Classification and Treatment Plans

OUTLINE

Learning Objectives

2.1 Describe the experiences of the client and the clinician

2.2 Assess the strengths and weaknesses of the *DSM* approach to psychological disorders

2.3 Identify the International Classification of Diseases (ICD)

2.4 Explain steps of the diagnostic process

2.5 Describe treatment planning and goals

2.6 Explain the course and outcome of treatment

CHAPTER 2

Case Report: Peter Dickinson

Demographic information: 28-year-old Caucasian male.

Presenting problem: Peter's girlfriend of one year, Ashley, referred him to an outpatient mental health clinic. He is in his second year of working as a defense attorney at a small law firm. Ashley reported that about six months ago, Peter's parents began divorce proceedings, at which point she noticed some changes in his behavior. Although his job had always been challenging, Peter was a hard worker who devoted himself to his studies throughout his academic career and had been just as motivated at his current job. Since the divorce, however, Ashley reported that Peter had only been sleeping a few hours a night and was having trouble keeping up with his caseload at work. It had gotten so bad that the firm considered firing him.

When he was seen at the psychotherapy clinic, Peter reported that the past six months had been very difficult for him. Although he stated he had always been a "worrier," he couldn't get his parents' divorce off his mind, and it was interfering with his ability to focus and perform well at his job. He described most of the worried thoughts as fears that his parents' divorce would destroy their lives as well as his. He stated that he would worry that somehow their divorce was his fault, and that once the thought entered his mind, it would play on repeatedly like a broken record. He also explained that Ashley had threatened to break up with him if he didn't "get it together," about which he was also spending a great deal of time worrying. He stated that he constantly worried that he had ruined her life and that this thought was also very repetitive.

Peter was noticeably anxious and irritable throughout the session, especially when talking about his parents or about Ashley. Early in the session, he expressed that he had been feeling very tense all day and that his stomach was "in knots." Throughout the session, his legs and hands were fidgety, and he stood up and sat down in his chair several times. He stated that since starting his new job, he had become very short-tempered with people, and often felt "wired" and tense, and as a result had a difficult time concentrating on his work and sleeping soundly. He explained that he couldn't remember the last time he felt calm or didn't worry about anything for an entire day. He also stated that he could barely think about anything other than his parents' divorce and his relationship problems with Ashley, even if he tried to get his mind off it. He reported that prior to learning of his parents' divorce, he was mainly "obsessive" about his work, which he noted was similar to how he was as an undergraduate and in law school. He stated that he was usually afraid that he would make an error, and would spend more time worrying about failing than actually doing his work. As a result, he said, he often had little time for friends or romantic relationships because he would feel guilty if he were engaging in pleasurable activities rather than focusing on his work. A serious relationship of four years ended after his ex-girlfriend grew tired of what she had called his "obsession" with working and his neglect of their relationship. Currently, faced with losing his job and another important relationship, Peter stated that he realizes for the first time that his anxiety might be interfering with his life.

Relevant history: Peter reported that his mother had a history of panic attacks and his father had taken anxiety medication, though he was unable to recall any further details of his family history. He stated that since he could remember he had "always" felt anxious and often worried about

Case Report *continued*

things more than other people. He remembered a particular instance in high school when he barely slept for two weeks because he was preparing for an argument for his school's debate team. Peter stated he has never had any psychotherapy or taken any psychiatric medication. He reported that although his worrying often makes him feel "down," he has never felt severely depressed and has no history of suicidal ideation.

Symptoms: Difficulty sleeping through the night, restlessness, difficulty concentrating, irritability. Peter stated that he found it difficult to control the worry and he spent most of his time worrying about either his parents' divorce, work, or his relationship with Ashley.

Case formulation: Peter meets all of the required *DSM-IV-TR* criteria for Generalized Anxiety Disorder (GAD). He had been displaying excessive worry for more days than not for at least the past six months, was unable to control his worry, and presented four of the six main symptoms associated with GAD. Additionally, Peter's worry was not related to fears of having a panic attack (as in Panic Disorder), or about being in social or public situations (as in Social Anxiety Disorder). His anxiety was causing him significant problems at work and in his relationship with Ashley. Finally, Peter's anxiety was not the result of substance use.

Multiaxial assessment:

Axis I: Generalized Anxiety Disorder
Axis II: Deferred
Axis III: None
Axis IV: Parents' divorce, relationship problems, work-related stress

Treatment plan: Peter's treatment plan will involve a combination of two approaches. First, he will be referred to a psychiatrist for antianxiety medication to ease the physical symptoms of his anxiety. Cognitive behavioral psychotherapy will also be recommended, as this has been shown to be the most effective current therapeutic modality for treating GAD.

Sarah Tobin, Ph.D.
Clinician

Peter's life was thrown into havoc by the worsening of his anxiety symptoms, putting him at risk of losing his job and his relationship. Dr. Tobin's treatment plan suggests a set of steps to address Peter's immediate symptoms and ultimately to bring him longer-term relief. In this chapter, you will learn about how clinicians proceed through the steps of diagnosis and treatment planning. In order to help you understand these steps, we will introduce you to the fundamental concepts that guide these key processes.

2.1 Psychological Disorder: Experiences of Client and Clinician

psychologist
Health care professional offering psychological services.

client
A person seeking psychological treatment.

Psychologists working in the field of abnormal psychology examine not only the causes of abnormal behavior, but also the complex human issues involved in the therapeutic process. Throughout this text, you will read many cases of individual **clients** who seek treatment to alleviate their symptoms so they can lead more fulfilling lives. We begin this exploration by introducing you to the relevant players of "client" and "clinician."

The Client

patient
In the medical model, a person who receives treatment.

People working in the area of abnormal psychology refer to individuals seeking psychological intervention as "client" and **"patient."** In this book, our preference is to use the term *client*, reflecting the view that the people in treatment collaborate with those who treat them. We feel that the term *patient* carries with it the connotation of a passive rather than active participant. However, there are times when it is appropriate to use the term *patient* such as in the context of "outpatient treatment" and "patients' rights."

In this context, we wish to point out that you should definitely avoid some terminology and call people with psychological disorders by the name of their disorder. If you call someone a "schizophrenic" you are equating the person with the disorder. Instead, you will show greater sensitivity if you refer to the individual as "a person with schizophrenia." People are more than the sum of their disorders. By using your language carefully, you communicate greater respect for the total person.

A trusting, positive relationship between therapist and client is crucial to a good therapeutic outcome.

The Clinician

In this book, we refer to the person providing treatment as the **clinician.** There are many types of clinicians who approach clinical work in a variety of ways, based on their training and orientation. **Psychiatrists** are people with degrees in medicine (MDs) who receive specialized advanced training in diagnosing and treating people with psychological disorders. **Clinical psychologists** have an advanced degree in the field of psychology and are trained in diagnosis and therapy. Clinical psychologists cannot administer medical treatments, but some U.S. states, such as Louisiana and New Mexico, as of 2011, grant them prescription privileges. Other states are also pushing to pass similar legislation.

There are two types of doctorates in psychology. The doctor of philosophy (PhD) is typically awarded for completing graduate training in research. In order to be able to practice, people who get their PhD's in clinical psychology also complete an internship. The doctor of psychology (PsyD) is the degree that professional schools of psychology award and typically involves less training in research. These individuals also must complete an internship in order to practice. Counseling psychologists, with either a doctorate in education (EdD) or (PhD) also serve as clinicians.

Professionals with master's degrees also provide psychological services. These include social workers, master's-level counselors, marriage and family therapists, nurse clinicians, and school psychologists. The mental health field also includes a large group of individuals who do not have graduate-level training but serve a critical role in the functioning and administration of the mental health system. Included in this group are occupational therapists, recreational therapists, and counselors who work in institutions, agencies, schools, and homes.

clinician
The person providing treatment.

psychiatrists
People with degrees in medicine (MDs) who receive specialized advanced training in diagnosing and treating people with psychological disorders.

clinical psychologist
A mental health professional with training in the behavioral sciences who provides direct service to clients.

2.2 Diagnostic and Statistical Manual of Mental Disorders (DSM)

A diagnostic manual serves to provide consistent diagnoses across people based on the presence or absence of a set of specific symptoms. Without an accurate diagnostic manual, it is impossible for the clinician to decide on the best treatment path for a given client. Researchers also use diagnostic manuals to provide investigators with consistent terminologies to use when reporting their findings.

The profession uses two factors in evaluating a diagnostic manual's ability to do its job. The first is **reliability,** meaning that practitioners will apply the diagnoses consistently across individuals who have a particular set of symptoms. A manual would not be very useful if the symptom of sad mood led one clinician to assign a diagnosis of some sort of depressive disorder and another to assign a diagnosis of some type of anxiety disorder. The second factor is **validity,** meaning that the diagnoses represent real and distinct clinical phenomena.

Current diagnostic manuals are based on the medical model in that they focus on accurately labeling groups of symptoms with the intention of providing targeted treatments. Not everyone in the mental health system is comfortable with this model.

reliability
When used with regard to diagnosis, the degree to which clinicians provide diagnoses consistently across individuals who have a particular set of symptoms.

validity
The extent to which a test, diagnosis, or rating accurately and distinctly characterizes a person's psychological status.

Toward the DSM-5

Changes in the DSM-5 Structure

All editions of the *DSM* have generated considerable controversy, and the fifth edition seems to be no exception, at least so far. The most significant questions will concern the multiaxial system—the categorization of disorders along five separate axes. Task forces are attempting to determine whether they should follow the system in use by the World Health Organization's International Classification of Diseases (ICD). The first three axes would be collapsed into one axis that contains *all* diagnoses, including psychiatric and medical. Both Axes IV and V might be restructured so that they, too, are more similar to the ICD. In addition to overhauling the axes, the *DSM*-5 Task Force is moving from a categorical to a dimensional rating system. The dimensional model would rate people according to the degree to which they experience a set of fundamental attributes, not whether or not they have an overall diagnosis. A dimensional system with numerical ratings would provide a clearer and perhaps more accurate representation of psychological disorders. The first and most significant change would eliminate most of the separate personality disorders, now found on Axis II. The second, almost equally important change would allow clinicians to assign severity ratings *within* a diagnosis. With the new system, clinicians could allow for gradations from minimal to severe. Along with changes in the classification of psychological disorders, the new approach would necessitate changes in assessment methods. We'll explore those in Chapter 3.

Those who object note that the current diagnostic systems assume that there is a recognizable distinction between normality and abnormality. In addition, by labeling a collection of behaviors as constituting a "disease," manual use can heighten the tendency to stigmatize those whose behavior falls outside the norm.

Despite these criticisms, mental health professionals must rely on diagnostic systems if for no other reason than to allow their clients to receive treatment in hospitals and reimbursement from health care providers. Insurance companies utilize the diagnostic codes they provide to determine payment schedules for both in-hospital and outpatient care.

It is worthwhile to be alert to the criticisms of these diagnostic systems, particularly since they serve as a reminder that it is the person, and not the disease, that clinicians aim to help.

Diagnostic and Statistical Manual of Mental Disorders (DSM)
A book published by the American Psychiatric Association that contains standard terms and definitions of psychological disorders.

axis
A class of information in *DSM-IV* regarding an aspect of the individual's functioning.

multiaxial system
A multidimensional classification and diagnostic system that summarizes a variety of relevant information about an individual's physical and psychological functioning.

As you learned in Chapter 1, clinicians use the standard terms and definitions contained in the ***Diagnostic and Statistical Manual of Mental Disorders (DSM)*** published by the American Psychiatric Association. We have organized this text according to the most recent version as the *DSM-IV* (fourth edition) - *TR* ("text revision") (American Psychiatric Association, 2000). The *DSM* organizes diagnoses using five separate axes. An **axis** is a category of information regarding one dimension of an individual's functioning. The **multiaxial system** in the *DSM-IV-TR* allows professionals to characterize clients in a multidimensional way, accommodating relevant information about their functioning in an organized and systematic fashion.

Axis I: Clinical Disorders

You can find the major clinical disorders, called "syndromes," on Axis I. Each syndrome is a collection of symptoms that constitute a particular psychological disorder. Many of the syndromes on Axis I represent a logical grouping of disorders that involve similar symptoms such as mood disturbances, anxiety, and substance abuse. However, the system doesn't always work that neatly, and as a result, the authors of *DSM-5* are rethinking both the groupings and the location of specific disorders within groupings. You can read the categories of disorders on Axis I along with examples of some of the disorders in each category in Table 2.1.

Axis II: Personality Disorders and Mental Retardation

The second axis includes disorders best thought of as enduring characteristics of an individual's personality or abilities. Personality disorders reflect disturbances in a person's underlying dispositions or traits. Personality traits that are inflexible and maladaptive, causing chronic distress or impairment, are characteristic of personality disorders. Mental retardation is also on Axis II. Although this is not a "disorder" in the same sense as personality disorders, the rationale is that they reflect fundamental qualities of an individual's ability to think and adapt to the world.

TABLE 2.1 **Axis I Disorders of the DSM-IV-TR**

Category	Description	Examples of diagnoses
Disorders usually first diagnosed in infancy, childhood, or adolescence	Disorders that usually develop during the earlier years of life, primarily involving abnormal development and maturation	Autistic disorders Learning disorders Attention-deficit disorders Learning disorders
Delirium, dementia, amnestic, and other cognitive disorders	Disorders involving impairments in thought processes caused by substances or medical conditions	Amnestic disorder Dementia (Alzheimer's type) Delirium
Substance-related disorders	Disorders related to the use or abuse of substances	Substance dependence Substance abuse
Schizophrenia and other psychotic disorders	Disorders involving symptoms that include distortion in perception of reality and impairment in thinking, behavior, affect, and motivation	Schizophrenia Brief psychotic disorder
Mood disorders	Disorders involving a disturbance in mood	Major depressive disorder Bipolar disorder
Anxiety disorders	Disorders involving the experience of intense anxiety, worry, or apprehension	Panic disorder Agoraphobia Social phobia Obsessive-compulsive disorder Post-traumatic stress disorder
Somatoform disorders	Disorders involving recurring complaints of physical symptoms with no medical causes	Hypochondriasis Body dysmorphic disorder
Dissociative disorders	Disorders in which the normal integration of consciousness, memory, sense of self, or perception is disrupted	Dissociative identity disorder Dissociative amnesia
Sexual and gender identity disorders	Disorders involving disturbance in the expression or experience of sexuality	Sexual dysfunctions Pedophilia Gender identity disorder
Eating disorders	Disorders characterized by severe disturbances in eating behavior	Anorexia nervosa Bulimia nervosa
Sleep disorders	Disorders involving disturbed sleep patterns	Insomnia Nightmare disorder
Impulse-control disorders	Disorders characterized by repeated expression of impulsive behaviors	Kleptomania Pathological gambling Trichotillomania
Adjustment disorders	Conditions characterized by the development of emotional and behavioral symptoms within 3 months after a clear stressor	Adjustment disorder with depressed mood Adjustment disorder with anxiety
Other conditions that may be a focus of clinical attention	Conditions or problems for which a person may seek professional help	Problems related to abuse or neglect Bereavement Occupational problem

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People can and often do have diagnoses on Axes I and II. For example, a young man may have a substance abuse disorder that we can find on Axis I. In addition, he may also behave manipulatively when dealing with others. He may chronically lie, and show lack of remorse for his harmful actions to others. We associate all these characteristics with the Axis II disorder that we call Antisocial Personality Disorder.

Axis III: General Medical Conditions

The clinician records the client's medical conditions using the medical profession's diagnostic numbering system, the ICD, which we discuss below. By specifying the client's physical illnesses, the clinician transmits information that has important therapeutic implications. For example, a person with chronic heart disease should not receive certain psychiatric medications. In addition, knowing about a client's medical condition can provide important information about the mental disorder's etiology, which is its presumed cause. It would be useful to know that a middle-aged man appearing in treatment for a depressive disorder for the first time had a heart attack six months ago. The heart attack may have constituted a risk factor for the development of depression, particularly in a person with no previous psychiatric history.

Axis IV: Psychosocial and Environmental Problems

In providing a total diagnostic picture of the client's psychological disorder, clinicians must evaluate the extent to which a person is under stress. Axis IV provides a place for the clinician to document events or pressures that may affect the diagnosis, treatment, or outcome of a client's psychological disorder. A person first showing signs of an anxiety disorder shortly after becoming unemployed presents a very different diagnostic picture than someone whose current life circumstances have not changed at all in several years. For the most part, the life events on Axis IV are negative. However, we might consider positive life events, such as a job promotion, as stressors. A person who receives a major job promotion may encounter psychological difficulties due to his or her increased responsibilities and demands with the new position. We have provided examples from Axis IV in Table 2.2.

TABLE 2.2 **Examples from Axis IV of the *DSM-IV-TR***

Problem	Examples
Problems with primary support group	Death of significant family member, physical or sexual abuse, remarriage of parent (for a child), divorce (for an adult)
Problems related to the social environment	Social isolation, adjusting to life cycle transition (such as retirement), difficulty with acculturation
Occupational problems	Unemployment, job dissatisfaction, difficult work situation
Housing problems	Homelessness, unsafe neighbors, inadequate housing
Economic problems	Poverty, serious credit problems
Problems with access to health services	Inadequate health insurance
Problems related to the legal system	Incarceration, victim of crime
Other psychosocial problems	Exposure to disasters

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Axis V: Global Assessment of Functioning

Clinicians rate the overall functioning of the client along Axis V, which documents the clinician's overall judgment of a client's psychological, social, and occupational functioning. The **Global Assessment of Functioning (GAF) scale,** which is the basis for Axis V, allows for a rating of the individual's overall level of psychological health. Table 2.3 illustrates the points in the full scale along with examples of each range of scores.

Clinicians make the GAF ratings for the client's current functioning at the point of admission or discharge, or the highest level of functioning during the previous year. The rating of the client's functioning during the preceding year provides the clinician with important information about the client's **prognosis,** or likelihood of recovering from the disorder. If a client has functioned effectively in the recent past, the clinician has more reason to hope for improvement. The prognosis may not be so bright if a client has a lengthy history of poor adjustment.

Global Assessment of Functioning (GAF) scale
Axis V of the *DSM-IV,* a scale that rates the individual's overall level of psychological health.

prognosis
A client's likelihood of recovering from a disorder.

Culture-Bound Syndromes

Within particular cultures, there are idiosyncratic patterns of symptoms, many of which have no direct counterpart to a specific *DSM-IV-TR* diagnosis. **Culture-bound syndromes** are behavior patterns that exist only within particular cultures. To qualify as a culture-bound syndrome, the symptoms must not have any clear biochemical or physiological sources. Only that particular culture, and not others, recognizes the symptoms of a culture-bound syndrome. Table 2.4 describes examples of some of the best-studied culture-bound syndromes.

culture-bound syndromes
Recurrent patterns of abnormal behavior or experience that are limited to specific societies or cultural areas.

TABLE 2.3 **Axis V: Global Assessment of Functioning Scale**

Rating	Level of Symptoms	Examples
91–100	Superior functioning; no symptoms	
81–90	No symptoms or minimal symptoms; generally good functioning in all areas; no more than everyday problems	Occasional worries such as feeling understandably anxious before taking examinations or feelings of disappointment following an athletic loss
71–80	Transient, slight symptoms that are reasonable responses to stressful situations; no more than slight impairment in social, occupational, or school functioning	Concentration difficulty following an exciting day; trouble sleeping after an argument with partner
61–70	Mild symptoms, or some difficulty in social, occupational, or school functioning	Mild insomnia; mild depression
51–60	Moderate symptoms or moderate difficulties in social, occupational, or school functioning	Occasional panic attacks; conflicts with roommates
41–50	Serious symptoms or any serious impairment in social, occupational, or school functioning	Suicidal thoughts; inability to keep job
31–40	Serious difficulties in thought or communication or major impairment in several areas of functioning	Illogical speech; inability to work; neglect of responsibilities
21–30	Behavior influenced by psychotic symptoms or serious impairment in communication or judgment or inability to function in almost all areas	Delusional and hallucinating; incoherent; preoccupied with suicide; stays in bed all day every day
11–20	Dangerous symptoms or gross impairment in communication	Suicide attempts without clear expectation of death; muteness
1–10	Persistent danger to self or others or persistent inability to maintain hygiene	Recurrent violence; serious suicidal act with clear expectation of death
0	Inadequate information	

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TABLE 2.4 Culture-Bound Syndromes in the *DSM-IV-TR*

Certain psychological disorders, such as depression and anxiety, are universally encountered. Within particular cultures, however, idiosyncratic patterns of symptoms are found, many of which have no direct counterpart to a specific *DSM-IV-TR* diagnosis. These conditions, called culture-bound syndromes, are recurrent patterns of abnormal behavior or experience that are limited to specific societies or cultural areas.

Culture-bound syndromes may fit into one or more of the *DSM-IV-TR* categories, just as one *DSM-IV-TR* category may be thought to be several different conditions by another culture. Some disorders recognized by the DSM-IV-TR are seen as culture-bound syndromes, because they are specific to industrialized societies (e.g., anorexia nervosa).

This table describes some of the best-studied culture-bound syndromes and forms of distress that may be encountered in clinical practice in North America, as well as the *DSM-IV-TR* categories they most closely resemble.

Term	Location	Description	*DSM-IV-TR* Disorders
Amok	Malaysia	Dissociative episode consisting of brooding followed by violent, aggressive, and possibly homicidal outburst. Precipitated by insult; usually seen more in males. Return to premorbid state following the outburst.	
Ataque de nervios	Latin America	Distress associated with uncontrollable shouting, crying, trembling, and verbal or physical aggression. Dissociation, seizure, and suicidal gestures possible. Often occurs as a result of a stressful family event. Rapid return to premorbid state.	Anxiety Mood Dissociative Somatoform
Bilis and colera	Latin America	Condition caused by strong anger or rage. Marked by disturbed core body imbalances, including tension, trembling, screaming, and headache, stomach disturbance. Chronic fatigue and loss of consciousness possible.	
Bouffée délirante	West Africa and Haiti	Sudden outburst of agitated and aggressive behavior, confusion, and psychomotor excitement. Paranoia and visual and auditory hallucinations possible.	Brief psychotic
Brain fag	West Africa	Difficulties in concentration, memory, and thought, usually experienced by students in response to stress. Other symptoms include neck and head pain, pressure, and blurred vision.	Anxiety Depressive Somatoform
Dhat	India	Severe anxiety and hypochondriacal concern regarding semen discharge, whitish discoloration of urine, weakness, and extreme fatigue.	
Falling out or *blacking out*	Southern United States and the Caribbean	A sudden collapse, usually preceded by dizziness. Temporary loss of vision and the ability to move.	Conversion Dissociative
Ghost sickness	American Indian tribes	A preoccupation with death and the deceased. Thought to be symbolized by bad dreams, weakness, fear, appetite loss, anxiety, hallucinations, loss of consciousness, and a feeling of suffocation.	
Hwa-byung (wool-hwa-byung)	Korea	Acute feelings of anger resulting in symptoms including insomnia, fatigue, panic, fear of death, dysphoria, indigestion, loss of appetite, dyspnea, palpitations, aching, and the feeling of a mass in the abdomen.	
Koro	Malaysia	An episode of sudden and intense anxiety that one's penis or vulva and nipples will recede into the body and cause death.	
Latah	Malaysia	Hypersensitivity to sudden fright, usually accompanied by symptoms including echopraxia (imitating the movements and gestures of another person), echolalia (irreverent parroting of what another person has said), command obedience, and dissociation, all of which are characteristic of schizophrenia.	

Term	Location	Description	*DSM-IV-TR* Disorders
Mal de ojo	Mediterranean cultures	Means "the evil eye" when translated from Spanish. Children are at much greater risk; adult females are at a higher risk than adult males. Manifested by fitful sleep, crying with no apparent cause, diarrhea, vomiting, and fever.	
Pibloktog	Arctic and sub-Arctic Eskimo communities	Abrupt dissociative episode associated with extreme excitement, often followed by seizures and coma. During the attack, the person may break things, shout obscenities, eat feces, and behave dangerously. The victim may be temporarily withdrawn from the community and report amnesia regarding the attack.	
Qi-gong psychotic reaction	China	Acute episode marked by dissociation and paranoia that may occur following participation in qi-gong, a Chinese folk health-enhancing practice.	
Rootwork	Southern United States, African American and European populations, and Caribbean societies	Cultural interpretation that ascribes illness to hexing, witchcraft, or sorcery. Associated with anxiety, gastrointestinal problems, weakness, dizziness, and the fear of being poisoned or killed.	
Shen-k'uei or *Shenkui*	Taiwan and China	Symptoms attributed to excessive semen loss due to frequent intercourse, masturbation, and nocturnal emission. Dizziness, backache, fatigue, weakness, insomnia, frequent dreams, and sexual dysfunction. Excessive loss of semen is feared, because it represents the loss of vital essence and therefore threatens one's life.	
Shin-byung	Korea	Anxiety and somatic problems followed by dissociation and possession by ancestral spirits.	
Spell	African American and European American communities in the southern United States	Trance state in which communication with deceased relatives or spirits takes place. Sometimes connected with a temporary personality change.	
Susto	Latinos in the United States and Mexico, Central America, and South America	Illness caused by a frightening event that causes the soul to leave the body. Causes unhappiness, sickness (muscle aches, stress headache, and diarrhea), strain in social roles, appetite and sleep disturbances, lack of motivation, low self-esteem, and death. Healing methods include calling the soul back into the body and cleansing to restore bodily and spiritual balance.	Major depressive Post-traumatic stress Somatoform
Taijin kyofusho	Japan	Intense fear that one's body parts or functions displease, embarrass, or are offensive to others regarding appearance, odor, facial expressions, or movements.	
Zar	Ethiopia, Somalia, Egypt, Sudan, Iran, and other North African and Middle Eastern societies	Possession by a spirit. May cause dissociative experiences characterized by shouting, laughing, hitting of one's head against a hard surface, singing, crying, apathy, withdrawal, and change in daily habits.	

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2.3 The International Classification of Diseases (ICD)

Most mental health professionals outside the U.S. and Canada use the World Health Organization's (WHO) diagnostic system, which is the International Classification of Diseases (ICD). WHO developed the ICD as an epidemiological tool. With a common diagnostic system, the 110 member nations can compare illness rates and have assurance that countries employ the same terminology for the sake of consistency. The tenth edition (ICD-10) is currently in use; it is undergoing a major revision, and WHO projects that ICD-11 will be available no earlier than 2014. The ICD is available in WHO's six official languages (Arabic, Chinese, English, French, Russian, and Spanish), as well as in 36 other languages.

2.4 The Diagnostic Process

The diagnostic process involves using all relevant information to arrive at a label that characterizes the client's disorder. This information includes the results of any tests given to the client, material gathered from interviews, and knowledge about the client's personal history. Clinicians use the first phase of working with clients to gather this information prior to proceeding with the treatment itself.

Diagnostic Procedures

Key to diagnosis is gaining as clear a description as possible of a client's symptoms, both those that the client reports and those that the clinician observes. Dr. Tobin, when hearing Peter describe himself as "anxious," immediately assumes that he *may* have an anxiety disorder. However, clients do not always label their internal states accurately. Therefore, the clinician also must attend carefully to the client's behavior, emotional expression, and apparent state of mind. The client may express anxiety, but his behavior may suggest that instead he is experiencing a mood disorder.

Clinicians first listen to clients as they describe the experience of their symptoms, but they must next follow this up with a more systematic approach to diagnosis. As you will learn in Chapter 3, a variety of assessment tools give the clinician a framework for determining the extent to which these symptoms coincide with the diagnostic criteria of a given disorder. The clinician must determine the exact nature of a client's symptoms, the length of time the client has experienced these symptoms, and any associated symptoms. In the process, the clinician also obtains information about the client's personal and family history. By asking questions in this manner, the clinician begins to formulate the **principal diagnosis**—namely, the disorder most closely aligned with the primary reason the individual is seeking professional help.

principal diagnosis
The disorder that is considered to be the primary reason the individual seeks professional help.

comorbid
The situation that occurs when multiple diagnostic conditions occur simultaneously within the same individual.

differential diagnosis
The process of systematically ruling out alternative diagnoses.

For many clients, the symptoms they experience reflect the presence of more than one principal diagnosis. In these cases, we use the term **comorbid,** meaning literally two (or more) disorders. Comorbidity is remarkably common. A major investigation, known as the National Comorbidity Survey (NCS), showed that over half of respondents with one psychiatric disorder also had a second diagnosis at some point in their lives. The most common comorbidities involve drug and/or alcohol abuse with other psychiatric disorders.

Differential diagnosis, the ruling out of alternative diagnoses, is a crucial step in the diagnostic process. It is important for the clinician to eliminate the possibility that the client is experiencing a different disorder or perhaps an additional disorder. Peter states that he is anxious, and his symptoms suggest the disorder known as "general anxiety disorder," but Dr. Tobin needs to consider whether this diagnosis best suits his symptoms or not. It is possible that Peter suffers from panic disorder, another anxiety disorder involving the experience of panic attacks. His symptoms may also suggest social

anxiety disorder. Alternatively, he might be suffering from adjustment difficulties following the divorce of his parents or the stress of his job. He may even have a substance abuse disorder, an undiagnosed medical condition, or even a third disorder. Dr. Tobin's initial diagnostic must be tested against these possibilities during the assessment period of treatment.

The diagnostic process can take anywhere from a few hours to weeks depending on the complexity of the client's presenting symptoms. The client and clinician may accomplish therapeutic work during this time, particularly if the client is in crisis. For example, Dr. Tobin will start Peter on antianxiety medications right away to help him feel better. However, her ultimate goal is to arrive at as thorough an understanding as possible of Peter's disorder. This paves the way for her to work with Peter throughout the treatment process.

Case Formulation

Once the clinician makes a formal diagnosis, he or she is still left with a formidable challenge—to piece together a picture of how the disorder evolved. With the diagnosis, the clinician can assign a label to the client's symptoms. Although informative, this label tells the client's full story. To gain a full appreciation of the client's disorder, the clinician develops a **case formulation:** an analysis of the client's development and the factors that might have influenced his or her current psychological status. The case formulation provides an analysis that transforms the diagnosis from a set of code numbers to a rich piece of descriptive information about the client's personal history. With this descriptive information, the clinician can design a treatment plan that is attentive to the client's symptoms, unique past experiences, and future potential for growth.

case formulation
A clinician's analysis of the factors that might have influenced the client's current psychological status.

Understanding the client from a developmental perspective is crucial to provide a thorough case formulation. In Dr. Tobin's work with Peter, she will flesh out the details of her case formulation as she gets to know him better in the initial therapy phases. Her case formulation will expand to include Peter's family history, focusing on the divorce of his parents, as well as the possible causes of his perfectionism and concern over his academic performance. She will try to understand why he feels so overwhelmed at work and gain a perspective on why his relationship with Ashley has been so problematic. Finally, she will need to investigate the possible role of his mother's panic attacks and how they relate to Peter's experience of anxiety symptoms. To aid in differential diagnosis, Dr. Tobin will also evaluate Peter's pattern of substance use as well as any possible medical conditions that she did not detect during the initial assessment phase.

Cultural Formulation

Clinicians need to account for the client's cultural background in making diagnoses. A **cultural formulation** includes the clinician's assessment of the client's degree of identification with the culture of origin, the culture's beliefs about psychological disorders, the ways in which the culture interprets particular events, and the cultural supports available to the client.

cultural formulation
Includes the clinician's assessment of the client's degree of identification with the culture of origin, the culture's beliefs about psychological disorders, the ways in which the culture interprets particular events, and the cultural supports available to the client.

We might expect cultural norms and beliefs to have a stronger impact on clients who strongly identify with their culture of origin. The client's familiarity with and preference for using a certain language is one obvious indicator of cultural identification. A culture's approach to understanding the causes of behavior may influence clients who strongly identify with their culture. Exposure to these belief systems may influence the expression of a client's symptoms.

Even if a client's symptoms do not represent a culture-bound syndrome, clinicians must consider the individual's cultural framework as a backdrop. Members of a given culture attach significant meanings to particular events. For example, within certain

Symptoms of psychological disorders often vary based on the culture the individual belongs to.

Asian cultures, an insult may provoke the condition known as *amok*, where a person (usually male) enters an altered state of consciousness in which he becomes violent, aggressive, and even homicidal. In Peter's case, although he is a product of middle-class white background, it is possible that cultural factors are influencing his extreme preoccupation with his academic performance. Perhaps his family placed pressure on him to succeed due to their own incorporation of belief in the importance of upward mobility. They may have pressured him heavily to do well in school, and as a result, he felt that his self-worth as an individual depended on his grades. As an adult, he is unable to shake himself from this overly harsh set of values.

Clinicians should look within the client's cultural background as a way of determining available cultural supports. Clients from certain cultures, particularly Black, Hispanic, Latino, and Asian, have extended family networks and religion, which provide emotional resources to help individuals cope with stressful life events.

Cultural formulations are important to understanding psychological disorders from a biopsychosocial perspective. The fact that psychological disorders vary from one society to another supports the claim of the sociocultural perspective that cultural factors play a role in influencing the expression of abnormal behavior.

Psychologists are increasingly gaining education in training in working within the multicultural framework to take into account not only a client's race and ethnicity, but also age, gender, sexual orientation, and disability status, among others (American Psychological Association, 2002). Through such education, clinicians can learn how to adapt not only their diagnostic methods more generally but to adopt a multicultural approach throughout treatment.

2.5 Planning the Treatment

treatment plan
The outline for how therapy should take place.

Clinicians typically follow up the diagnosis phase by setting up a **treatment plan,** the outline for how therapy should take place. In the treatment plan, the clinician describes the treatment goals, treatment site, modality of treatment, and theoretical approach. The decisions the clinician makes while putting the treatment plan together reflect what he or she knows at the time about the client's needs and the available resources. However, clinicians often revise the treatment plan once they see how the proposed intervention methods are actually working.

You Be the Judge

Psychologists as Prescribers

In 2002, New Mexico became the first state to approve prescription privileges for psychologists. Louisiana followed shortly thereafter, passing similar legislation in 2004. These landmark pieces of legislation are paving the way for other states to take similar action. However, the question remains controversial. In 2010, the Oregon legislature passed a bill (SB 1046) granting prescriptive authority to psychologists, but Governor Ted Kulongoski vetoed the bill, in response to pressure from various lobbying groups, including psychiatrists.

There are several arguments against the granting of prescription privileges to psychologists. Unlike psychiatrists, psychologists do not receive medical training and therefore do not have the undergraduate pre-medical training or the years of medical school, internship, and residency that physicians receive. Philosophically, research-oriented psychologists argue that the granting of prescription privileges takes away from the notion that psychologists are scientists as well as practitioners. Psychologists should not be in the business, they argue, of handing out medication. A second argument against prescription privileges concerns the role of medication in psychological treatment. From this perspective, psychologists should be focused on psychotherapy. The long-term benefits of psychotherapy, these critics argue, are equal to if not greater than the long-term benefits of medication for the majority of disorders including major depression, anxiety disorders, and other nonpsychotic disorders. In the exceptional cases of serious mental illness, such as schizophrenia and bipolar disorder, psychologists can work as a team with psychiatrists to maintain their clients on long-term medication regimens.

The arguments in favor of prescription privileges are also compelling. If psychologists have the power to prescribe medications, they can do a better job than psychiatrists do integrating medication into psychotherapy. From the client's point of view, there is greater continuity of care, in that the individual does not need to see more than one mental health practitioner. Psychologists in favor of prescription privileges also point to the fact that specialized training is required for a clinical psychologist to be able to prescribe medications aimed at psychological disorders. Therefore, the psychologists who do prescribe have an equal knowledge base as do physicians. A second argument in favor of prescription privileges is that there are other nondoctoral level health professionals with this legal power including psychiatric nurse practitioners and psychiatric nurse specialists, among others, although the exact nature of their privileges varies across states.

The American Psychological Association's Practice Directorate continues to lobby in favor of more widespread acceptance of prescription privileges across the United States. However, as the Oregon case demonstrates, this legislation is likely to face a rocky road in other states.

Q: *You be the judge:* Does having prescription privileges reduce the scientific status of psychology as a profession? Would you prefer that the psychologist you might see for treatment can also incorporate medications into your treatment?

Goals of Treatment

The first step in treatment planning is for the clinician to establish treatment goals, ranging from immediate to long term. Ideally, treatment goals reflect what we know about both the disorder and the recommended therapy, and the particular needs and concerns of the individual client.

The immediate goal of treating clients in crisis is to ensure that their symptoms are managed, particularly if they are at risk to themselves or others. Peter, for example, needs psychiatric treatment in order to bring his anxiety symptoms under control. The

At this crisis center, telephone counselors are available 24 hours a day.

clinician may need to hospitalize a client who is severely depressed and suicidal. The treatment plan may only include this immediate goal until the clinician gains a broader understanding of the client's situation.

Short-term goals are aimed at alleviating the client's symptoms by addressing problematic behavior, thinking, or emotions. The plan at this point might include establishing a working relationship between the clinician and client, as well as setting up specific objectives for therapeutic change. Another short-term goal might be to stabilize a client taking medications, a process that might take as long as several weeks or longer if the first round of treatment is unsuccessful. In Peter's case, Dr. Tobin will need to ensure that the medications he is receiving are in fact helping to alleviate his anxiety. She will also need to work with the psychiatrist to monitor any adverse side effects. Her short-term goals with Peter will also include beginning to examine the nature of his anxiety and how he can start to manage his symptoms using psychological interventions.

Long-term goals include more fundamental and deeply rooted alterations in the client's personality and relationships. These are the ultimate aims of therapeutic change. Ideally, the long-term goals for any client are to cope with the symptoms of the disorder and to develop a strategy to manage them, if not achieve complete recovery. Depending on the nature of the client's disorder, available supports, and life stress, these long-term goals may take years to accomplish. Dr. Tobin's long-term goals with Peter are to take him off the medication. At the same time, she would plan to help him gain an understanding of the causes of his symptoms, and in the process, reduce their severity if not eliminate them altogether.

In many cases, clinicians carry out treatment goals in a sequential manner. First the clinician deals with the crisis, then handles problems in the near future, and finally addresses issues that require extensive work well into the future. However, many clients experience a cyclical unfolding of stages. New sets of immediate crises or short-term goals may arise in the course of treatment. Or there may be a redefinition of long-term goals as the course of treatment progresses. It is perhaps more helpful to think of the three stages not as consecutive stages per se, but as implying different levels of treatment focus.

Treatment Site

Clinicians juggle a number of issues when recommending which treatment site will best serve the client. Treatment sites vary in the degree to which they provide a controlled environment and in the nature of the services that clients will receive. Clients who are in crisis or are at risk of harming themselves or others need to be in controlled environments. However, there are many other considerations including cost and insurance coverage, the need for additional medical care, availability of community support, and the projected length of treatment. In some cases, clinicians recommend client treatment in outpatient settings, schools, or the workplace.

Psychiatric Hospitals

In a psychiatric hospital, a client receives medical interventions and intensive forms of psychotherapy. These settings are most appropriate for clients at risk of harming themselves or others and who seem incapable of self-care. In some cases, clinicians may involuntarily hospitalize clients through a court order until they can bring the symptoms under control (we will discuss this in more detail in Chapter 15).

Community treatment centers, like this one, provide much needed care to individuals with a wide range of psychological disorders.

Specialized Inpatient Treatment Centers

Clients may need intensive supervision, but not actual hospital care. For these individuals, specialized inpatient treatment centers provide both supportive services and round-the-clock monitoring. These sites include recovery treatment centers for adults seeking to overcome substance addiction. Clinicians may also recommend this treatment site to children who need constant monitoring due to severe behavioral disturbances.

Outpatient Treatment

By far, the most common treatment site is a private therapist's outpatient clinic or office. **Community mental health centers (CMHCs)** are outpatient clinics that provide psychological services on a sliding fee scale for individuals who live within a certain geographic area. Professionals in private practice offer individual or group sessions. Some prepaid health insurance plans cover the cost of such visits, either to a private practitioner or to a clinician working in a health maintenance organization (HMO). Agencies supported partially or completely by public funds may also offer outpatient treatment. Dr. Tobin will see Peter in outpatient treatment because his symptoms are not sufficiently severe to justify hospitalization.

community mental health center (CMHC)
Outpatient clinic that provides psychological services on a sliding fee scale to serve individuals who live within a certain geographic area.

Clients receiving outpatient services will, by necessity, receive more limited care than what they would encounter in a hospital, in terms of both the time involved and the nature of the contact between client and clinician. Consequently, clinicians may advise that their clients receive additional services, including vocational counseling, in-home services, or the support of a self-help organization, such as Alcoholics Anonymous.

Halfway Houses and Day Treatment Programs

Clients with serious psychological disorders who are able to live in the community may need the additional support that they will receive in sites that are intended to serve the needs of this specific population. These facilities may be connected with a hospital, a public agency, or a private corporation. **Halfway houses** are designed for clients who have been discharged from psychiatric facilities, but who are not yet ready for independent living. A halfway house provides a living context with other deinstitutionalized people, and it is staffed by professionals who work with clients in developing the skills they need to become employed and to set up independent living situations. **Day treatment programs** are designed for formerly hospitalized clients as well as for clients who do not need hospitalization, but do need a structured program during the day, similar to what a hospital provides.

halfway house
A community treatment facility designed for deinstitutionalized clients leaving a hospital who are not yet ready for independent living.

day treatment program
A structured program in a community treatment facility that provides activities similar to those provided in a psychiatric hospital.

Guidance counselors are often the first professionals to whom troubled students turn for professional assistance.

Other Treatment Sites

Clinicians may recommend that their clients receive treatment in the places where they work or go to school. School psychologists are trained to work with children and teenagers who require further assessment or behavioral interventions. In the workplace, Employee Assistance Programs (EAP) provide employees with a confidential setting in which they can seek individual treatment in the form of counseling, assistance with substance abuse, and family treatment. These resources may prove important for clinicians who wish to provide their clients with as many resources over the long term as possible.

Modality of Treatment

The **modality,** or form in which the clinician offers psychotherapy, is another crucial component of the treatment plan. Clinicians recommend one or more modalities depending on the nature of the client's symptoms and whether or not other people in the client's life should be involved.

Clients receive treatment on a one-to-one basis in **individual psychotherapy.** In couples therapy, both partners in a relationship, and in **family therapy,** several or all family members are involved in treatment. In family therapy, family members may identify one person as the "patient." The therapist, however, views the whole family system as the target of the treatment. **Group therapy** provides a modality in which clients who face similar issues can openly share their difficulties with others, receive feedback, develop trust, and improve their interpersonal skills.

A clinician may recommend any or all of these modalities in any setting. Specific to psychiatric hospitals is **milieu therapy,** which is based on the premise that the milieu, or environment, is a major component of the treatment. Ideally, the milieu is organized in a way that allows clients to receive consistently therapeutic and constructive reactions from all who live and work there. In addition to traditional psychotherapy, clients participate in other therapeutic endeavors through group or peer counseling, occupational therapy, and recreational therapy.

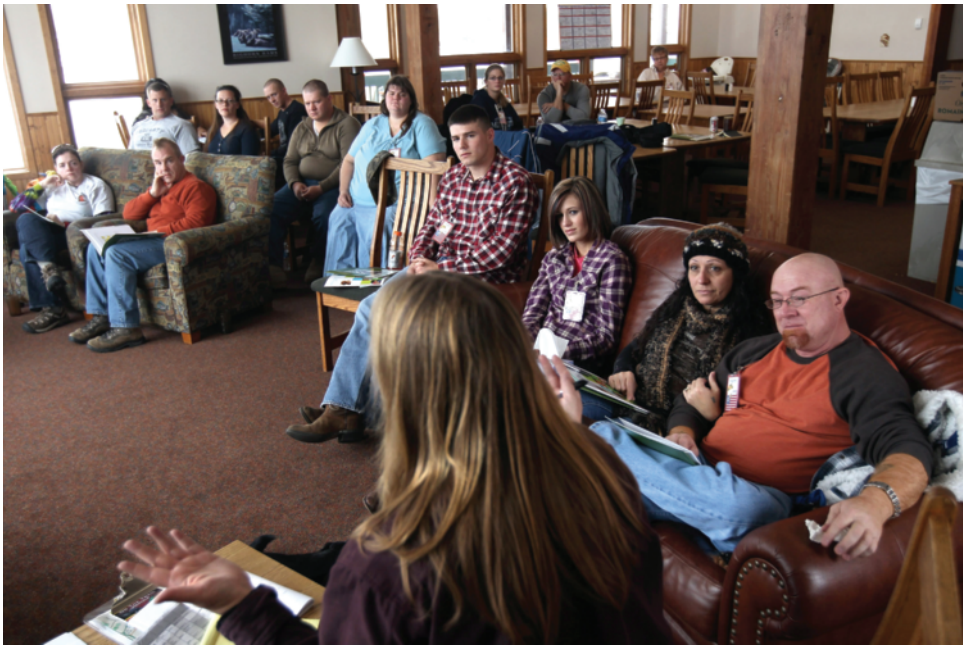
modality
Form in which the clinician offers psychotherapy.

individual psychotherapy
Psychological treatment in which the therapist works on a one-to-one basis with the client.

family therapy
Psychological treatment in which the therapist works with several or all members of the family.

group therapy
Psychological treatment in which the therapist facilitates discussion among several clients who talk together about their problems.

milieu therapy
A treatment approach, used in an inpatient psychiatric facility, in which all facets of the milieu, or environment, are components of the treatment.



Milieu therapy involves many patients participating within a community setting.

Determining the Best Approach to Treatment

Whatever treatment modality a clinician recommends, it must be based on the choice of the most appropriate theoretical perspective or combination of perspectives. Many clinicians are trained according to a particular set of assumptions about the origins of psychological disorders and the best methods of treating these disorders. Often, this theoretical orientation forms the basis for the clinician's treatment decisions. However, just as frequently, clinicians adapt their theoretical orientation to fit the client's needs.

After decades of debate regarding which treatments are most effective, and for whom, psychologists adopted the principles of **evidence-based practice in psychology**—clinical decision making that integrates the best available research evidence and clinical expertise in the context of the cultural background, preferences, and characteristics of clients (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). In other words, clinicians should base their treatments on state-of-the-art research findings that they adapt to the particular features of the client, taking into account the client's background, needs, and prior experiences. Clinicians currently use these criteria as the basis for curricula in graduate programs and postdoctoral continuing education (Collins, Leffingwell, & Belar, 2007).

evidence-based practice in psychology
Clinical decision making that integrates the best available research evidence and clinical expertise in the context of the cultural background, preferences, and characteristics of clients.

As you read in this book about various disorders and the most effective treatments, it will be important to keep in mind the empirical basis for the treatment conclusions. Findings from efficacy studies shed light on appropriate interventions, but they are insufficient for conclusively determining what is most effective with real people with complex problems.

2.6 The Course of Treatment

The way treatment proceeds is a function of the clinician's and client's contributions. Each has a part to play in determining the outcome of the case, as does the unique interaction of their personalities, abilities, and expectations.

The Clinician's Role in Treatment

Above and beyond whatever techniques a clinician uses to treat a client's problems, the quality of the relationship between the client and clinician is a crucial determinant of whether therapy will succeed or not. A good clinician does more than objectively administer treatment to a client. The best clinicians infuse a deep personal interest, concern, and respect for the client into the therapeutic relationship. Dr. Tobin will work with Peter in the initial weeks of therapy to establish this solid basis for their further work together.

The Client's Role in Treatment

In optimal situations, psychotherapy is a joint enterprise in which the client plays an active role. It is largely up to the client to describe and identify the nature of his or her disorder, to describe personal reactions as treatment progresses, and to initiate and follow through on changes.

The client's attitudes toward therapy and the therapist are an important part of the contribution the client makes to the therapeutic relationship. There is a special quality to the help that the client is requesting; it involves potentially painful, embarrassing, and personally revealing material that the client is not accustomed to disclosing to someone else. Most people are much more comfortable discussing their medical, legal, financial, and other problems outside the realm of emotions. Social attitudes toward psychological disorders also play a role. People may feel that they should be able to handle their emotional problems without seeking help. They may believe that, if they can't solve their

REAL STORIES

Daniel Johnston: Mood Disturbance

"Wherever I am, I have music in my heart."

Daniel Johnston, born on January 22, 1961, is an American singer-songwriter well known for his unique musical talent as well as his life-long struggle with bipolar disorder. The 2005 documentary, *The Devil and Daniel Johnston*, depicts his incredible story from childhood in West Virginia to the present day. Though Daniel has had an extraordinary musical career, his tumultuous journey with mental illness is not unlike that of many other individuals who suffer from severely debilitating psychological disorders. Through his music, Daniel expresses both the soaring, sometimes delusional manias and the dark, unbearable depths of depression he has faced throughout his life.

The youngest of five children, Daniel's mother, Mabel, recalls that ". . . he was different . . . I noticed that from the start." As a teenager, inspired mostly by comic books, he took on countless artistic endeavors including drawing and making playful movies about his life at home. His creativity helped him gain attention from friends and classmates, but also endlessly frustrated his highly religious and traditional parents, who would rather he spend his time attending church, working, and helping out around the house. Daniel's passion for creating has remained with him his entire life. In the words of Daniel's best friend, David Thornberry, "He exudes art . . . he can't stop making art."

As with many individuals with severe mood disorders, Daniel's behavior began to change for the worse after leaving home for college. His family was used to him acting differently than his peers, but in college Daniel started to become confused and disoriented. A visit to the family physician resulted in a diagnosis of manic-depression (bipolar disorder). Unable to continue with the challenges he faced at school, he returned home and enrolled in a small arts college in nearby Ohio. In art school, Daniel met and subsequently fell in love with his classmate Laurie. Though they never had a romantic relationship and she went on to marry another man, Daniel's unrequited love for her has been one of his most powerful creative muses and also caused his first major depressive episode. It was at this point, his mother recalls, that he began to play the piano and write songs.

Daniel was having trouble in his courses at art school, and so his family once again took him out of school. This time they sent him to live with his older brother in Houston, in hopes that he could start building a productive life. Daniel worked part-time at a local amusement park and began recording music in his brother's garage. After his brother grew frustrated that Daniel was not finding stable work, he sent him to live with his sister, Margie. One morning, Margie noticed that Daniel had never returned home the night before. His family did not hear from Daniel for months; when they did, they learned that he had spontaneously purchased a moped and joined a traveling carnival. When the carnival stopped in Austin, Texas, Daniel was assaulted on the fair grounds and fled to a local church for help. He was able to find housing in Austin and began taking his homemade tape-recorded albums to local musicians and newspapers. One of the local musicians he met was Kathy McCarthy. The two briefly dated, and after meeting him, Kathy remembers, "It was undeniable after one or two weeks that something was dreadfully wrong with him."

In one scene of *The Devil and Daniel Johnston*, he reads a detailed account of the characteristics of an individual with his condition, stating, "There you have it. I'm a manic depressive with grand delusions." The majority of his delusions were paranoid and religious in nature, perhaps the result of his highly religious upbringing. Although Daniel was well aware of his illness, at the time he was doing little to assuage it. In Austin, Daniel began to smoke marijuana and regularly experimented with LSD, causing several bizarre and sometimes violent episodes. Simultaneously, Daniel's music career began to blossom as he gained recognition as well as notoriety for his music and his often bizarre live performances.

In 1986, a Christmas gathering with his siblings soon turned into a horrifying event. Daniel began preaching about Satan to his family, and began attacking his brother,

Daniel Johnston's songs provide a glimpse into his struggles with mental illness.

breaking his rib. Frightened by his behavior, and unsure of what to do, his siblings drove him to a nearby bus station. Soon after, the police discovered Daniel at the University of Austin, splashing in the middle of a pond and again preaching about Satan. It was at this point that his friends and family began to realize that, as one friend put it, "he was a really sick person." While his music had been a way for him to filter the demons in his mind, Daniel's illness was beginning to wreak havoc on his life, and drastic measures were necessary to ensure he did no further harm to others or to himself. Doctors prescribed Daniel the antipsychotic medication, Haldol, and he spent the entire year of 1987 in bed (what he called his "lost year"). Although he was stabilized, Daniel found himself unable to write any music during this period. Indeed, throughout his life and like many individuals with bipolar disorder, Daniel often struggled with medication compliance. He felt that he was better at creating and performing when his mind was allowed to run free rather than be confined to the numbness he felt while on medication.

Because he often went off his medication, Daniel experienced a five-year whirlwind of breakdowns that cycled between delusional mania and clinical depression, resulting in numerous hospitalizations that lasted months at a time. When first going off his medication, Daniel's behavior and mood were normal for up to a few days until he would quickly and unexpectedly take a turn for the bizarre. In one particular instance, Daniel had stopped taking his medication before playing to a large auditorium for a music festival in Austin, Texas. The appearance was one of the most acclaimed performances of his career. Shortly afterwards however, when he and his father boarded the two-person plane to take them home to West Virginia, Daniel seized the controls from his father, sending their plane crashing toward the ground. Luckily, Daniel's father was able to regain control of the plane in time, and they survived after landing on a treetop. Daniel's father now recalls that at the time Daniel believed he was Casper (from the children's cartoon about Casper the friendly ghost), and that taking over the plane was a heroic act.

Since that dark period of his life, Daniel has been stable in large part because of his supportive network of family and friends. He lives with his parents in Waller, Texas, and continues to write music and tour around the world. Many regard Daniel Johnston as one of the most brilliant singer-songwriters in American history. His heartbreaking battle with mental illness has been a destructive yet inspiring force in his work that blurs the line between artistic creativity and mental illness.

own emotional problems, it means they are immature or incompetent. Moreover, having to see a clinician may make a person believe that he or she is "crazy." Although attitudes toward therapy are becoming more accepting in current Western culture, there is still a degree of potential shame or embarrassment that clients must confront.

Most people would, though, feel less inclined to mention to acquaintances that they are in psychotherapy for personal problems. The pressure to keep therapy secret usually adds to a client's anxiety about seeking professional help. To someone who is already troubled by severe problems in living, this added anxiety can be further inhibiting. With so many potential forces driving the individual away from seeking therapy, the initial step is sometimes the hardest to take. Thus, the therapeutic relationship requires the client to be willing to work with the clinician in a partnership and to be prepared to endure the pain and embarrassment involved in making personal revelations. Moreover, it also requires a willingness to break old patterns and to try new ways of viewing the self and relating to others.

2.7 The Outcome of Treatment

In the best of all possible worlds, the treatment works. The client remains in treatment until the treatment runs its course, shows improvement, and maintains this improved level of functioning. Many times, though, the road is not so smooth, and either the client does not attain the treatment plan goals or unanticipated problems arise.

Clinicians find it particularly frustrating when their clients do not seem willing to follow through on their desire to change. Change is very difficult, and many clients have become so accustomed to living with their symptoms that the necessary effort to solve the problem seems overwhelming. At times, clinicians also face frustration over financial constraints. They may recommend a treatment that they are confident can succeed, but that is financially infeasible. In other cases, people in the client's life refuse to participate in the treatment, even though they play central roles. Other pragmatic issues can disrupt

therapy: Clients may move, lose jobs, or lack consistent transportation to the clinic. Over time, those in the mental health field learn that they are limited in how effective they can be in changing the lives of people who go to them for help. However, as you will learn in this book, therapy is usually effective and the majority of treatments do result in significant improvement.

Return to the Case: Peter Dickinson

Peter was prescribed antianxiety medication through the psychiatrist at the mental health clinic. Within four weeks, he reported that he was able to sleep through the night and was feeling less restless. His psychotherapy focused on relaxation techniques such as deep breathing as well as cognitive techniques such as labeling and challenging his worrying, and coming up with various ways to cope with stress rather than worrying excessively. Therapy was also helpful for Peter to discuss and sort through his feelings about his parents' divorce, and to understand how his anxiety affected his romantic relationships.

Dr. Tobin's reflections: Typical of many individuals with GAD, Peter has always felt like a constant "worrier," but this anxiety was recently aggravated by a stressful event: his parents' divorce. Additionally, his lack of sleep was likely contributing to his difficulty with the concentration that is necessary for keeping up with the standards of work required by his career. Since he had been doing well at work up until this point, he may not have felt that his anxiety was a problem. His anxiety may have also gone unnoticed due to the intense pressure and sacrifice that face all individuals who work in Peter's career area. It was clear however, that Peter worried about many issues to a greater degree than do others in his situation. At the time he presented for treatment, however, it was clear that his inability to control his worry over his parents and his girlfriend were causing major problems in his work and social life. Not only that, but his past anxiety had caused problems that he did not recognize at that time. For many people who suffer from GAD, the longer it goes untreated the worse it may get. Fortunately for Peter, his girlfriend recognized that he was struggling and was able to obtain help for his overwhelming anxiety. I am pleased with the progress of therapy so far, and am hopeful that given his many strengths, Peter will be able to manage his symptoms through the psychological methods over which he is gaining mastery. Peter has the potential to be a successful lawyer, and given the strength of his relationship with Ashley, I am hopeful that he will be able to turn his life around with only a slight chance of re-experiencing these symptoms.

SUMMARY

The field of abnormal psychology goes beyond the academic concern of studying behavior. It encompasses the large range of human issues involved when a client and a clinician work together to help the client resolve psychological difficulties.

- People working in the area of abnormal psychology use both "**client**" and "**patient**" to refer to those who use psychological services. Our preference is to use the term "client," reflecting the view that clinical interventions are a collaborative endeavor.
- The person providing the treatment is the **clinician.** There are many types of clinicians who approach clinical work in a variety of ways based on training and orientation. These include psychiatrists, clinical psychologists, social workers, counselors, therapists, and nurses. The field also includes those who do not have graduate-level training. These include occupational therapists, recreational therapists, and counselors who work in institutions, agencies, schools, and homes.
- Clinicians and researchers use the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition (*DSM-IV-TR*), which contains descriptions of all psychological disorders. In recent editions, the authors of the *DSM* have strived to meet the criterion of reliability so that a clinician can consistently apply a diagnosis to anyone showing a particular set of symptoms. At the same time, researchers have worked to ensure the validity of the classification system so that the various diagnoses represent real and distinct clinical phenomena.

- The *DSM-IV-TR* presents diagnoses using five separate **axes,** categories of information. The classification system is descriptive rather than explanatory, and it is categorical rather than dimensional. The axes include: Axis I (Clinical Disorders), Axis II (Personality Disorders and Mental Retardation), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning).
- The diagnostic process involves using all relevant information to arrive at a label that characterizes a client's disorder. Key to diagnosis is gaining as clear a description as possible of a client's symptoms, both those that the client reports and those that the clinician observes. **Differential diagnosis,** the ruling out of alternative diagnoses, is a crucial step in the diagnostic process.
- To gain full appreciation of the client's disorder, the clinician develops a **case formulation:** analysis of the client's development and the factors that might have influenced his or her current psychological status.
- A **cultural formulation** accounts for the client's cultural background in making diagnoses.
- **Culture-bond syndromes** are behavior patterns that we find only within particular cultures.
- Clinicians typically follow up the diagnosis phase by setting up a **treatment plan,** the outline for how therapy should take place. The first step in a treatment plan is for the clinician to establish treatment goals, ranging from immediate to long-term.
- Treatment sites vary in the degree to which they provide a controlled environment and in the nature of the services that clients receive. These include psychiatric hospitals, specialized inpatient treatment centers, outpatient treatment ranging from a private therapist's outpatient clinic or office, or a community based mental health center. Other treatment sites include halfway houses, day treatment programs, or places of work or school.
- **Modality,** or the form in which one offers psychotherapy, is also a crucial component of the treatment plan. It can be **individual, family, group,** or **milieu** therapy. Whatever treatment of modality a clinician recommends, it must be based on the choice of the most appropriate theoretical or combination of perspectives.
- In optimal situations, psychotherapy is a joint enterprise in which clients play an active role. In the best of all possible worlds, the client remains in treatment until the treatment runs its course, and the client shows improvement and maintains the improved level of functioning. While not always successful, therapy is usually effective, and the majority of treatments do result in significant improvement.

KEY TERMS

Axis 28
Case formulation 35
Client 26
Clinician 27
Clinical psychologist 27
Community mental health center (CMHC) 39
Comorbid 34
Culture-bound syndromes 31
Cultural formulation 34
Day treatment program 39
Diagnostic and Statistical Manual of Mental Disorders (DSM) 28
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