lived experience

Personal Bias:

- The therapist must be aware where he or she is culturally situated
- The therapist must be aware of his or her cultural values, beliefs, customs, and norms
- The therapist stays aware of these elements of culture to avoid imposing them on the client

Rapport building is accomplished through a genuine interest in understanding the world from the client's point of view and conveying a respect for the client's experiences of difference and otherness

Curiosity means staying open to the client and not making assumptions

The proper source of information about our clients should be our clients, and not, for example, books that tell us about who our clients should be based upon a particular aspect of their inclusion in a particular diversity group

In the exam, **avoid answers** in which the therapist knows what the client needs or in which the therapist tells the clients how they must be feeling

Educate yourself by asking the client:

- Taking a genuine interest in understanding what it is like to be in the client's shoes builds rapport and provides the therapist with information
- Being open to learning about the client's unique experience of difference conveys respect
- Seeking to see, feel and understand the lived experience of another builds rapport

Treatment Plan:

- Treatment goals must be sensitive in the context of human diversity
- Assumptions about what the client needs may be irrelevant or contrary to the client's goals, based upon a lived experience the therapist cannot presume to know
- In the WCV exam, avoid answer that establish goals without collaborating with the client

How to Proceed if an Intervention Did Not Work:

- C** - Client Reaction
- A** - Alliance
- V** - Values Differences
- L** - Lifestyle
- T** - Timing
- D** - Different Interventions

Client Reaction:

- Why did the client not respond or not respond favorably to the intervention?
- In the WCV exam, look for answers that respect the client's unfavorable reaction
- In the WCV exam, avoid answers that make assumptions about why an intervention did not work

Alliance:

- Does the client's reaction indicate a problem with the therapeutic alliance?
- Did the intervention not work because the client was reactive to something going on between therapist and client?

Values Differences:

- Are you asking psychodynamic questions of a client who is more interested in life coaching?
- Is your intervention subtly promoting heterosexual values with a gay or lesbian couple?

Lifestyle:

- Are you assigning homework to a harried single mother?
- Are you making geographically difficult referrals for a client who doesn't have a car?
- Are you assuming gay relationships have the equivalent of masculine / feminine roles?

Timing:

- Was the intervention attempted before there was adequate trust in the therapeutic relationship?
- Were you too far ahead of the client in the session? Did you move too quickly to use your intervention?

Different Interventions:

- Therapists must be flexible and adaptable to client needs, values and lifestyles
- In considering alternative interventions, be sure they achieve the same goal as the one that didn't work
- In considering alternative interventions, be sure it will not evoke the same client reaction as the one that didn't work
- Consider interventions from another theoretical orientation