Discussion 2

Prior to beginning work on this discussion read Hill (2013) "Partnering with a Purpose: Psychologists as Advocates in Organizations," Cohen, Lee, & McIlwraith (2012) "The Psychology of Advocacy and the Advocacy of Psychology," Heinowitz, et al. (2012) "Identifying Perceived Personal Barriers to Public Policy Advocacy within Psychology," Lewis, Ratts, Paladino, & Toporek (2011) "Social Justice Counseling and Advocacy: Developing New Leadership Roles and Competencies," and Fox (2008) "Advocacy: The Key to the Survival and Growth of Professional Psychology" articles.

For this discussion, you will compare the various professional activities common to clinical and counseling psychologists and assume the role of an advocate for a client in one of the case studies from *Case Studies in Abnormal Psychology* (Gorenstein & Comer, 2015). Select a case study that has not been covered in this course or in the PSY645 course, and identify systemic barriers, sociopolitical factors, and multicultural issues impacting the client at the micro, meso, exo, and/or macro levels. Develop an action plan that outlines how you might advocate for the client at each appropriate level of the ecological model. Identify two potential partnerships that you would establish in order to support your client and those like him or her outside of the therapeutic environment.

attached

PLEASE USE attached RESOURCES FOR DISCUSSION THE Selected Case Study IS attached →

CASE 15

Borderline Personality Disorder

Table 15-1

Dx Checklist

Borderline Personality Disorder

1. Individuals display pronounced, wide-ranging, unstable, and impulsive patterns in their relationships, sense of self, and emotions. Such patterns begin by the time they reach their mid-20s.
2. The individuals specifically exhibit at least 5 of the following symptoms:
   - (a) Desperate efforts to avoid perceived abandonment.
   - (b) Fluctuations between idealizing and denigrating family members, friends, and coworkers.
   - (c) Highly changeable self-concept.
   - (d) Self-damaging displays of impulsivity.
   - (e) Repeated self-mutilating or suicidal acts or gestures.
   - (f) Significant fluctuations in moods and emotions.
   - (g) Long-term sense of emptiness.
   - (h) Experiences of extreme and often uncontrollable anger.
   - (i) Periodic, short-term paranoid ideas or dissociation during times of stress.

(Based on APA, 2013.)

Karen, a 36-year-old woman, single and unemployed, was admitted to the West Raymond Medical Center after deliberately taking an overdose of sedatives combined with alcohol. She made this suicide attempt when the man she had been dating for 3 months told her he didn't want to see her any more. Karen lost consciousness from the overdose, and spent the next 3 days in West Raymond's intensive care unit.

Because doctors at the hospital were reluctant to discharge her until they were certain that she would receive follow-up counseling, Karen called her psychotherapist and asked him to tell the hospital staff that she was indeed in counseling. The therapist, however, did not respond as Karen expected. He pointed out that this was her third suicide attempt in the past 2 years and, as a result, he was not prepared to vouch for anything. In fact, the therapist did not think that he should continue to treat Karen. He described her suicide attempts as "manipulation," and said that she was using the suicide attempts and other forms of self-harm to draw attention to herself and to avoid confronting her underlying disturbance.

A personality disorder is a very rigid pattern of inner experience and outward behavior that differs from the expectations of one's culture and leads to dysfunctional behavior and psychological pain.

Karen had been giving herself minor injuries several times a week for years. She inflicted the injuries in a slow, deliberate fashion, typically when alone and feeling rejected or abandoned. She would sit down with a

razor blade in hand and watch closely as she dragged the blade across the flesh of her arm or leg. The cuts were relatively superficial, but deep enough to draw a thin line of blood that she observed with fascination. For a brief moment, she felt reassured of her own existence. The pain was physical, real, and deserved—quite unlike the feelings of emptiness or depression she tended to experience much of the time.

The frequency of Karen's cutting, and her use of drugs and alcohol to deaden emotional pain, varied according to her relationships with men. When she had a steady boyfriend, she generally felt more positive, as though life had meaning and focus. On the other hand, the slightest hint of problems in the relationship could trigger deep emotional distress.

Karen A Typical Relationship

Karen's relationship with Gary, a 32-year-old construction worker, was in many ways typical. They met in a bar and immediately began an intense love affair; for the next 2 weeks they were together almost every night. Karen felt happy and on top of the world; after only a week, she started to fantasize about their life together, even to the point of naming their future children. She stopped drinking alone in the evenings, or doing any of the cutting that accompanied her darker moods.

As time passed, Karen and Gary stopped seeing each other every day, but her focus on him was still complete. While at work, she would check her phone and Facebook page several times an hour to see if he had left any messages. If she was home in the evening and she hadn't heard from him, she would frantically try to locate and call him, even if he had told her earlier in the week that he couldn't come over.

With time, Karen grew more and more sensitive to signs that Gary might be pulling away. She would keep asking him about his feelings for her, and she became irritated if he seemed evasive. At first, he told her he "liked her a lot"; but after a while he said he didn't understand why they had to talk about their relationship and their feelings all the time. He began texting her less and less, and Karen started feeling rejected.

On nights when she had no contact with Gary, she would sit alone in a darkened room just holding her phone in her lap. She would check his Facebook, Instagram, and Twitter pages to see if she could determine where he was and who he was with. Often, when her anxiety was especially high, she would text him. Gary sometimes would text her back, but his responses seemed distant and strained. When Karen would try to pin him down as to when they could get together, he would just reply, "I'll let you know." And if Gary did text her first, he rarely asked her to do anything special anymore. He usually texted her late at night, and his interest in seeing her seemed physical at best.

One night, Karen and Gary went to the movies together and, just as they were taking their seats, he said he wanted to get some popcorn. Karen immediately became suspicious, as she recalled seeing a cute, young woman working at the concession stand. Karen demanded that Gary stay with her. He left his seat anyway, explaining that he would be right back. Karen then reached out, grabbed his arm, and yanked him back in his seat with surprising force. Gary was momentarily shaken but, after collecting himself, he rose again and stalked out of the theater. Karen followed him out to the sidewalk; by the time she reached the curb, he was already across the street and moving briskly. She just stood on the curb screaming, "Come back, you bastard!" and finally, "I hate you!"

Karen returned home feeling miserable. She tried to call Gary, but he ignored her calls. She got out a razor blade and did some of her first cutting in weeks, making two superficial cuts on her left thigh. She tried Gary's number one more time, but still no answer.

When Karen finally got in touch with Gary the following evening, she tried apologizing, but he told her he didn't want to see her any more. She pleaded with him, declaring that she loved him and couldn't live without him. She promised to be more considerate of his need for space. Gary replied that he just didn't think it was working out and that they should part company as friends. At this, Karen became furious and threw her phone across the room. She found a bottle of wine to ease her misery, but even after drinking it all, she still couldn't bear the pain of separation. She began obsessively checking his Facebook page and sure enough, Gary had already changed his status to Single. Karen posted a nasty message on his wall and within an hour she discovered that Gary defriended her. It was then that she decided to end it all. She went to her nightstand, reached for a bottle of sedatives, looked at them for a few seconds, and then swallowed about 30 pills.

When Karen's roommate, Cecily, came home, she found Karen unconscious on the floor of her bedroom. Cecily phoned for an ambulance and Karen was rushed to the emergency room where her stomach was

pumped.

Approximately 75 percent of people with borderline personality disorder attempt suicide at least once in their lives. Of the people who attempt suicide, as many as 10 percent will actually commit suicide (Gunderson, 2011; Leichsenring et al., 2011).

In some ways, Karen's stormy affair with Gary had actually been more positive than many of her relationships. Gary, for example, did not take advantage of her, whereas some of her past boyfriends were happy to maintain a sexual relationship long after losing interest in her. Several even abused her physically. She was so desperate for the sense of worth she received from being in a relationship—any relationship—that she would put up with a great deal. When a relationship did end, it was almost always at the man's instigation, and Karen always felt a profound sense of emptiness, abandonment, and despair.

Unrewarding though her relationships were, she considered almost all of them preferable to being alone. When not in a relationship, she practically felt as if she didn't exist. She never really developed any personal interests or work ambitions, and seemed to go from low-level job to low-level job.

A Roommate's Perspective "Two Years of Hell"

After finding Karen near death and finally getting her to the hospital, her roommate, Cecily, was shaken and drained. At first, she thought that she would feel better within a few days, but a week later she took stock and realized that she was feeling, if anything, worse. Cecily's family persuaded her to make an appointment with a counselor to discuss the ordeal and her reactions. During her session, the shaken woman declared that finding Karen on the bedroom floor was, in fact, the culmination of "two years of hell."

Cecily explained to her therapist that she had met Karen 2 years earlier, after posting an ad on Craigslist for a new roommate. At the time, Karen did not really confide in Cecily about her emotional problems. She did say that she was "in therapy" and described herself as "really crazy, totally neurotic." However, since Cecily herself had been in therapy, she thought little of it, and even believed that their common neurotic tendencies might be a bonding issue. As it turned out, the 2 years that followed were far from a bonding experience.

As Cecily told the therapist:

> At first Karen was a lot of fun, but then she would become really depressed off and on, and . . . well, weird. For the first month, I thought that we were having fun living together, discovering that we liked a lot of the same movies and music and things. Then one night, about 2 months after she moved in, I was getting ready to go out with a friend, and Karen demanded to know where I was going. I told her I was going out. That wasn't good enough for her. Where was I going? Who was I seeing? What was I doing?
>
> Then she tried to make me feel guilty for going. "Fine, just leave," she pouted. She complained that we were no longer spending any time together, which was ridiculous because we had just spent a whole day at an art museum together. When I pointed that out to her, she got hysterical, yelling at me, telling me that I only cared about myself and that I was leaving her with nothing to do. By then, I was mad, and I told her in no uncertain terms that I did not plan to spend every waking moment of my life with her just because we were roommates. I stormed out.

Prevalence rates of borderline personality disorder in the general population range from 1.6 percent to 5.9 percent. Up to 20 percent of psychiatric inpatients may be given a diagnosis of borderline personality disorder (APA, 2013).

> When I came home that night, it was really scary. There was a little blood on the floor, and it made a trail that led to her bedroom door. When I banged on the door to see if she was all right, she said that she'd accidentally cut herself making a sandwich and everything was fine. I wasn't sure I believed her, but I preferred to go along with that, rather than consider the possibility that she might be seriously disturbed.
>
> After that evening, she was distant from me for a while. She seemed very angry, and I must admit that I was really put off. The last thing I needed was to be living with someone who wanted all my attention, who was so high-maintenance. I wasn't so much scared as annoyed. Dealing with her was starting to take a lot out of me. Eventually, she got over being angry with me and went back to her old ways: constantly draining my attention and making me feel guilty about not spending more time with her. No matter how much time I did give her, it was never enough.
>
> Then she started dating this guy, Eric, and I thought that things were getting better. I didn't know much about

him, but Karen was spending almost no time at home and that was just fine with me. When I did see her, she would gush about how incredibly happy she was—I mean, this was just weeks after she met him—how deep their relationship was and how perfect everything was. She was sure he was "the one." Of course, by now I knew how unbalanced she was and I suspected she was probably being crazy like always, but I didn't want to look a gift horse in the mouth. She was no longer my problem for the moment.

I should have seen what was coming next but, like an idiot, I didn't. Eric left her, and she was totally my problem again. She stayed home and cried for days at a time. She made me take care of her, telling me she was too depressed to do anything for herself. She even fantasized about the violent things she would do to Eric when she felt up to it, and cursed a blue streak while talking about him. And that's pretty much how it's been ever since.

After Eric, there was Ahmad, then James, then Stefan. Always the same story, always the same ending. And always with me in the middle—having to smile while she gushed endlessly about the latest relationship and having to pick up the pieces when the relationship would end.

Karen The Early Years

Karen grew up in a family that seemed stable and loving on the outside. Her father was a prominent local businessman who was also the lay minister of a church. Her mother worked at a small law office in town and volunteered in the church day care. Karen also had two older brothers who were considered model students.

In private, however, the family was violent and abusive. Even as a toddler, Karen was frequently beaten with a belt by both parents. Some of the beatings were inspired by misbehavior. Others were carried out on general principle, to "keep the devil out of her," in her father's words.

Studies have often found instances of great trauma in the early lives of people who develop borderline personality disorder (Huang, Yang, & Wu, 2010).

Her parents were extremely unpredictable. Her father might hold her on his lap and tell her she was a "darling girl" and how much he loved her, but minutes later he would once again be "beating the devil out of her." Nor was the abuse Karen suffered at the hands of her family limited to beatings or words. Beginning at about age 6, her father began abusing her sexually, by fondling her genitals and engaging in oral-genital contact. This occurred about a dozen times and continued until Karen reached the age of 12. After molesting her, her father would call her a "cheap whore" who was "going to hell." Then he would beat her severely and make her kneel in prayer to confess her "sins."

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Starting at age 6, she was also sexually abused on a weekly basis by her oldest brother, John, who was 13 years old and favored by her parents. This abuse involved both oral-genital contact and intercourse. When she was 9 years old, two of John's friends also participated in the abuse. When the young victim told her mother what was happening, the woman responded by beating her daughter for using "sexual language" and for being "seduced by the devil."

Even after John left for college, he would continue to abuse Karen during visits back home. Finally, when she was 16 years old, she told her other brother, Ted—who was 18 years old at the time and a senior in high school—what was happening. Ted, who had been Karen's only source of comfort throughout her childhood, confronted John and said he would kill him if he ever touched their sister again. This put an end to the abuse.

Two years later, on the day Karen graduated from high school, she left her family and moved to a small studio apartment in the next county. She found work as a waitress in a local diner, started dating a man whom she met there, and married him just a few weeks later. Her new husband, George, a car salesman who was 15 years her elder, began dominating Karen in short order. In many respects, their life together was a replay of Karen's upbringing.

George suspected, without basis, that Karen was flirting with other men and carrying on affairs behind his back. He made her quit her waitressing job and kept her a prisoner in their home. He demanded that his wife leave the house only with him or to do necessary food shopping; he also forbade her to buy any new clothes. On one occasion, Karen visited her former coworkers at the diner, despite George's house rules. When word of that visit got back to her husband, he confronted her with her "deceitfulness" and beat her when she defended herself.

When not in a jealous mood, George could be romantic to Karen. Often he would take her out for dinner

When not in a jealous mood, George could be very nice to Karen. Often, he would take her out for dinner or dancing, tell her she was "the prettiest girl in town," and apologize for any of the hurtful things he had done. He would describe his hopes of making "a pile of money" someday and his desire to then treat Karen "like a queen." Such affection was typically short-lived, however. The next day he might very well return home from work and beat her for cheating on him.

Karen's family background made it extremely difficult for her to accurately assess her life with George. Of course, she hated the beatings, but she could not judge whether they were undeserved or whether she might be able to find better treatment elsewhere. As it happened, she never had to leave George, because he was killed in a car accident 3 years into their marriage.

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After George's death, Karen went through a period of utter confusion, in which feelings of both devastation and relief rose to the surface. She was now free of his cruelty, but Karen had nevertheless become completely dependent on him. She felt lost and developed clinical depression, leading to a psychiatric hospitalization.

Karen underwent at least 10 more psychiatric hospitalizations over the next 15 years. She received a wide range of diagnoses during this period, and dozens of different drugs were prescribed for her without much benefit. When not hospitalized, she would support herself with waitressing or secretarial positions. Work was of little importance to her, however. It was relationships with men that filled her thoughts or her dreams, as she moved from one intense and unrealistic attachment to another.

Karen feared abandonment more than anything else in life. She tried to kill herself three times during this period, and indeed, all three of the attempts were direct responses to being jilted by men to whom she had formed passionate attachments.

> Close to 75 percent of the people who receive a diagnosis of borderline personality disorder are women (APA, 2013; Grilo et al., 1996).

During those 15 years, in addition to her hospitalizations, she saw at least nine different psychotherapists —psychiatrists, psychologists, and social workers—on an outpatient basis. She even had a sexual relationship with one of her male therapists, who later lost his license after two other women filed charges against him for sexual misconduct.

Karen in Treatment "The Break of a Lifetime"

After Karen's third suicide attempt and her therapist's refusal to continue working with her, the hospital discharged the troubled woman to the local community mental health system, where she received once-a-month medication management and weekly group therapy. After a while, she concluded that her treatment there was only "maintaining [her] misery" and she was about to stop when, without warning, her life took a very positive turn. In what she would later describe as "the break of a lifetime," a staff member at the mental health center recognized Karen's broad pattern for what it was, and referred her to Dr. Dierdra Banks, a psychologist specializing in dialectical behavior therapy.

During a lengthy initial session, in which Karen described her problems and history, Dr. Banks grew confident that the woman's condition met the DSM-5 criteria for a diagnosis of borderline personality disorder. Karen repeatedly engaged in frantic efforts to avoid abandonment; she exhibited a pattern of unstable and intense interpersonal relationships; she had a markedly unstable self-image, or sense of herself; she engaged in recurrent suicidal behavior and self-mutilation; her moods were unstable; she had chronic feelings of emptiness; and she frequently displayed inappropriate anger.

For years, borderline personality disorder seemed almost untreatable, as various approaches brought little or no change to the emotional turmoil and self-destructive lifestyles of those afflicted. However, by the early 1990s, an increasing number of therapists were applying dialectical behavior therapy in cases of borderline personality disorder. Dr. Banks was one such therapist.

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> Research indicates that individuals with borderline personality disorder often improve markedly during treatment with dialectical behavior therapy (Kliem, Kröger, & Kosfelder, 2010; Linehan et al., 1991, 1993; Panos, Jackson, Hasan, & Panos, 2013).

Karen in Treatment Dialectical Behavior Therapy

Like other practitioners of dialectical behavior therapy, Dr. Banks believed that people with borderline personality disorder primarily experience emotional dysregulation, a reduced capacity to regulate their emotions, particularly negative emotions such as sadness, anger, and anxiety. Because of a biological vulnerability, the individuals have a high sensitivity to emotional stimuli, an intense response to such stimuli, and a slow rate of recovery from their emotional arousal. And because of a skills deficit, the individuals cannot hold back inappropriate behaviors or consider constructive behaviors when they experience strong emotions. In short, people with borderline personality disorder have a dual handicap. Not only are their emotions stronger than the average person's, their skills for managing emotions are deficient. The result is a lifelong pattern of emotional and behavioral instability.

According to dialectical behavior theory, the failure to acquire adequate skills for managing emotions arises from an invalidating environment during childhood. In such an environment, a child's thoughts and feelings are not taken seriously or supported. One of the most harmful kinds of invalidating environments is one in which a child is repeatedly victimized. Children who grow up in this situation may learn to not trust their own feelings or thoughts. In addition, they may develop little sense of who they are. They must depend on other people for direction, support, and meaning.

Like other dialectical behavior therapists, Dr. Banks would typically address such problems in stages throughout treatment. During a pretreatment stage, she would explain the principles of dialectical behavior therapy and ask clients with borderline personality disorder to commit themselves to the treatment program for a minimum period. Then she would move on to three treatment stages. In the first stage, she would address issues fundamental to survival and functioning, such as decreasing suicidal behaviors, decreasing therapy-interfering behaviors, decreasing behaviors that were interfering with the quality of a client's life, and increasing behavioral skills. In the second stage, the psychologist would work to reduce distress due to past trauma, such as sexual abuse. And in the final stage, she would address longer-term issues, such as increasing self-respect and achieving career, social, and interpersonal goals.

> The theory and techniques followed by Dr. Banks and other dialectical behavior therapists are based largely on the work of Marsha Linehan (1993).

Also, like other dialectical behavior therapists, Dr. Banks would typically conduct treatment on two fronts. She would have clients participate in behavioral skills training groups, where they would develop needed behavioral skills. At the same time, she would conduct individual psychotherapy sessions with her clients, focusing on what was happening at the moment. The goal of individual therapy was to soothe clients, help them through crises, and guide them in the application of their new behavioral skills. The relationship between client and therapist was a key part of treatment; Dr. Banks would strive to create a validating environment that had been, according to the dialectical behavior therapy model, missing in the client's past.

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In addition, Dr. Banks would encourage clients with borderline personality disorder to contact her, either by texting or calling, between visits. She considered such contacts opportunities for her to provide immediate help in a crisis; to guide clients in problem solving at the time the problem arose; and to deal with any strong, negative emotions that the clients might develop about therapy between sessions. The active use of consultations in dialectical behavior therapy differs from most other approaches in treating this disorder. In fact, other approaches typically view between-session contacts from borderline clients as attention-seeking, manipulative, or maladaptive, and most therapists discourage such efforts.

> The term *dialectical* is meant to suggest that the goals and methods in dialectical behavior therapy often involve achieving a balance between two opposing forces, especially a balance between self-acceptance and making changes for the better.

Pretreatment Stage Dr. Banks's primary goal during the pretreatment sessions was to obtain a commitment from Karen to stay with therapy for a minimum period. She considered such a commitment essential in cases of borderline personality disorder, in light of most such clients' disappointing past experiences in therapy and their explosive reactions, which could lead to impulsive, premature terminations of therapy.

At the same time, Dr. Banks recognized that, prior to obtaining any sort of commitment, it was important first to discuss Karen's history fully and gain a proper appreciation of her experiences, both in therapy and

out. Only then could Karen feel that the therapist's recommendations were well considered. Accordingly, Dr. Banks spent two full sessions with Karen before asking for a commitment to treatment. During these sessions, she empathized with how much fear and mistrust of the treatment process Karen must have developed because of her unsuccessful past therapies. She also expressed empathy for Karen's own attempts to handle her feelings, through the use of self-harm, dependent relationships, and, occasionally, alcohol. Finally, the psychologist expressed admiration for Karen's persistence in trying to improve her situation, despite a long history of invalidation and abuse.

Karen expressed surprise at the psychologist's recognition of her strengths, noting that more typically therapists would shake their heads over how "messed up" she was. Dr. Banks replied that she recognized Karen indeed had problems, but that she also recognized Karen was probably coping with them in the best way she knew how.

To help her client decide whether to commit herself to this therapy, the psychologist described the principles and techniques of dialectical behavior therapy. To begin, she explained that Karen's problems fit a pattern known as borderline personality disorder, a term that Karen said she recognized from some of her previous treatments. The therapist explained that the term *borderline* was unfortunate, being a holdover from days when clinicians mistakenly thought that people with the condition were "on the border" between neurosis and schizophrenia. She said that current thinking on this disorder was that it primarily involved difficulty in managing strong emotional feelings; many of the behavior problems—self-harm, impulsive behavior, interpersonal difficulties—were now seen as stemming from the individual's understandable need to cope with these feelings. The treatment, Dr. Banks explained, would involve learning more effective ways of coping with emotions. She then described the various stages of treatment and the two formats of treatment group behavioral skills training and individual psychotherapy.

Karen said she was impressed with the organization of the treatment approach. In all her previous therapies, a systematic plan had never been laid out for her. She said the approach made sense to her, but she was wary of her ability to succeed. Dr. Banks expressed sympathy for her wariness, and also tried to shift some of the burden of success, explaining that success was dependent not only on Karen's efforts but on the psychologist's ability to apply the treatment appropriately.

Moreover, she suggested that Karen define treatment success by how well she was sticking to the treatment plan, and let the symptom improvements take care of themselves.

The psychologist and Karen agreed to work together for at least 6 months. Dr. Banks estimated that the total treatment time might be 2 years.

First-Stage Treatment: Addressing Issues of Survival and Basic Functioning In the first stage of treatment Dr. Banks focused on issues critical to survival and functioning: increasing behavioral skills, decreasing suicidal behaviors, decreasing behaviors that interfered with therapy, and decreasing behaviors that reduced the quality of one's life.

Increasing behavioral skills (group training) Karen began attending a weekly dialectical behavior therapy behavioral skills training group, designed to teach behavioral skills in a systematic fashion, using lecture material, group practice exercises, and homework assignments. Five specific skill areas were covered: (a) mindfulness skills, (b) interpersonal effectiveness skills, (c) emotion regulation skills, (d) distress tolerance skills, and (e) self-management skills.

> Although termed *behavioral,* the techniques of dialectical behavior therapy also draw from such sources as psychodynamic therapy, meditation practices, Zen Buddhism, and feminism.

Mindfulness skills refer to the ability to step back from and look at one's emotions, while at the same time not being judgmental about them. Interpersonal effectiveness skills involve being able to make and decline requests, while at the same time maintaining self-respect and sound interpersonal relationships. Training in these skills resembles the social skills or assertiveness training techniques used with other patients who have social skills deficits. Emotion regulation skills involve being aware of intense and inappropriate emotional arousal, and behaving rationally in spite of inappropriate arousal. Distress tolerance skills refer to the ability to cope with negative emotional arousal, by employing such techniques as distracting oneself during a crisis, soothing oneself, or considering various responses. Finally, clients in the group were taught self-management skills, including how to set and achieve realistic goals.

At first, Karen was reluctant to participate in the behavioral skills training group, asking why she couldn't just see Dr. Banks for the individual sessions and forget about the "group thing." The psychologist, however, explained the importance of learning the skills; she also pointed out that if the individual sessions were spent entirely on skills training, there would be no time to deal with Karen's day-to-day concerns. The client agreed to attend as part of her commitment, and, after a few weeks, began to feel that the group training was worthwhile. In addition to gaining mastery in certain skill areas, she came to feel comfort in the emotional support supplied by the group, and a sense of gratification in providing support to others. She continued to attend the group for close to a year.

Decreasing suicidal behaviors In the first individual therapy session, Dr. Banks explained that she would like to focus on Karen's tendency to harm herself. She invited Karen to join a file-hosting service that contained a folder full of various forms and handouts she had created. Dr. Banks began by having the client keep a daily record detailing her level of suicidal thinking, her misery level, her self-harm urges, her self-harm actions, what she did to cope with any self-harm urges, and her use of new skills.

Dr. Banks was able to access Karen's records at any time via Dropbox and then at the next session, Karen and the psychologist would review the records of the past week. In the second session, the records revealed that the client was cutting her upper arms or inner thighs with a razor blade approximately five times a week. The injuries, which she bandaged herself, were visible to others only if she wore shorts or a tank top. Unlike Karen's previous therapists, Dr. Banks was careful not to criticize her for creating these injuries, label them as "manipulation," or threaten to stop treatment if the behavior continued. Instead, she responded to each instance with a behavioral analysis, trying to get Karen to see how the cutting was serving a function. In one case during the week, a man whom Karen had met at a party took her phone number, then failed to call her the next day as promised. Karen's misery level rose as the hours passed without a phone call, and she eventually made two superficial cuts on her upper thigh, which briefly reduced her emotional pain. At that point in time, Karen had called Dr. Banks to tell her what she had done and to receive support.

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Because people with borderline personality disorder are more emotional than analytic, dialectical behavior therapists teach clients how to make a behavioral analysis of problems. The therapists help them to see a larger context; that their problems —emotional, behavioral, or interpersonal—are usually just one element in a chain of events.

During the next session, when reviewing the incident and Karen's reactions, the psychologist validated the woman's sense of disappointment, but also recommended that she start coping differently with her urges to cut. Dr. Banks explained that she wanted Karen to begin managing her emotions with a different device, by contacting the therapist and discussing her feelings *prior* to doing any cutting. In fact, they put a "24-hour rule" into effect. Karen would be prohibited from contacting the therapist for at least 24 hours following any cutting. The rationale was twofold. First, calls or texts to the therapist immediately after cutting have no problem-solving value, because the cutting has already taken place by then. Second, the rule against speaking with Dr. Banks until 24 hours after any cutting behavior would create an incentive to use the new problem-solving procedure of calling the therapist before the cutting happened..

In the early morning following this session, at about 3:00 A.M., Karen called Dr. Banks. Breathing heavily and almost sobbing, the client said that she had not yet cut herself, but desperately wanted to do so. She was afraid, on one hand, that the therapist would reject her if she carried out the cutting and, on the other, that Dr. Banks would be angered by her calling so late at night.

According to dialectical behavior theorists, the self-mutilation of people with borderline personality disorder serves to produce physical pain that competes with—and, hence, partially reduces—the much more painful experience of negative emotions. Other impulsive behaviors, such as gambling, substance abuse, irresponsible spending, reckless driving, binge eating, or unsafe sex, may similarly help reduce negative emotions (Muehlenkamp, Brausch, Quigley, & Whitlock, 2013).

Though desperately tired, Dr. Banks made it clear to Karen that it was "absolutely wonderful" that she had taken this step, and was glad she had taken the risk of calling rather than doing the cutting. These words alone had a very calming effect on the client. The psychologist reminded Karen of some of the distraction, self-soothing, and distress tolerance strategies she had learned at the behavioral skills-training group. The client, in turn, decided to make herself a cup of hot cocoa, take a warm bath, and read her favorite magazine.

Karen made a similar call 2 days later, and the day after that. In both cases, Dr. Banks encouraged her to use distress tolerance strategies, and Karen was able to resist the urge to cut herself.

At the next session, her records revealed no instances of self-harm for the week. Dr. Banks devoted most of the session to analyzing this achievement, noting how Karen had successfully replaced cutting with more constructive coping strategies. Still, Karen's misery level had remained high during the week: a 10 on a scale of 10 on most days.

Over the next 3 months, she contacted the therapist an average of three times a week and succeeded in avoiding all self-harm during this period. Correspondingly, her misery level began to improve. Then she started dating a man to whom she was strongly attracted. They had sex on their second date. At her therapy session the next day, Karen announced that she had found the perfect man and felt certain she was in love. She was brimming with enthusiasm—more than Dr. Banks had ever seen in her. The psychologist supported her feelings, noting how wonderful it was to be in love.

Unfortunately, the man didn't share Karen's enthusiasm and failed to call the following evening as promised. When Karen finally reached him and suggested they make plans for the weekend, he said he really didn't feel like "getting involved." Karen was devastated and, over the next several days, cut herself multiple times before calling Dr. Banks. When she did call to tell the therapist what had happened, she felt certain that Dr. Banks would reject her for having regressed. She begged her not to end the treatment.

Dr. Banks:	Why would I want to end treatment?
Karen:	I started cutting again, and I didn't even try to call you to get help.
Dr. Banks:	What kept you from calling?
Karen:	I just felt so ashamed.
Dr. Banks:	But you're calling now, and that's great! I understand your reluctance to call. It's perfectly natural. No one likes to bring bad news. But try not to think of this as such bad news. You were under a lot of stress for the first time since our therapy began; it's understandable that you might not be able to manage it perfectly. But, look at what you did do. You did stop the cutting eventually, and you did call me. I think it's best to look at this as a temporary slip, as opposed to a complete relapse. I think you'll find that you can get back on track again and avoid the cutting once the distress from this experience subsides.
Karen:	I think I can stop cutting now. Just hearing you tell me that it was natural to get upset helps. But I feel so miserable.
Dr. Banks:	I know. Let's discuss some concrete things you can do now to cope with that feeling.

Dr. Banks then reviewed some concrete problem-solving strategies. Karen agreed to make out a schedule of things to do for the rest of the day, including three errands and one recreational activity, so as to reduce her thoughts about being rejected. In the evening, she would go to a movie rather than waiting around in her apartment to see if anyone else would call her.

At the next session, Karen said she had carried out the scheduled activities the day before, and this had helped reduce her focus on the dating situation. However, now she was feeling "completely hopeless" about the progress of therapy itself. She said there was no point in continuing with something that just didn't work. She demanded that the psychologist admit that she was a hopeless case who could never live a normal life.

Psychotropic medications, particularly mood stabilizers and antipsychotics, have helped calm the emotional and aggressive reactions of some people with borderline personality disorder (Haw & Stubbs, 2011; Lieb, Völlm, Rücker, Timmer, & Stoffers, 2010). However, given the heightened risk of suicide by these individuals, the use of medication on an outpatient basis can be quite risky.

Dr. Banks was momentarily at a loss for words. But before she could speak, Karen herself came to her assistance. "Don't be upset," the client said, smiling. "Sometimes I say these things. If you don't overreact, if you believe in me, it's easier for me to believe in myself, and not in the hopeless part." The psychologist replied that she certainly did believe in Karen, and then offered the client a parable. She said that the way out of misery is like finding your way out of the desert; you walk and walk, and often things look just the same: dirt, sagebrush, rocks, no water, no shade, no relief. However, if you follow a fairly straight path for a long time, even though things look and feel the same, you're in a very different place, much closer to getting out of the desert.

A number of times after this exchange, Karen expressed the same kind of hopelessness and claimed to be giving up. However, such claims were typically followed by her working even harder, and achieving new goals the next day or week. She gradually came to appreciate that she had a tendency to experience hopelessness, and that she should not believe the thoughts that often intruded.

Over the next year, Karen had only two episodes of self-injury, which she described as mainly due to habit. She then remained injury-free for the remainder of treatment.

Decreasing therapy-interfering behaviors Karen frequently displayed two kinds of therapy-interfering behavior. She would repeatedly express extreme hopelessness and insist that she could not follow the treatment plan any longer, and she would experience extreme anger toward the therapist.

Although Karen seemed, overall, to have warm feelings toward Dr. Banks, there were many occasions when feelings of fear, hopelessness, shame, or depression caused her to lash out. She would turn bright red and criticize the psychologist or call her names. For example, on one occasion, she said, "Thanks for your brilliant suggestion. You know, other therapists I've had were stupid, too, but at least they cared about me."

Although at first taken aback by comments such as this, Dr. Banks recognized that they were signs that she had unwittingly invalidated some aspect of Karen's experience. Unlike her client's friends, the psychologist knew that it was important not to respond defensively to an attack or an insulting remark from her. Indeed, the most therapeutic reaction, for Karen's sake, was for Dr. Banks to admit right away that she might indeed have said something unwise. During the initial stages of therapy, for example, she would respond to Karen's outbursts by saying something like, "Boy, I must have really messed up for you to be this angry. What am I missing? I really want to know what's going on." As therapy progressed, Karen was able to exercise more and more self-restraint in her angry reactions. Instead of criticizing or attacking the psychologist, she would say something like, "Hey, I don't think you're understanding me."

Because therapists are continually confronted with the emotional crises, self-destructive acts, and intense anger of, and even insults from, clients with borderline personality disorder, treatment is emotionally demanding for the practitioners. Thus, dialectical behavior therapists often consult with other therapists to help them remain professional and stay on track with the principles of dialectical behavior therapy.

Other times, the anger that Karen expressed toward Dr. Banks actually had more to do with people she had encountered and had been upset by outside of therapy. With time, she was able to distinguish between these reactions and the feelings produced by Dr. Banks's words. At later points in therapy, she was able to simply tell the psychologist, "I'm in a bad mood. It has nothing to do with you, just some idiot in the parking lot. It's okay. I'll get over it." Ultimately, Karen was able to apply such skills to her interactions with friends, as well.

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Decreasing behaviors interfering with quality of life When Karen began therapy with Dr. Banks, she was unemployed and dependent on disability benefits. However, as therapy progressed and Karen developed greater control over her feelings and actions, she was in a position to consider improving the quality of her life. Accordingly, about 9 months into therapy, she decided to obtain some job training, and enrolled in a training program for medical assistants at a local college. The specific job skills that were taught included answering doctors' phone calls, making appointments, retrieving and filing medical records, and filling out insurance forms.

Karen did not find the training easy. Although a bright woman, it had been 18 years since she had been in school, and sticking to a curriculum was an unfamiliar experience. The skills training that she had already received in the dialectical behavior therapy group helped her to keep up with the course work. At one point in the training, Karen temporarily stopped attending classes after becoming depressed over a broken date. However, when faced with the prospect of not obtaining her certificate and remaining stuck in her current living situation, she eventually pulled herself together and resumed the work, making up for the missed classes.

During this stage of therapy, Dr. Banks also helped Karen to see that sometimes her difficulties in relationships were not due to her own interpersonal ineffectiveness, but to a lack of compatibility between herself and the people she chose. Accordingly, Karen worked hard not only on increasing her personal effectiveness but also on choosing more stable and trustworthy friends, including romantic partners.

In spite of her efforts, she endured several failed relationships over the course of her treatment, which often brought back suicidal feelings. As she and Dr. Banks worked on managing these feelings, they became less intense. The process was helped along by a truly supportive and mutual friendship that Karen developed with another trainee in her medical assistants' training program. This friend, Ann, was a divorcee who lived not far from Karen. In response to a suggestion from Dr. Banks, Karen asked Ann to join her for coffee one

day after class, and it soon became a regular event. In the past, the client had been so single-mindedly focused on her relations with men that she sometimes entirely overlooked friendships with women. And the relationships that she did develop with women were often one-sided, with Karen so completely absorbed in her own problems that other women viewed her as unbearably self-centered. With Ann, however, she showed some of the consideration and emotional restraint that she had developed in her relationship with the therapist. Ultimately, they became close friends.

During their 30s and 40s, most individuals with borderline personality disorder obtain somewhat greater stability in their relationships and jobs (APA, 2013).

Second-Stage Treatment: Reducing Distress Due to Past Traumas The focus of the second treatment stage was to help Karen overcome lingering feelings of distress due to past traumas, such as her sexual abuse. In fact, her abuse history had been addressed to some degree from the beginning of treatment. Indeed, in the first stage of therapy, Karen had developed skills to help her tolerate her abuse memories. She had learned, for example, to soothe herself—to do especially nice things for herself, such as eat favorite foods, dress in favorite clothes, or go for a walk in her favorite park; and to distract herself, which involved finding constructive and engaging projects to work on, such as repairing her bicycle.

At the second stage of treatment, however, the goal was not only to manage the emotional distress that would result from abuse memories, but to reduce the capacity of the memories to produce distress. Dr. Banks used exposure techniques similar to those used in the treatment of posttraumatic stress disorder, in which clients undergo repeated, controlled exposures to stimuli—external or internal—that have been linked to past traumas.

Initially, the psychologist asked Karen to describe her past abuse experiences in general terms only. As the client described the same experiences over and over again as a regular exercise, the exposure seemed to result in reductions in her distress levels. Thus, after repeatedly describing her father's molestation of her in general terms—three times per session for three sessions—Karen's distress level was relatively mild by the ninth description. The procedure was then repeated using greater and greater levels of detail, until even the most detailed descriptions of her traumatic experiences produced only moderate distress. The same procedure was applied to Karen's other traumatic memories, with similar results.

People with borderline personality disorder often have another mental disorder, as well. Common ones are mood disorders, substance-related disorders, bulimia nervosa, posttraumatic stress disorder, and other personality disorders (APA, 2013).

Third-Stage Treatment: Addressing Longer-Term Issues The focus of the third stage of treatment was to help Karen gain greater self-respect and achieve career, social, and interpersonal goals. In fact, in her case, the achievement of these goals had been occurring naturally, as a result of the gains she had been making during the first and second stages of treatment. As Karen had stopped injuring herself, developed stable behavior patterns, increased her interpersonal effectiveness, and pursued career training, she was in fact valuing herself increasingly and providing a more dignified existence for herself. Thus, sessions with the therapist at this stage of treatment tended to solidify a process that was already well under way.

Epilogue

Karen remained in individual therapy once a week for a total of 2 years, and now continues with periodic follow-up sessions or phone calls every month or two. Overall, her life has improved greatly, especially compared with what it was prior to beginning dialectical behavior therapy with Dr. Banks.

Above all, she no longer hurts herself, even when extremely upset. She also rarely uses alcohol to deal with feelings of distress, and has not been hospitalized since her final suicide attempt, a month before her therapy began. She works part-time as an assistant in the medical records department of a local hospital, and takes courses at a nearby college, with the goal of obtaining a bachelor's degree. Once a week, she coleads a dialectical behavior therapy support group.

Most important, Karen has regained control over her mental and emotional life. As she puts it, "I get to have my feelings, and nobody has the right to control me anymore." In addition, she feels that a major achievement of therapy has been "my recognition, deep down inside, that, like other people, I am an acceptable human being and that life can be safe. My life is my own now."

Assessment Questions

1. What led to Karen's admission to West Raymond Medical Center?
2. Why did Karen's therapist decide to discontinue treatment with her at that time?
3. How many individuals with borderline personality disorder attempt suicide?
4. Describe Karen's typical relationships with men.
5. What was Karen's "greatest fear" that led to her frequent suicide attempts?
6. How did Karen's behavior meet the DSM-5 criteria for borderline personality disorder?
7. Describe the concept of dialectical behavior therapy. Be sure to describe the six main points of this type of treatment.
8. What is Dr. Banks's primary goal during the pretreatment stage? How did Dr. Banks relate this to Karen in her initial therapy sessions?
9. How did the term *borderline* originate and how accurate is it in describing Karen's problems?
10. What were the two basic formats Dr. Banks told Karen would be part of her treatment program?
11. List the five specific skill areas covered in the first-stage of treatment with Karen.
12. Why is it common for individuals to use self-destructive behaviors when they are disappointed by life events?
13. How did Dr. Banks handle Karen's cutting behaviors both to help her prevent the behaviors but also support her when she relapsed?
14. What were two therapy-interfering behaviors frequently displayed by Karen?
15. What was the focus of the second treatment stage? What types of therapeutic interventions did Dr. Banks use with Karen during this time?
16. Describe some other comorbid disorders that individuals with borderline personality disorder may develop.
17. Describe the third stage of treatment for Karen.
18. What is the ultimate achievement Karen feels she has realized from her treatment?

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Partnering With a Purpose: Psychologists as Advocates in Organizations

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To ensure that psychological issues are on policymakers' agenda, psychologists often focus professional advocacy efforts in the political and social realm. Psychologists working in organizations, however, also have a role in ensuring that professional issues rise into the consciousness of organizational decision makers. In an era of health care reform, the advent of program-based management, limited resources, and managed care, psychologists are under increasing pressure to show their worth inside organizations and often have limited ability to communicate with organizational leaders. Psychologists typically report to nonpsychologists who may have only a general understanding of what psychology offers and can often misunderstand requests from psychologists about patient care alternatives, time for research, ability to present at conferences, and so forth. Advocacy is one avenue for increasing effective communication of psychologists' perspectives and interests that can serve to educate leaders about the value of psychology and how to best use psychological expertise. A major benefit of organizational advocacy is learning advocacy skills in a known environment, which can then be transferred to broader social advocacy. The article discusses the development of advocacy skills in organizations and suggests possible advocacy activities that are consistent with the professional role. It is argued that clarity of the message and partnering with decision makers are important as psychologists advocate for the role of psychology in service delivery.

Keywords: organizational advocacy, professional psychology, collaboration, communication

Psychologists do not do a good job at advocating (Fox, 2008), and they certainly do not advocate as well as other professions (DeLeon, Loftis, Ball, & Sullivan, 2006; Lating, Barnett, & Hororwitz, 2010). This argument is the theme in almost every article that discusses professional advocacy within the discipline. Myriad reasons are put forth that explain why psychologists do not promote, or even defend, our discipline. Lack of time, lack of training in/understanding of advocacy, no guarantee of success, or finding professional satisfaction in other elements of the role may all partially explain psychologists' disinterest in advocacy. Another barrier that may thwart many psychologists is that social advocacy seems so monumental that it is easier to focus on more familiar tasks. Most professional associations have some form of advocacy committee, but psychologists may not have the time or organizational support to join such groups. Advocacy within the workplace offers an initial step for psychologists who want to promote their discipline but are daunted by the unfamiliar territory of political advocacy (i.e., lobbying government, political contributions). By working with partners and promoting a clear message, psychologists in organizations can present their issues to decision makers.

Advocacy is a process of communicating benefits and ensuring that policymakers can access high-quality information. Fox (2008) defined *advocacy* as "*the use of political influence to advance the profession through such means as political giving, legislative lobbying, and other active participation in the political decision-making process*" (p. 633). Often the goals are to influence social policy funding and decision making that relate to issues core to the practice of psychology. Other efforts might be to highlight research findings applicable to public policy. Finally, advocacy may simply involve collaborating with others to better meet common goals.

In the workplace, psychologists can refine advocacy skills in an environment that builds on already established positive relationships that are part of their professional role. This is especially true in organizations in which psychologists are not supported by a departmental model but are simply another professional on the team. There may also be an immediate and tangible benefit to advocacy efforts by an increased potential of seeing one's actions effect change. Once psychologists hone their advocacy skills within a familiar workplace environment, these skills can generalize to political and social advocacy. This article highlights the importance of organizational advocacy in developing skills to promote the profession of psychology as essential to effective client care.

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Organizational Advocacy[1]

For the present purpose, *organizational advocacy* is the process by which professional members influence organizational change so that the discipline's clients, goals, programs, and interests can be met within the broader organization. This can be done within a structure that includes a psychology department, but even the sole psychologist on a team can engage in advocacy. Table 1 summarizes some professional activities that offer potential for organizational advocacy, including the target audience commonly associated with the activity. Advocacy efforts can target both client services and the profession as a whole (Fox, 2008; Lating et al., 2010). Psychologists interested in organizational advocacy would typically target their employer or contracting agency; however, there may be opportunities to advocate in partner organizations. For example, when receiving a consultation request or a referral, psychologists can take the opportunity to provide more details regarding the role or service options provided by the discipline. Many familiar professional issues could be advocated at the organizational level, such as clinical services, retention issues, evidence-based practice, or ethical issues.

In discussing advocacy, Safarjan (2002) noted that there are four prerequisites in advocating change: (a) identifying a clear problem, (b) assessing the goal, (c) developing a strategy, and (d) implementing a plan. Of note, this is often psychologists' approach when providing clinical services. Psychologists have a goal of helping clients change, moving from assessment to intervention to reach agreed-on goals. In fact, everyday clinical skills relate to advocacy: writing (Radius, Galer-Unti, & Tappe, 2009), relationship building and maintenance (DeLeon et al., 2006; Lating et al., 2010), public speaking (Lating et al., 2010), and high-level analytical skills to synthesize information. Clinical psychologists are also accustomed to providing clear, unbiased information and recommendations to decision makers regarding diverse clinical issues. When psychologists make recommendations, they are *advocating* for a specific plan; they use data to direct those recommendations. In social advocacy, psychologists report believing that they will have little effect, do not feel knowledgeable, or are simply unaware of key issues (Heinowitz et al., 2012). It is unlikely that these factors will be as pervasive at work. A positive intermediary step to building confidence would be to highlight how many skills psychologists use every day in the workplace related to advocacy.

Table 1
Summary of Organizational Advocacy Activities

Activity	Advocacy target
Highlight unique contribution	Team members Supervisor/manager
Provide timely and effective consultations	Referral agent Team members Supervisor/manager
Provide research information for key decisions/discussions	Team members Referral agent All managers
Sit on committees	Committee members Supervisor/manager Senior management
Create standard business plans for making a case for new psychology positions	Supervisor/manager Other managers Human resources Senior management
Coordinate a message with partners (other disciplines)	All levels
Fill in service gaps	All levels
Clearly say, "This is what psychology offers" rather than allowing people to assume the skills are unique to the individual psychologist	All levels

In organizational advocacy, the target of change is ensuring that clients have access to prompt and effective psychological services within the organization. This may be easy in some organizations (e.g., hospitals with psychology departments), but can be a challenge if the system itself does not have clear psychology leadership (e.g., program-based systems). Thus, the goal in organizational advocacy is the promotion of psychological services within the organization, not as peripheral services or consulting, but as a vibrant discipline essential to client well-being. This strategy focuses on leveraging a psychologist's activities with professional promotion and advocacy. To use this strategy, psychologists would highlight and celebrate their unique contribution to the team and organization. Of course, the success of this strategy depends on whether the organization facilitates such efforts or whether the barriers to change outweigh the psychologist's ability and energy to advocate.

It is within organizations that psychologists can test their skills, use their expert role, set aside time to advocate, and see the fruits of their efforts. Psychologists often informally advocate in their organization and on their team. Organizational advocacy is part of the role, but can benefit from more structure and emphasis. Psychologists engaged in organizational advocacy must assertively educate leaders about psychology's role and value in effective service delivery while maintaining professional integrity by using solid evidence grounded in theory and research.

Advocacy and the Professional Training Model

It is often noted that psychologists do not tend to include advocacy as part of their professional model (Radius et al., 2009; Thompson, Kerr, Dowling, & Wagner, 2011). Physicians and nurses trained in professional schools are better at advocating for their patients while promoting their role as being essential to providing quality services (DeLeon et al., 2006; Lating et al., 2010). These professions see the benefit of having their members at planning, policymaking, and leadership tables and support those interested in these leadership roles. Psychologists, on the other hand, seem content to focus on professional tasks related to a specific client or limited to issues related to their clients. Lating et al. (2010) point out that psychology is one of the few professions with a high-level academic training model as the norm (i.e., doctorate). Thus, training focuses less on developing a professional identity and more on developing an academic portfolio; publications and research often outweigh professional practice issues within universities. This bias may also explain why academic psychologists do not often discuss professional issues such as advocacy and the presence of psychology as a profession, and

[1] This article focuses on health care environments, but the arguments are equally applicable to other settings: schools, correctional facilities, businesses/organizations, and human resource departments.

practitioners facing clinical demands often do not have time to write journal articles.

Lating et al. (2010) note the duality with respect to professional advocacy:

> Fostering an attitude of advocacy is instilling the notion that as psychologists we may need to be the active voice for those who cannot speak for themselves. At other times, we may need to be the active voice that advances and protects our profession. (p. 203)

This duality is central to professional advocacy; psychologists advocate in those areas in which they believe their role will improve service quality. This concept needs to be more central to our professional training model and stated explicitly. Although advocacy seems central to our professional role, and provision of excellent services is a subtle form of advocacy, overt advocacy efforts are often minimized or ignored in our training and practice. In essence, psychologists need to see advocacy as consistent with, and perhaps essential to, their professional role (Burney et al., 2009).

Finally, in understanding advocacy barriers, psychologists should be clear on their partners and their message. What unique contribution does psychology bring to the partnership? What benefits are there to the client, team, service, and organization of having a psychologist instead of another professional? Psychologists need to have the answers to these questions as they advocate so that they know their role in the partnership. For example the scientist–practitioner approach, which is often unique to psychologists, promotes critical evaluation and debate. Other professionals may not understand this cultural norm in psychology, which can result in misinterpretation. Those unused to this norm may personalize debate or dismiss psychologists as overly critical or not team players. A simple discussion around the traditional psychologist training model can clarify some misunderstandings. For example, the debating of ideas is a positive strategy that psychologists use to get to the best solution; it is unrelated to interpersonal conflict. Once this professional value is clear, it may be easier to highlight the benefits of fostering spirited discussion and debate with psychologists' partners in the organization. Thus, this ability to be impartial and critical becomes a key role within advocacy partnerships instead of a professional liability.

Organizational Advocacy as Partnering

A collaborative approach to advocacy can be beneficial, with advocates educating others in the organization about the value of psychological services. Under this perspective, the goal of advocacy ceases to be convincing others to the psychological perspective but, rather, increasing potential partners' understanding and support of psychology issues. By creating a partnership, psychologists position themselves as key players in solutions that meet the collective goals of the partnership. Even when the final goal is not what one first envisioned, the fact that the psychological perspective was part of the process is a positive outcome, and reasonable goal, of a successful advocacy partnership.

If psychologists believe they have something to offer, they need to offer it and take credit for its benefits, especially in the current social and economic climate. Psychologists in independent practice often need to show the benefits of their role by providing timely, effective, and targeted consultative services; those in organizations would be well served to adopt a similar approach. This might include prompt return of phone calls, efficiently completing written reports, providing summaries in user-friendly language, or including follow-up consultation meetings so that clients/teams/referring agents can ask questions once they have received the report. These approaches are good business in independent practice, and can be good business in organizations as psychologists use these methods to become more integrated with the team, decision makers, and organization. Under this perspective, judiciously using professional activities as opportunities to promote the discipline becomes the core avenue of advocating for psychological services. These avenues might also include providing clinical, research, or ethical consultations, which show psychology's value to the organization at large. Thus, other disciplines become partners and advocates, arguing for inclusion of psychology in key sectors while lessening the likelihood that psychologists' advocacy efforts will be perceived as self-serving (Cohen, Lee, & McIlwraith, 2012). In my experience, having those outside psychology making such arguments has met with the most success in advocating for service change and improvement of psychological services. Thus, partnering can be essential to advocacy, especially in sectors in which psychology has less voice.

In discussing the health sector, Safarjan (2002) notes, "Psychologists have the knowledge, expertise, and experience necessary to change health care delivery system, yet in state hospitals, they are not positioned to easily promote change" (p. 949). This is true because psychologists often find themselves focused on service delivery, a role for which they trained and in which they feel comfortable. It is through partnering at the organizational level, however, that psychologists can position themselves to effect change and provide broader support for the discipline. Cohen et al. (2012) identify getting more involved in health care administration as one way to become better positioned. For example, psychologists sitting on committees within the organization automatically raise the profile of the discipline. Natural committees for psychologists often involve research and ethics, but other committees on professional issues or specialty populations are also good options. This helps to position psychologists as key stakeholders in organizational improvement and allows them to identify new organizational priorities. The key in working on committees is not simply promoting a psychological perspective, but also supporting other views that help improve services; this is also advocacy. Another opportunity is to identify and, if possible, fill service gaps. This raises psychology's status as an essential service partner while providing an opportunity to advocate for both clients and the discipline. If psychologists cannot fill the gap, one can advocate by diplomatically noting the limitation of current resources and show how changes in psychological services might help meet ever-changing needs.

Another way to position oneself through partnering is to become the content expert on key service issues (e.g., competency models, evidence-based practice, trauma-informed care). Whether through a committee process or not, psychologists can provide organizational leaders with information that helps decision making. This education role, to which psychologists are accustomed, might be as simple as forwarding a research article or as complex as writing a briefing note or longer report. As psychologists build their reputation as an essential discipline in improving decision making, their influence improves. In organizations in which psychology has

a strong history, such efforts may be more welcomed and effective. Often, when there is a limited history, good work can often be dismissed as being specific to that psychologist. Thus, it is essential for psychologists to explicitly state that their work is consistent with the discipline and not simply a skill unique to the individual psychologist. Psychologists interested in organizational advocacy would be well served to assess their specific skill sets and status within the organization and be realistic in choosing advocacy activities that fit their strengths. Advocacy efforts should emphasize natural relationships and grassroots partnering when one feels one has less influence on the broader organization or when working outside a departmental model.

Psychologists can view partnership as part of working for improvement in service delivery. Focusing on areas of growth is essential to moving forward and initiating change. Many have noted that senior management is often ignorant about problem areas within their organization (Jurkiewicz, Knouse, & Giacalone, 2002; Tourish, 2005; Tourish & Robson, 2006), and the respectful sharing of information may be invaluable to leaders. Psychologists' skills in partnering and motivating are useful in highlighting difficult messages. This is the point of advocacy: If leaders already agreed, then there would be no need to advocate. Yet being too open in sharing negative information may have an equally negative impact on one's position in the organization (Eisenberg & Witten, 1987); open communication and advocacy come with some risk. The key elements of reducing risk when sharing criticism in the organization are to (a) use a professional approach, avoid personalizing; (b) build on already established relationships; and (c) be transparent and accountable.

By maintaining a respectful, professional approach to providing constructive feedback, the target audience may be more willing to listen. Furthermore, building on positive relationships already developed via the professional role can be important to targeting the message. Kassing (2001) labeled open dissent to organizational decision makers as *articulated dissent*. People perceive articulated dissenters as being less argumentative and verbally aggressive than those who use more passive ways to dissent. Furthermore, observers assessed articulated dissenters as having high-quality relationships with supervisors and believing that the organization would welcome input. Much depends on the organizational culture. Do leaders encourage open discussion, or do they ignore the constructive nature of the process and dismiss criticism? Correctly assessing the culture helps to identify key partners for relationship building. Psychologists should partner with leaders in the organization who meet goals by encouraging autonomy, manageable workloads, work–life harmony, service accessibility, and valuing relationships (Robertson & Tinline, 2008).

On establishing a receptive audience within the organization, it is essential that there is a clear message to communicate. Interviews with current staff, surveys, focus groups, and so forth can serve as data-gathering devices to highlight core issues faced by psychologists in the organization. Questions can focus on two related areas: (a) *Internal:* What can the discipline do to support its members; and (b) *External:* What organizational issues impact professional psychology practice? These questions could be added to a psychology meeting agenda or, depending on the situation, a more formalized interview process may be necessary to cover all issues. Using a formalized process to gather the information reflects systematic data gathering. A formalized process communicates the goals and priorities of the initiative so that people can make an informed choice regarding participation. A formalized process also sends a signal to the rest of the organization that the results reflect the professional nature of the activity and should be taken seriously. The power of documentation also means that psychologists will need to be careful about how they conduct any data-gathering process and report the results; however, these skills are generally part of the psychologist's repertoire.

Organizational Advocacy as Communication

Identifying partners and having a clear message are elements of building a cogent communication strategy. Safarjan (2002) describes several principles for advocates, three of which are particularly relevant to organizational advocacy and communication: (a) Improve quality of life, (b) do not make assumptions, and (c) speak their language. The goal in organizational advocacy is the improvement of services and quality of life of clients, the discipline, and professional service partners. Psychologists need to educate administrators and management about their unique contribution and not assume leaders already know how psychology helps them meet organizational targets. Psychologists can also use leader language by understanding and linking corporate goals and pressures to their core interests. Advocacy at its best creates win–win solutions to complex problems. Thus, psychologists also need to recognize the organizational and social realities of what can be improved and ensure that their advocacy efforts fit within those realities, giving decision makers room to interpret messages so that everyone can have success (Eisenberg & Witten, 1987). For example, advocating for increased assessment services might allow several solutions (hiring a psychologist, hiring a psychometrist, increased part-time/contract use, use of overtime, improved technology), whereas advocating for a new psychologist may end with no change. Being clear on the goal but vague on the solution allows effective communication to build collaborative partnerships.

Informal avenues of communication can be successful depending on the willingness of leaders to hear and act on concerns. Many psychologists, however, do not provide information in a way that is useful to leaders. At best, an informal conversation can serve to vent frustration, brainstorm ideas, or even plan in a targeted meeting. Savvy psychologists might follow up informal meetings with an e-mail to highlight issues, but these rarely rise to containing the level of information managers need to understand and become partners in advocacy efforts. Communication must become two-way, with both management and psychologists working together to meet common goals. Motivating leaders to listen can be a big challenge in organizational advocacy, especially when psychologists are not decision makers. Not listening may not be disinterest, but simply a reflection of workload demands or not truly understanding what leaders can do to facilitate change.

An easy way to support and motivate managers, especially in large organizations, is to help managers meet their goals. For example, if managers are focused on best practices and meeting externally set targets, a briefing note on the research evidence related to key practices may be welcome. If management is dealing with a professional ethical issue, such as dual relationships, then psychologists might provide a description of how they grapple with that professional issue. Another useful strategy to highlight

commonalities is targeted messaging (Fox, 2008). By targeting communication to specific groups, psychologists can have a greater influence. The central element of targeted messaging is to merge psychologists' interests with the interest of the target audience, similar to lobbying in the political realm (Galer-Unti, Tappe, & Lachenmayr, 2004). For example, if a manager is working on a 3-year plan, it can be useful to provide clear easily understood information about psychology's activities and workload projections. For example, I maintain a generic psychologist position business case that can be modified in partnership with managers to highlight why their specific service might want to add a psychologist. Communicating solutions can be a much more effective form of advocacy than simply indicating deficits (Cohen et al., 2012).

By clearly identifying the discipline's role in meeting objectives and emphasizing leadership, psychologists may counter management's natural tendency to dismiss criticism (Tourish, 2005). Fox (2008) notes that accurate and current information is important in advocacy, but that targeted messages that speak to leaders' concerns can be effective in gaining influence. Targeting efforts by directly linking psychologists' issues to the corporate vision, mission, and core values can increase the likelihood they will be heard. One might briefly review how the issue is consistent with stated corporate values and how it diverges. Corporate values are often aspirational, so identifying areas of growth can be helpful in understanding how to progress. One might also show how proper support and use of psychologists increase the chances of meeting stated goals. By engaging leadership partners in a collaborative discussion, psychologists become allies in meeting goals and any requests are not dismissed as more demands on limited resources. Most leaders understand that they are responsible for leading the organization to live stated values.

Finally, communicating results can have an impact on the success of advocacy efforts. If the target audience ignores a detailed report, psychologists could provide a one-page briefing note. If a full business case is overwhelming, they can provide a one-page cost–benefit analysis. If leaders are uninterested in the issues important to psychology, they can ensure that reports go to colleagues or potential partners in the organization. Deciding whether a written report should be detailed or simply a brief one-page highlight depends on two interrelated elements: (a) the message and (b) the audience. If the message is clear and concise, a brief report might be best. In these cases, the hope is that those reading the report will want to follow up, giving an opportunity to provide more detail in person. Providing clear information that helps busy audiences quickly understand key points also gives structure to any future discussions. This approach also helps to "plant a seed" so that even if there is no immediate follow-up meeting, the discipline's issues are now known. Complex issues or messages may warrant a more detailed report, allowing discussion of the conflicting issues. Although psychologists might find the issues interesting, others may not; psychologists should motivate the audience by highlighting common ground. Interested audiences are more likely to read and absorb a detailed report if it helps reach goals. Part of having an effective message is having something to say; the remainder is how it is communicated.

Psychologists should target and coordinate the message and identify the paths of least resistance so that ideas can build momentum. They should avoid making an end run around managers and ensure that sharing the information is constructive criticism not venting frustration. If a report is too critical, they should tone down those elements so that some goals are met and be realistic in what one can achieve. As DeLeon et al. (2006) point out, ". . . half a loaf really is better than none" (p. 150). Advocacy is about coordinating a message to increase its chances of being heard and then working to improve the system for clients and psychologists. If one's voice is discounted at the outset, or the message is seen as offensive, one is unlikely to see the change one hopes to achieve.

Conclusion

Organizational advocacy offers a strategy for psychologists to develop political advocacy skills within a known environment: their own workplace. By trading on their positive professional relationships, psychologists can look at honing their communication and partnering skills to serve their clients, their discipline, and the organization as a whole. This can be especially important to psychologists who work outside a departmental model, who might struggle with raising professional service issues beyond their immediate team. One motivator to this targeted form of advocacy over political advocacy is that psychologists may enjoy immediate feedback as they see their efforts improve their daily work. A key part of communicating a targeted message is to base the message on solid data and partnering with the audience and key decision makers. Linking to corporate goals helps psychologists partner with leaders and promote the discipline while improving their workplaces and client service. If psychologists are to be seen as a core constituency in society, they must promote themselves as a core constituency within their organizations.

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The Psychology of Advocacy and the Advocacy of Psychology

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Abstract

How can we understand the lack of attention to advocacy issues in graduate training in psychology? Several beliefs may work against the idea of preparing students for advocacy activities. The first is the conviction that it is the role of an academic to generate and disseminate knowledge and the responsibility of agencies outside the academy to advocate for the application of such knowledge in policy ([Lating] et al., 2009). Proponents of this position are aware that the interests of Canadian psychology are represented at the provincial, territorial, and national levels by committed advocates. Both the Canadian Psychological Association (CPA) and the Canadian Register of Health Service Providers in Psychology (CRHSP) embrace the objective of promoting the dissemination and application of psychological knowledge. In addition each province and one territory has a psychological association devoted to advocacy for the practice of psychology within their jurisdictions (CPA, n.d.). Second, the dominant model in a great deal of professional psychology focuses intensively on facilitating change through direct services offered to individuals. Quite simply, in psychology it is more common to examine issues at the level of the person rather than at the level of the system (Lating et al., 2009). Nevertheless, there is evidence that psychological knowledge can be applied in influencing schools (Saklofske, Schwean, Harrison, & Mureika, 2007), the criminal justice system (Wormith, 2011), workplaces (Budworth & Latham, 2009), and even governments (Sanders, 2010). Third, over the course of their training psychologists develop competence in interacting with research ethics boards, granting councils, and scholarly journals, but have no exposure to learning about decision-making outside the academy (Howell, 2007). Some psychologists may believe that advocacy is the purview of seasoned, highly experienced psychologists and that it is premature for students to consider these issues.

We hope that in this brief article we have convinced you that advocacy is the responsibility of all psychologists. Advocacy for the science and profession of psychology is essential for Canadian Psychology to be sustained and to grow. We believe that strong Canadian Psychology can improve the lives of Canadians. We are also convinced that effective advocacy relies on a skill set that can be learned. In this article we've sketched some ways that we can change our training, practice, and administration of psychology to facilitate stronger advocacy. We are not aware of any Canadian graduate program that includes courses on advocacy, but are hopeful that these issues may become a routine part of the future curriculum. In 2010/11, the CPA began offering preconvention workshops on how to be an advocate, given presentations to departments and services of psychology across the country, and presented on advocacy at the CPA's annual convention. CPA also has a media guide available to its membership and a revision to a 1999 advocacy guide is underway (CPA, n.d.). Further, in 2011 CPA helped mobilize the psychology community to take issues related to the science and practice of psychology to their political candidates. CPA purchased access to an e-campaigning service that allowed members and nonmembers alike to send templated and/or customized messages to their political candidates during the federal and six provincial/territorial elections. Advocacy is a key mandate of most professional associations - a mandate realised not just by association' leadership but by every one of its professional members. We welcome future discussion and participation in this vital activity.

Full Text

Headnote

This article addresses needs and opportunities for advocacy for the science, education and practice of psychology from the perspectives of three leaders within organized psychology, academia, and hospital practice. The authors make distinctions between knowledge transfer and knowledge translation as well as between lobbying and advocacy. They define proactive and reactive advocacy and draw attention to the impact of self-promotion and the need for collaboration in advocacy activity. Further, the authors define the need for and application of advocacy within the university environment, highlighting how advocacy skills can be taught and can have a broad reach within university student populations. The authors then address the characteristics of a practice environment upon which successful advocacy in this setting depends: the size of the problem, the effectiveness of available solutions, and the unique role psychology can play in the application of solutions. The article concludes by underscoring the collective responsibility psychologists have to be advocates and offers 12 steps in support of successful advocacy for psychology at individual, departmental, and organisational levels.

Keywords: advocacy, lobbying, knowledge translation, advocacy training, steps in support of advocacy

As the national organisation representing psychologists, the Canadian Psychological Association (CPA) has a long history of advocacy on behalf of the science and the profession of psychology. The mission and mandate of the CPA include two specific advocacy objectives:

* "To promote excellence and innovation in psychological research, education, and practice;

* To promote the advancement, development, dissemination, and application of psychological knowledge." (CPA, n.d.) http://www.cpa.ca/aboutcpa/

The importance of these objectives to the membership of the CPA and to Canadian psychology is as salient now as it was in the early days of CPA's organisation. The fruits of Canadian psychology's advocacy efforts are evident as Canada boasts a strong scientific community of psychologists (Carleton, Peluso, & Asmundson, 2010), record-breaking enrolment in both undergraduate and graduate programs in psychology (Canadian Association of University Teachers, CAUT, 2010), a well-established accreditation mechanism for professional psychology programs (Hunsley & Barker, 201 1), and psychologists contributing vital roles in diverse employment settings (Ronson, Cohen, & Hunsley, 2010). Advocacy initiatives are a prominent focus of the CPA's newly formed Science and Practice Directorates. In addition to those advocacy efforts and activities supported by CPA, many important advocacy activities have been undertaken by provincial and territorial associations of psychology in the form of developing government and media relations kits, TV commercials, media training, and leadership conferences. A number of these latter activities were made possible by funds returned to Canada by the Committee for the Advancement of Professional Practice of the American Psychological Association (APA) - the funds representing a proportion of the Practice Assessment Dues paid by Canadian members of the APA (J. Frain, personal communication, November 24, 201 1).

In addition to the explicit advocacy engaged in by the highly experienced staff of the CPA, there are countless ways that members of the Canadian psychological community promote our science and our profession via the products of their work. From early in their training, graduate students in psychology are encouraged to present their findings at scholarly conferences and to submit their work for publication in peer-reviewed journals. Psychological research is published in a vast array of scholarly journals. Practitioners train and consult to service agencies and fellow practitioners. Many among our science, practice and training communities consult to public agencies and participate in public events and lectures.

These accomplishments in knowledge transfer - exchanging information among science and health care communities - are impressive. More can be done, however, in the realm of knowledge translation; that is, interpreting this knowledge and its implications for the public and decision-makers. To an important extent, psychologists across the country do this via their activities during Psychology Month when they work to inform their communities about the exciting developments in our science and profession. We need to do more of this and get better at it.

Psychologists need to develop skills in communicating to decision-makers and funders (DeLeon, Loftis, Ball, & Sullivan, 2006). For example, in talking about the findings of a study on the developmental trajectory of autism, the

efficacy of exposure therapy for a simple phobia, or the conditions that maximize new learning in older adults, we need to also talk about the implications of these findings for research funding, service provision, patient care, and public policy. Knowledge of the determinants of autism and the factors that mitigate its course need to inform the services that are offered and the policies which mandate service delivery. People with anxiety disorders require access to interventions that have been shown to be both clinically effective and cost-effective. Psychological research should inform the development of programs and services to enable older adults to function to the fullest of their capacities.

The need for advocacy for psychologists and by psychologists is growing (Lating, Barnett, & Horowitz, 2009). Whatever their employment setting, whether supported by public or private funds, all psychologists must be equipped and willing to demonstrate the value of their work. At both the individual and organisational levels, science and practice communities must respond to demonstrated need and do so effectively.

Associations support individuals in coming together to define who they are, what they do and what they need in order to do their work effectively. Associations also give voice to individual members to communicate who they are, what they do and what they need. Consequently, in addition to its direct advocacy initiatives, the CPA is committed to engage the psychological community around advocacy, by promoting greater awareness among psychologists of the need for promotion of psychology and of the advocacy tools at their disposal. At the 2010 annual convention in Winnipeg, a town hall meeting offered a forum to explore the ways that psychologists in different settings can advocate for the science and practice of psychology. The presenters at the town hall meeting share the belief that many of our current activities as psychologists do and can constitute advocacy. We are convinced that psychologists can engage in greater advocacy often by extending what they already do - by taking their work from knowledge transfer to knowledge translation.

In the following sections, Karen Cohen, the Chief Executive Officer of the CPA, who has advocated on behalf of psychologists for many years, offers a primer on advocacy, clarifying the distinction between advocacy and lobbying, between advocacy and self-promotion and offering specific recommendations for effective advocacy. Catherine Lee, from the University of Ottawa, addresses ways that academic psychologists can engage in advocacy and can prepare future psychologists as advocates. Bob McIlwraith, who holds joint appointments with the Winnipeg Regional Health Authority and the University of Manitoba medical school, addresses ways that psychologists working in a publicly funded health care setting can become effective advocates. Our goal is to raise awareness and understanding about the need and timeliness for advocacy for psychology - advocacy for the science and the profession at the level of the university and the researcher, and at the level of practitioner and service delivery organisation.

An Advocacy Primer

Advocacy Versus Lobbying

Not-for-profit associations, like the CPA, can engage in both advocacy and lobbying. Advocacy is an umbrella term for a range of activities designed to change society by appealing to individuals, employers or government. Broadly defined, psychology advocacy is a process of "informing and assisting decision-makers . . . who promote the interests of clients, health care systems, public and welfare issues, and professional psychology" (Lating et al., 2009, p. 106). Lobbying, on the other hand, has a strict legal definition. In the United States, lobbying refers to a set of activities designed to influence legislation (NP Action, 2005). In Canada, the activities of lobbyists are governed by the 2008 Lobbying Act, which defines a number of activities which when carried out for compensation constitute lobbying, for example: "communicating with public office holders with respect to changing federal laws, regulations, policies or programs, obtaining a financial benefit such as a grant" (Government of Canada, 2008). To ensure transparency, Canadian lobbyists are required to be registered (Government of Canada, 2008). This legislation addresses not only the paid or contracted lobbyist, but also the lobbying of an individual or of an employee of an association who meets with government officials for the purposes of changing a law, a regulation, a policy, or for financial benefit.

The CPA has engaged in lobbying to change legislation around issues such as same-sex marriage and assessment of fitness to stand trial. As these examples nicely illustrate, the CPA lobbies in response to a piece of proposed legislation about which psychology has knowledge or expertise. There is ample psychological research about the psychological health of children growing up in different kinds of family configurations (Lambert, 2005; Telingator & Patterson, 2008) - an issue that is pertinent to same sex marriage legislation. Similarly, there is a body of psychological knowledge pertinent to assessment of fitness to stand trial (Pirelli, Gottdiener, & Zapf, 2011). Consequently, in the service of the CPA' s mandate to improve the health and welfare of Canadians, lobbying for legislation which promises fairer or better practice when it comes to psychological health and well-being is a key activity for the CPA.

Whereas the CPA's lobbying activities are often reactive or responsive to an initiative from government, the lion's share of its advocacy efforts more often involve communication of a message that is initiated by Canadian psychologists. The two key advocacy messages that resonate with Canadian psychologists are calls for increased funding for psychological research and calls for better access to psychological services. The CPA is committed to engaging in both advocacy and lobbying as both are critically important in influencing public policy, and ultimately, the public good. Individual psychologists may engage in one or both of these promotion activities. It is important, however, that psychologists who engage in lobbying understand the relevant legislation and requirements for registration as a lobbyist in Canada. Although it is beyond the scope of this article to present the legislation or its requirements, the interested reader can consult the Web site of the Office of the Commissioner for Lobbying for helpful documents (http:www.ocl-cal.gc.ca).

Advocacy Versus Self-Promotion

Advocacy usually involves informing and influencing decision-makers on behalf of a vulnerable group (Lating et al., 2009). However, Executive Staff of the CPA have found that when the advocacy message can be seen to benefit the group delivering it, particularly if it is already an advantaged group, the message is more likely to be dismissed. It is critical that the issue being advanced is clearly linked to the public good (DeLeon et al., 2006). For example, enhanced access to psychological services should result in more Canadians receiving the psychological care they need for themselves or their families. Although enhanced access to psychological care will likely also result in advantages to psychology practitioners (e.g., more clients and potentially more income), anecdotally we know that psychologists in independent practice are fully employed and many maintain wait lists for service - enhancing access to psychological service is not a pocket book issue for psychology practitioners. However, for the access message to have an impact on decision-makers (e.g., government, insurers, employers), it must provide compelling evidence that better access will result in better health and well-being for individuals, workers, parents, and families, and reduced need for other costly services and supports.

Psychology has a strong commitment to working with partners in science, education, and practice. A review of the Head Office Updates in Psynopsis reveals the number of alliances and coalitions in which CPA has active roles (e.g., CPA Co-Chairs the Health Action Lobby, sits on the Steering Committee of the Canadian Consortium for Research, and is a member of the Association of Accrediting Agencies of Canada to name only a few). These partnerships engage around common goals and messages when it comes to health and science. However, what we are only beginning to do is engage our partners around psychology's unique messages (e.g., the need for better access to psychology services). Response to our request for these kinds of engagements has been positive from both consumer and health professional groups.

Without the support of partners and stakeholders - be they users or potential users of psychological service or other health care providers who might benefit from better access to psychological service - our advocacy message will be less effective in creating change. Similarly, unless we can demonstrate both cost effectiveness and clinical effectiveness of our services, we will not be sufficiently successful in our advocacy efforts. We need to show how providing psychological services costs less than not providing them (Mihalopoulos, Vos, Pirkis, & Carter, 201 1). The tremendous economic impact of psychological disorders on individuals, families, the workforce and the Canadian economy is staggering (Institute of Health Economics, 2008). We need to demonstrate to decision-makers that poorly or untreated psychological problems cost more in terms of lost productivity in the workplace and increased

health care utilization than they cost to be effectively treated (London School of Economics, Centre for Economics Performance, Mental Health Group, 2006).

Successful advocacy, therefore, needs to transcend the selfinterests of the group advocating for it. To do this we need partners - organisations and individuals who are willing to lend their voices to ours. These might be clients who have benefitted from service, legislators, and decision-makers who have first-hand experience of psychological problems and treatment, associations of consumers, or other health care providers who have benefitted or would like to benefit from having their patients seen by a psychologist.

Successful advocacy campaigns are mounted and cumulative - these are not conversations that happen once or with one person (DeLeon et al., 2006). Advocacy is a collective responsibility of every member of the group calling for change and consultation; collaboration and coordination are equally essential (Lating et al., 2009). Twenty psychologists calling for 40 solutions is not an effective message.

Advocacy in Academe

What Does Academic Psychology Have to do With Advocacy?

For many psychologists, the answer is "nothing." Although there is a long history of academic lobbying and advocacy with respect to university funding, tuition fees, research support, and ethics, the bulk of this has been undertaken by national bodies such as the Canadian Association of University Teachers (CAUT), the Association of Colleges and Universities of Canada (AUCC) and the Canadian Federation for the Humanities and Social Sciences (CFHSS) rather than by individual psychologists. When psychologists think back to their student days, they are unlikely to be able to recall any aspect of training that prepared them for advocacy activities. With the exception of community psychologists, who frequently advocate on behalf of vulnerable populations (Nelson & Aubry, 2010), most psychologists pay little attention to the implications of their work for influencing public policy (Lating et al., 2009).

Psychology is a discipline and profession that is evolving rapidly (DeLeon et al., 2006). Graduates with doctoral degrees in psychology obtain employment in a wide range of settings. Not surprisingly, graduate program directors are regularly solicited by a variety of stakeholders who survey the extent to which their programs prepare students for a changing workplace. Program directors may be exhorted to address "gaps in training" by including in their curriculum greater attention to populations that are diverse in terms of gender, ethnicity, sexual orientation, and age. In addition, they are encouraged to ensure that graduates are competent in a host of activities, including assessment, intervention, consultation, supervision, research, teaching, and program evaluation. A recent survey by the National Council of Schools and Programs of Professional Psychology (Lating et al., 2009) revealed that the majority of programs did not offer specific advocacy training, although most included courses addressing issues related to community and public service.

What Accounts for the Limited Attention to Advocacy Issues in Academe?

How can we understand the lack of attention to advocacy issues in graduate training in psychology? Several beliefs may work against the idea of preparing students for advocacy activities. The first is the conviction that it is the role of an academic to generate and disseminate knowledge and the responsibility of agencies outside the academy to advocate for the application of such knowledge in policy (Lating et al., 2009). Proponents of this position are aware that the interests of Canadian psychology are represented at the provincial, territorial, and national levels by committed advocates. Both the Canadian Psychological Association (CPA) and the Canadian Register of Health Service Providers in Psychology (CRHSP) embrace the objective of promoting the dissemination and application of psychological knowledge. In addition each province and one territory has a psychological association devoted to advocacy for the practice of psychology within their jurisdictions (CPA, n.d.). Second, the dominant model in a great deal of professional psychology focuses intensively on facilitating change through direct services offered to individuals. Quite simply, in psychology it is more common to examine issues at the level of the person rather than at the level of the system (Lating et al., 2009). Nevertheless, there is evidence that psychological knowledge can be applied in influencing schools (Saklofske, Schwean, Harrison, & Mureika, 2007), the criminal justice system (Wormith, 2011), workplaces (Budworth & Latham, 2009), and even governments (Sanders, 2010). Third, over the

course of their training psychologists develop competence in interacting with research ethics boards, granting councils, and scholarly journals, but have no exposure to learning about decision-making outside the academy (Howell, 2007). Some psychologists may believe that advocacy is the purview of seasoned, highly experienced psychologists and that it is premature for students to consider these issues.

The recent successful lobbying efforts by a group of graduate students at Memorial University, in response to the threatened closure of their doctoral programme, however, demonstrated the effectiveness of student advocacy. Though largely self-taught, these student advocates clearly based their tactics in the psychological principles they acquired during their education (Patterson, O'Leary, Keating, Chaulk, & Button, 2011).

Why Should Academic Psychologists Hone Their Advocacy Skills?

Although these are legitimate arguments, they leave psychology vulnerable because broad-based advocacy is essential for the funding of research and training in psychology (DeLeon et al., 2006). As psychology is a wide discipline, Canadian psychologists conduct research that may be funded by all three of the federal granting agencies. Sustained advocacy is required to ensure ongoing funding of both basic and applied psychological research. Psychology is one of the most popular undergraduate programs (CAUT, 2010), yielding an abundance of qualified candidates keen for graduate training. Our capacity to train professional psychologists is limited by the number of applied settings in which students can obtain supervised practicum and internships. Advocacy is required to increase the number of internship and practicum placements for future generations of psychologists (Hatcher, 2011). Although psychologists have been at the forefront of the development of evidence-based services, their services are not covered by provincial health care plans, so that only a limited portion of the population has access to psychological services (Sanders, 2010). Advocacy is required to ensure that access to psychological services is not limited to wealthy clients with adequate health insurance coverage.

Fortunately, advocacy is not a dichotomous variable. Psychologists do not need to decide whether to advocate or not to advocate. Nor do young psychologists need to set aside thoughts of advocacy until they are at the peak of their careers. Advocacy can be delivered in different dosages, in different contexts, using a variety of methods, so psychologists can choose the extent to which they engage in advocacy (DeLeon et al., 2006). Furthermore, successful advocacy requires a skill set that can be learned, so academic psychologists should be well-placed to instill in their students the foundational skills for this activity (Lating et al., 2009).

How Can We Flex Our Advocacy Muscles Within The Academy?

The tripartite role of an academic psychologist requires that professors divide their energies between research, teaching, and "service to the community." These varied roles offer diverse opportunities for advocacy. As researchers, psychologists have an eminent tradition of knowledge generation. Libraries bulge with psychology journals and books on erudite topics. Like other scientists, psychologists have become increasingly aware of the need for more concerted efforts to ensure the dissemination of psychological knowledge to a larger public, including research participants, funders, and decision-makers (Lating et al., 2009).

In teaching undergraduate students, academic psychologists have a wonderful opportunity to influence the decision-makers of tomorrow. Our classrooms are Filled with the next generation of teachers, health professionals, lawyers, and politicians. In undergraduate courses as they learn about the science of human behaviour, these future voters, taxpayers, and decision-makers can learn to appreciate the value of psychological research and the importance of this knowledge in countless areas of our life. It would be wasteful indeed to squander this opportunity to showcase our discipline. It is perhaps tempting to focus our teaching on those few students who will go on to become psychologists, but by ignoring the majority of our students, we miss the opportunity to inform the broader public about the value and potential application of our work.

Graduate training in professional psychology already focuses on the development of strong interpersonal skills and addresses the ways that psychologists can work with diverse stakeholders such as teachers, health providers, the legal system, and insurance companies. Nevertheless, we could do more to sensitize students to the diverse contexts in which they will work. We already teach students how to present psychological findings and the

recommendations that flow from them in a compelling fashion. Nevertheless, we could expand our training to sensitize students to the need for advocacy roles by an explicit focus on the skill set required in advocacy.

In graduate education we already train students in many of the core competencies of advocacy and lobbying. An effective advocate engages in clear, succinct communication. The advocate adjusts the message to match the needs and interests of the decisionmaking person or organisation, making a compelling case based on the best available evidence (DeLeon et al., 2006). If we wish to train students in these competencies, we must model these skills, provide students with ample opportunities to practice them and we must evaluate the extent to which students have mastered them. Course assignments requiring lengthy articles written in jargon, concluding that the current evidence is ambiguous and that further research is required, clearly fall short of the mark. We must train students to concisely express an authoritative position based on the best available evidence (Lee, 2007).

Involvement in administrative responsibilities within their academic units, their faculty, and at university-level offers countless opportunities to advocate for psychology. Given the breadth of the discipline of psychology, departments and schools of psychology are found in faculties of arts, sciences, social sciences, and health sciences. Within each faculty, psychology administrators must defend the needs for laboratoriesis and small group teaching, for research infrastructure, for professional training. For psychology to be successful, we must be visible. We must publicize our activities and our accomplishments. The enthusiasm of undergraduate students presenting the results of their research at an honours thesis conference can be effective in convincing university administrators of the value of this (expensive) pedagogical approach. To be heard within the university community psychologists must participate at all levels of governance.

Academic psychologists also serve as site visitors and evaluators during periodic evaluations of programs and accreditation site visits. In this role, they have a unique opportunity to advocate for psychology in their meetings with university administrators. It is clear then that academic psychologists have countless opportunities to engage in advocacy for our science and profession, to model the skill set required for effective advocacy, and to create learning opportunities for students to develop these competencies.

The Role of Advocacy in Health Care

All practicing psychologists, both in the public sector and the independent practice sector, have a responsibility to advocate for their patients and the public's (children's, families') health, wellbeing, and access to needed services, though different settings require different approaches. Besides advocating for improved access to services generally, there are many health issues and many areas in which psychologists can or could be helpful - how do we choose which issues to advocate for? One approach is to focus opportunistically on issues that are already the priority of government, such as problems they have identified as needing a solution, and for which psychology has pertinent knowledge (Howell, 2007). Another useful guideline is to choose issues that foster alliances with other programs and organisations because joint proposals often get more attention from decision-makers than do proposals by a single programme or professional group. Another way to prioritize which services to advocate for is to ask the following three questions about each health problem:

* What is the size of the problem? Data on population health and burden of illness are useful here.

* Is there an effective intervention? The problem may be both serious and widespread, but is there anything that really works to address it? Emphasis on science-based clinical services is important here.

* Is there a particular psychological contribution we can make that others couldn't? Does psychology have the only or the best intervention for this problem? What is the "value-added" contribution that could be specifically made by a psychologist, rather than just another pair of hands helping to address the problem in a generic way that could be done by many others?

What do Practitioners Need to Know About Advocacy Within the Publicly Funded Health Care System and How Can They Learn It?

Health care practitioners need to know how health care organisations work. Ideally, they should learn about this in their academic programs and from their earliest practicum experiences. Interprofessional training facilitates awareness of the contributions of other disciplines as well as effective ways to work with them. To be effective advocates, it is useful for psychologists to understand the other professions around them and what their issues are.

Psychologists need to know how to get to the table where decisions are made. Currently, many hospital and health care psychologists are organized within a "program management" model in which psychologists are managed in a decentralized fashion along with other health professional groups within a variety of clinical programs, often without budgetary control or direct reporting relationships to senior management. This fragmentation and lack of direct representation in administration means that typically psychology's issues must be represented by others - if they are represented at all - rather than directly by psychologists. In very few cases is psychology a clinical program itself.

The program management model has been around a long time, and something else is going to replace it eventually, maybe fairly soon. It is not clear yet what the new model will look like, but it is safe to predict that the new model will be driven by costcontainment and accountability concerns. For example, we are already seeing models where physicians are on salary rather than fee-for-service, and other models where hospital chief executive officers' pay is tied to measurable performance indicators. Psychologists must be ready for the new organisational model when it comes. It might be a good idea for clinicians to consult with their colleagues in Industrial-Organisational Psychology about the advantages of various models of organisational structure, so that they can convincingly argue that the organisation's priorities and patients' needs would be best served by a different structure and model. Psychologists need to get more involved in administration within health care organisations - an activity which other health professions have taken on to a much greater degree.

The Baby Boomers have shown a great ability to make their current life stage issue the national agenda. As they continue to age, their big issue will likely be chronic illness. Behaviour change, self-management, health maintenance, and treatment adherence are all areas that psychologists in health care know a lot about. (Newman, Steed, & Mulligan, 2004; Toumbourou, 2010) Many of these services can be addressed by a different, much more efficient and empowering model than one-to-one care. Clinical and health psychologists are developing, and should continue to develop, expertise in the technologies for efficient dissemination of services at a distance in ways that are accessible to a broad range of individuals such as online services (e.g., Spence et al., 2011; Vincent, Lewycky, Hart Swain, & Holmqvist, 2009), tele-health (e.g., Sloan, Feinstein, Lee, & Pruneau, 201 1), or services based in low-overhead community sites rather than hospitals. Acceptance and uptake of many of these health psychology interventions is enhanced when they are framed in terms of health rather than illness, offered in a group format and presented as "classes" rather than as "therapies" (Dyck, personal communication, 2011).

Private Practice Psychology and Advocacy

Issues and context are different for psychologists in independent practice, the most obvious being the difference between selfemployment and being employed within a large institutional structure. Psychologists in independent practice settings may feel more isolated from other psychologists than do psychologists in institutional settings, and need to rely more on professional organisations to provide collaborators for joint advocacy efforts. On the other hand, private practitioners may have more advocacy opportunity than may be afforded those who are accountable to their employers for their activity. In independent practice, relationships with community agencies, other health care providers, referral sources, and insurance companies are very important. Relationships with clients and the public may be more direct, less mediated by intervening organisations and structures. The advocacy guidelines that follow apply to all psychologists, however, whether they are academics, researchers, publicly funded or fee-for-service practitioners.

What Are the Strengths That Psychologists Bring to an Advocacy Role?

* We are a small group and well-connected nationally through organisations like the CPA and the Canadian Council for Professional Psychology Programs (CCPPP). For example, because of the size of Canada, it is possible to know all internship and doctoral programme directors of training on a first-name basis.

* We have a good product to sell: our interventions are rigorously science-based and demonstrably effective. The integration of research with practice is our strength.

* The interests of psychologists are largely the same as the interests of the public; we are offering them what they want.

* Psychology has a good reputation and enjoys the trust of the public.

So Where to Start Down the Advocacy Road?

No matter your role as a psychologist, there are some common places to start.

12 Steps in Support of Successful Advocacy for Psychology

1. Bring your issue to your local, regional, or national association. They might have information or resources to assist you.

2. Find out what your association or others are doing about the issue. Remember to consult, collaborate and coordinate your efforts.

3. When speaking out about anything related to the science and practice of psychology - not just a particular issue - identify yourself as a psychologist.

4. When meeting with someone of whom you want to ask something (e.g., an elected official, a university, or hospital administrator), find out something about him or her before you meet. Does he or she have a stand on your or a similar issue? What issues are currently on his or her agenda?

5. Give the person with whom you will be meeting some background information before you meet so that you can have a more focused discussion. Busy people are not likely to give you a lot of time - make the most of it.

6. Consider what is important to the person you are meeting with and how that might that interface with your issue. Remember that successful advocacy is built on relationships characterised by reciprocal understanding and assistance.

7. Understand the policy and procedure governing the institution in which the person you are meeting with works, especially as these might relate to your issue. If you are lobbying the government, you need to understand how legislation is made and passed.

8. Be clear and be succinct. The crux of what you have to say should fit on one page with a clear take-away message or "ask."

9. Accompany your "ask" with an "offer." Don't just identify a problem - offer a solution. Policy and decision-makers have desks and inboxes full of identified problems. You will make their jobs easier if you can offer them a solution.

10. Find a way to say yes to a request. Find a way to offer help.

11. Follow up and follow through. If you promise something, deliver it. If you ask for something, follow up on its delivery.

12. Mentor, mentor, mentor. The changes you might help to bring about may well benefit successive generations of psychologists more than yours. Pass along what you have learned so that the next generation can make a similar contribution.

Where Do We Go From Here?

We hope that in this brief article we have convinced you that advocacy is the responsibility of all psychologists. Advocacy for the science and profession of psychology is essential for Canadian Psychology to be sustained and to grow. We believe that strong Canadian Psychology can improve the lives of Canadians. We are also convinced that effective advocacy relies on a skill set that can be learned. In this article we've sketched some ways that we can change our training, practice, and administration of psychology to facilitate stronger advocacy. We are not aware of any Canadian graduate program that includes courses on advocacy, but are hopeful that these issues may become a routine part of the future curriculum. In 2010/11, the CPA began offering preconvention workshops on how to be an advocate, given presentations to departments and services of psychology across the country, and presented on advocacy at the CPA's annual convention. CPA also has a media guide available to its membership and a revision to a 1999 advocacy guide is underway (CPA, n.d.). Further, in 2011 CPA helped mobilize the psychology community to take issues related to the science and practice of psychology to their political candidates. CPA purchased access to an e-campaigning service that allowed members and nonmembers alike to send templated and/or customized messages to their political candidates during the federal and six provincial/territorial elections. Advocacy is a key mandate of most professional associations - a mandate realised not just by association' leadership but by every one of its professional members. We welcome future discussion and participation in this vital activity.

Sidebar

Résumé

L'article souligne à la fois les besoins et les occasions relatives à la promotion de la science, de l'éducation et de la pratique de la psychologie selon le point de vue de trois leaders au sein des milieux de la psychologie organisée, universitaire et hospitalier. Les auteurs établissent la distinction entre les notions de transfert des connaissances et d'application de connaissances, ainsi qu'entre lobbying et promotion. Ils définissent la promotion proactive et réactive, et rappellent les effets de G autopromotion et le besoin de collaboration en matière de défense des intérêts. En outre, les auteurs soulignent le besoin de promotion au sein du milieu universitaire et expliquent en quoi les compétences en cette matière peuvent être enseignées et avoir une grande portée au sein de la population estudiantine. Ils expliquent ensuite les caractéristiques d'un environnement de pratique sur lequel dépend la réussite des activités de promotion : la gravité du problème, l'efficacité des solutions possibles et le r]]&#xl2C960;

Mots-clés : promotion, lobbying, application de connaissances, formation en promotion, étapes en appui à la promotion.

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Identifying Perceived Personal Barriers to Public Policy Advocacy Within Psychology

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Public policy advocacy within the profession of psychology appears to be limited and in its infancy. Various hypothesized barriers to advocacy within the field are analyzed in this study. Findings indicate that those who advocate do so regardless of whether the issue is specific to the profession of psychology or specific to another field. Furthermore, several components, including disinterest, uncertainty, and unawareness, were identified as barriers to advocacy. However, all barriers were subsumed by a lack of awareness of public policy issues. By identifying barriers to advocacy in psychology, programs promoting advocacy could be fine-tuned to address the lack of knowledge, which inhibits students, professionals, and clinicians from engaging in the essential role of public policy advocacy.

Keywords: advocacy, public policy, professional involvement

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There is an urgent and growing need for professional and social justice advocacy within the psychological community (Ratts & Hutchins, 2009; Kiselica & Robinson, 2001; Ratts, D'Andrea, & Arredondo, 2004; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006). Psychology, as a field as well as a profession, aims to reduce negative treatment outcomes and to enhance personal well-being through research and practice (Council of Specialties in Professional Psychology, 2009; American Psychological Association, 2010b). The viability of the profession and its capacity to provide fundamental and essential services are directly affected by legislation and regulations (Barnett, 2004). As a result, advocacy is integral to the roles of all psychologists, with the future and success of their profession and careers depending on their incorporation of advocacy into their professional identity (Burney et al., 2009). Despite the recognition and high appraisal of advocacy, little information is known about how, why, and to what degree individual professionals within the psychological arena participate in public policy advocacy.

The essential question is what does the advocacy role entail? That is the first concern that negatively influences advocacy rates—the vague, ill-defined, and at best multifaceted definition applied to this concept (Trusty & Brown, 2005). It is likely that the act of advocating is conceptualized in markedly distinct ways from one practitioner to the next and, in some cases, may even be inaccurate (Lating, Barnett, & Horowitz, 2009). Lating et al. (2009) describe advocacy as "a process of informing and assisting decision makers, [which] entails developing active 'citizen psychologists' who promote the interest of clients, health care sys-

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tems, public health and welfare issues, and professional psychology" (p. 201). Trusty and Brown (2005) offer a streamlined summary of the various descriptions of advocacy as "identifying unmet needs and taking actions to change the circumstances that contribute to the problem or inequity" (p. 259). Regardless of definition, advocacy remains a necessary component of the psychology profession (Burney et al., 2009; Fox, 2008).

Advocacy can be divided into three sectors: public policy, social justice, and professional advocacy (see Figure 1). Public policy advocacy is defined as the attempt to influence practice, policy and legislation through education, lobbying and communication with legislators and elected officials. Social justice advocacy, most broadly, involves championing for the basic human and civil rights of all people regardless of race, class, gender, or socioeconomic status. In the context of psychology, however, social justice advocacy can more aptly be understood as the recognition "that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists" (American Psychological Association *Code of Ethics*, 2010a). Lastly, professional advocacy is a synthesis of both public policy and social justice advocacy. Professional advocacy in the field of professional psychology demands that clinicians advocate not only for fair access to appropriate services but also for the important legislative changes necessary to enhance the quality of life of patients and at-risk populations.

The literature cites several important triumphs within the field (e.g., mental health parity) that can be attributed to the efforts of diligent advocates. Perhaps one of the greatest events was the combined advocacy effort of individual psychologists working with the National Association for the Advancement of Colored People (NAACP) in response to the *Brown v. Board of Education* Supreme Court case in 1954 (Benjamin & Crouse, 2002). Awareness of these accomplishments is important to understanding psychology's roots in public and social advocacy and to provide impetus for continuing advocacy efforts. However, it should be noted that a great deal more work is still necessary (DeLeon, Loftis, Ball, & Sullivan, 2006; Fox, 2008). Expanding and protecting markets, maintaining funding, providing education and training, and disseminating important information to the public are just a few current initiatives requiring ongoing advocacy (Fox, 2008). Fox (2008) advised, "addressing such an agenda will require efforts far beyond the scope and magnitude of all our past efforts put together" (p. 634).

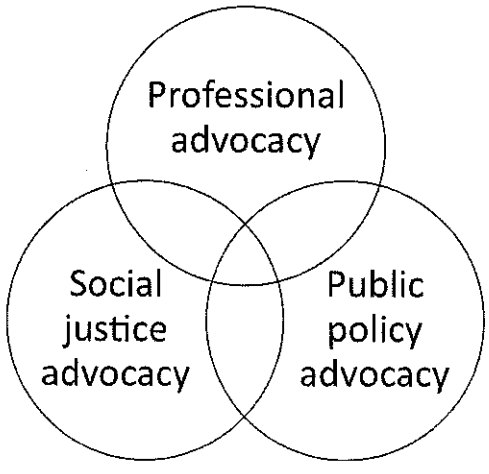

Figure 1. Three facets of advocacy roles for professional psychologists. Social justice advocacy entails those efforts that are aimed at facilitating the fair, beneficent, and just treatment of all individuals. Public policy advocacy addresses the more legislative and governmental efforts. Lastly, professional advocacy encompasses both social and public policy advocacy.

Despite the acknowledgment of advocacy as an essential responsibility for psychologists, many individuals remain uninformed and uninvolved. With regard to financial support, psychologists rank among the lowest contributors when compared with other medical professions (Pfeiffer, 2007). Furthermore, psychologists have maintained poor political representation at the national level (DeLeon et al., 2006). Of utmost concern resulting from this lack of involvement is the forfeiture of opportunities to provide input on critical issues. This, in turn, would affect the overall future of the profession as well as the future careers of individual psychologists and the well-being of clients.

Previous research has identified a number of potential barriers to public policy advocacy, which reinforces the immediate need for further research, not only to identify obstacles, but also to pave pathways of enhanced efforts. Myers and Sweeney (2004) initially introduced an exploration of obstacles to professional advocacy via a survey of 71 professionals in the counseling community in local, regional, or national leadership positions. Fifty-eight percent of respondents cited inadequate resources as their primary obstacle to advocacy. Additionally, 51% indicated there was opposition by other providers, 51% noted a lack of collaboration, and 42% suggested a lack of training was responsible for insufficient advocacy efforts. While these findings highlight important structural and fiscal challenges, it is prudent to examine the personal barriers, which may further hinder psychologists' participation in advocacy.

Individual experiences and personality traits may impede psychologists' participation in advocacy in significant ways. Previous literature highlights the impact of awareness (Gronholt, 2009) and professional agendas (Lating et al., 2009) on psychologists' participation in advocacy endeavors. More specifically, Gronholt (2009) revealed that despite active participation in academia, students and faculty cited an absence of interest in advocacy and inadequate awareness of advocacy issues and opportunities as the most significant factors inhibiting participation. These findings suggest that a lack of training or education is a considerable and consistent obstacle in advocacy participation.

When assessing the impact of awareness and training upon psychologists' underrepresentation in the advocate role, it is necessary to evaluate the perceived personal sacrifices associated with some advocacy efforts. According to Chang, Hays, and Milliken (2009) there are numerous perceived personal costs. For example, they cite burnout, job loss, and harassment from other professionals who may have the belief that client difficulties are not systemically related. Additionally, psychologists are likely to contextualize their chosen advocacy issues as either inappropriate or incongruent with their professional agenda (Chang et al., 2009; Lating et al., 2009). Similarly Benjamin and Course (2002) suggest "psychologists' aversions to political or social pronouncements have a long history in American psychology, grounded in part in the belief that science and application are separate activities and in

the long-standing prejudices held against applied work" (p. 46). In other words, some psychologists experience difficulty aligning their professional identities and values with larger, sociopolitical issues and may fear professional ramifications.

In addition to these perceived challenges, advocacy literature must articulate the personal attributes that influence effective involvement in public policy advocacy. Interestingly, an identified barrier to psychologists' participation in advocacy relates to the nature of the person drawn to the profession. Psychologists are likely to focus their attention on the interpersonal issues that affect clients rather than considering the larger, systemic issues contributing to pathology (Chang et al., 2009; Lating et al., 2009). In fact, it may be that psychologists view advocacy on an individual-level rather than global-level. For example, fostering development of self-advocacy skills and encouraging clients to be resourceful may be a primary focus rather than becoming an advocate for the clients or the field (Waldmann & Blackwell, 2010). Perhaps this tendency precludes psychologists from identifying or promoting the need for social change.

Despite the helpful studies previously conducted on advocacy, there are distinct limitations to the current state of advocacy research. The literature related directly to advocacy within psychology is underdeveloped. There is an immediate need for research assessing perceived barriers to participation in advocacy via the development of "rigorous assessment tools to evaluate practitioner awareness, knowledge, and skills related to advocacy counseling efforts" (Green, McCollum, & Hays, 2008, p. 26). This study not only moves forward the field of research assessing perceived barriers to psychologists' involvement in public policy, but it also suggests important implications for guiding enhancement of professional advocacy efforts and directing training programs.

Statement of Problem

Advocacy within the profession of psychology appears to be limited and in its infancy. Strikingly, research shows that other fields engage in high rates of advocacy. This study seeks to understand what the perceived barriers are to advocacy within the field of psychology. Further, it strives to elucidate whether there are differences between those who advocate specifically on behalf of psychological issues versus those who may advocate in other related domains.

Method

Participants were recruited via a mass email sent to the graduate psychology department of a private southeastern university. Those who decided to participate completed an anonymous online survey created with the purpose of understanding barriers to advocacy. The survey contained a total of 18 items that included demographic information, rates of advocacy involvement, and attitudes toward various types of advocacy efforts. Items followed a four-choice response scale measuring frequency of behavior (e.g., "I advocate for issues within my specific field of psychology": *very frequently, somewhat frequently, rarely, never*), and belief in personal effectiveness (e.g., "I do not believe my participation will generate much of an effect": *very relevant, somewhat relevant, somewhat irrelevant, very irrelevant*"). Items were chosen based off of the literature review, which identified several barriers to advocacy within the field of psychology. The portions of the survey that were used for the current analysis can be found in the online-only data supplement.

Participants ranged in age from 18 to 64 years, with most between the ages of 18 and 34. The majority of participants were students (63.5%), with the remaining sample consisting of alumni, staff, and faculty members. Of those who endorsed being a student affiliate, almost 60% were working toward a postgraduate degree (masters or doctorate).

Pearson correlations, a stepwise linear regression, and a principal components analysis were used to examine the data.

Results

Descriptives

Participants included 85 adults from the previously mentioned university. However, only 59 participants completed demographic information. The sample was predominantly composed of females (94.8%). Participants were asked to select their age via different ranges: 20.3% were between the ages of 18–24, 44% were between the ages of 25–34, 11.9% were between the ages of 35–44, 20.3% were between the ages of 45–54, and 3.4% were between the ages of 55–64. The percentages reported were rounded to the nearest tenth; as such, the valid percent equals 99.9%. The sample consisted predominately of students (91.5%) currently working toward a master's degree (38.6%) or a doctoral degree (38.6%) in psychology or a closely related field. The remainder of the sample consisted of university faculty (3.4%), alumni (3.4%), and clinical staff (1.7%). The self-described political orientations of participants varied among very liberal (20.7%), somewhat liberal (27.6%), moderate (37.9%), somewhat conservative (12.1%), and very conservative (1.7%).

Pearson Correlations

To investigate the influence of barriers to advocacy within psychology, several statistical analyses were conducted on responses to the online survey. Pearson correlations between self-reported relevance of potential barriers and advocacy in psychology are presented in Table 1. Results indicated that those who advocate more frequently tend to believe that the relevant barriers are having a poor past experience ($r = -.261$, $p = .048$) and not believing one has enough knowledge to discuss issues competently ($r = -.348$, $p = .007$). Meanwhile, feeling as though not being aware of current public policy issues was a relative inhibitor to advocacy was significantly correlated with less advocacy ($r = .404$, $p = .001$). Additionally, significant correlations were present between several potential barriers, indicating a considerable degree of consistency among items.

Stepwise Linear Regression

Although some barriers to advocacy were individually correlated with advocacy participation, the overlap of variance among items can make it difficult to determine which barriers are most important in predicting advocacy. Thus, a stepwise linear regression was used to determine which predictors (i.e.,

Table 1
Pearson Correlation Matrix Among Barriers to Advocacy Efforts and Self-Reported Public Policy Advocacy

	1	2	3	4	5	6	7	8	9	10	11
1. No time	1										
2. Unaware of opportunities	−.205	1									
3. Lack of interest	.158	−.169	1								
4. Belief that there is no need for advocacy	.104	.077	.546**	1							
5. Belief that participation will be ineffective	.078	−.168	.393**	.371**	1						
6. Poor past experiences	.153	.039	.331*	.423**	.479**	1					
7. I do not want to give out my information	.274*	−.097	.365**	.286*	.313*	.343**	1				
8. Lack of knowledge to discuss issues	−.264*	.223	−.055	.017	.309*	.060	−.008	1			
9. Belief that person lacks persuasiveness	.065	−.107	.152	.326*	.352**	.149	.024	.394**	1		
10. Unaware of current issues	−.096	.475**	.065	.252	.053	−.017	−.194	.504**	.404**	1	
11. Advocating for issues within one's field of psychology	.225	−.176	−.250	−.115	−.044	.261*	.201	−.348**	−.234	−.404**	1

*$p < .05$. **$p < .01$.

barriers) work in combination with one another to predict advocacy involvement within one's specific field of psychology most effectively. The following nine predictor variables were entered into the model: unawareness of public policy issues, lack of belief in the effect one's participation will have on issues, lack of time, disinterest, belief that one is not persuasive enough, poor past experiences, lack of awareness of opportunities to become involved, belief that there is no need for advocacy, and belief that one does not have enough knowledge to discuss such issues competently.

After conducting a stepwise linear regression analysis, it can be concluded that the overall model significantly predicts public policy advocacy, $F(1, 54) = 17.270$, $p < .001$ (A statistical table summarizing the results is available in the online-only data supplement). Results of the stepwise linear regression procedure indicated that the only significant barrier present, after considering overlap of variance among variables, was awareness of public policy issues ($r = .492$, $R^2 = .242$).

Principal Components Analysis

To investigate the constructs behind lack of advocacy within psychology, a principal components analysis (PCA) with varimax rotation was conducted. The results of these analyses are available in the online-only data supplement. Using Kaiser's eigenvalue-greater-than-one-rule, three components were extracted from the 10 barriers. Items loaded onto each component were considered if they had a correlation (i.e., loading) of at least .4 with a given component. Given these criteria, the first component yielded could be named "disinterest," the second component could be named "uncertainty," and the third component could be named "unawareness."

The three components accounted for 60% of the total variance after performing a PCA. The first component contributed 28% of the variance, the second component contributed 21%, and the third component contributed 11%. These three factors were reproduced on the Extraction Sums of Squared Loadings, indicating that only these factors had eigenvalues that were greater than or equal to one.

The first component included not having an interest in participating, not believing there is a need for advocacy, not believing that participation will generate an effect, having a poor past experience, and not wanting to give out information (termed "disinterest"). The second component included not having enough knowledge and not feeling persuasive enough (termed "uncertainty"). Finally, the third component included lack of awareness of public advocacy issues as well as opportunities to advocate (termed "unawareness").

The results of the PCA taken in tandem with the results of the correlation and regression analysis indicate that there are three distinct components regarding barriers to advocacy (disinterest, uncertainty, and unawareness); however, the influence of several barriers (e.g., poor past experience, lack of knowledge) are subsumed under the impact of unawareness of public policy issues.

Discussion

Results indicate that those who advocate do so regardless of whether the issue lies within or outside of their specific field. More simply, those who advocate, advocate. This finding may be indicative of unique personal characteristics of those who are involved in advocacy efforts. Relative to other health professions, those drawn to professional psychology may be more interested in individual issues rather than larger sociopolitical concerns (Lating et al., 2009). In other words, psychologists may more readily advocate for individuals but advocate less for larger platforms. This advocacy pattern may be further influenced by the tendency for public policy issues to be presented in polarized views, in contrast to the tendency for psychologists to view things in shades of gray.

Results further revealed that several barriers were independently correlated with psychologists' participation in advocacy; however, a substantial overlap of variance was also indicated. Considering poor past experiences with advocacy as a barrier was, ironically, associated with greater participation in advocacy. This suggests that negative past experiences do not deter people from advocating in the future. It is also likely that those who advocate are more apt

to have negative (as well as potentially positive) experiences than those who do not advocate.

The overall regression model with nine predictor variables entered in was deemed statistically significant. The only significant barrier, however, was awareness of public policy issues. In other words, much of the predictive influence of the assessed barriers to advocacy was actually subsumed under the barrier of feeling unaware of public policy issues for which to advocate. For example, not believing one has enough knowledge to discuss issues competently inhibits public policy advocacy, but not over and above the influence of not being aware of public policy advocacy issues in the first place. These results suggest that lack of awareness of advocacy issues strongly inhibits involvement in psychology advocacy. In fact, the impact of some other speculated barriers might actually be better accounted for by this lack of awareness. For instance, psychologists or psychology students may feel as though they lack adequate knowledge to discuss public policy issues simply because they are in the dark about what the issues are.

Furthermore, areas previously assumed to be relevant barriers to advocacy, (e.g., unawareness of opportunities to become involved, lack of time) appear less important than expected. Instead of emphasizing awareness of avenues for advocacy or suggesting time-efficient opportunities, interventions should be aimed primarily at improving education with regard to current, relevant public policy concerns. Lating et al. (2009) indicated that 60% of psychology programs do not offer specific advocacy training. However, the authors note that 88% cover advocacy issues in class. This suggests that improvements in education are slowly developing and perhaps will someday result in full-fledged advocacy training as an integral part of psychology programs.

Although lack of awareness was found to be the most meaningful barrier, moderate semipartial correlations (i.e., correlations after considering the impact of other investigated barriers) suggest future studies are needed to establish the roles of variables to assess interest in participating in as well as the belief in a need for public policy advocacy. In the current study, these variables failed to meet statistical significance as predictors of advocacy; however, increased sample size in future replications may provide the power necessary to yield a significant result.

After performing a PCA, three components emerged. The three components accounted for 60% of the total variance. The first component contributed 28% of the variance (not having an interest in participating, not believing there is a need for advocacy, not believing that participation will generate an effect, having a poor past experience, and not wanting to give out information). The second component contributed 21% (not having enough knowledge and not feeling persuasive enough), and the third component contributed 11% (lack of awareness of public advocacy issues as well as opportunities to advocate).

The three components identified by the PCA (disinterest, uncertainty, and unawareness) as barriers to advocacy corroborate the findings of previous advocacy research (Myers & Sweeney, 2004; Gronholt, 2009). The first component, termed "disinterest," included not having an interest in participating, not believing there is a need for advocacy, not believing that participation will generate an effect, having a poor past experience, and not wanting to give out information. Though this is a complex and multifaceted component, results remain consistent with previous research suggesting that advocacy is not a priority among many psychologists due to a general lack of interest (Myers & Sweeney, 2004). More explicitly, the authors found that 28% of clinicians did not view advocacy as a priority. Furthermore, 27% of clinicians reported that they did not have any interest in advocating (Myers & Sweeney, 2004). Other studies have used the lack of "motivational spark" as a synonym for the disinterest in participating experienced by professionals (London, 2010).

The second component, termed "uncertainty," included items such as not having enough knowledge and not feeling persuasive enough. The lack of knowledge identified by our participants is likely related to a lack of training in advocacy. Myers and Sweeney (2004) established that 41% of their sample found a lack of training to be a significant barrier in advocacy work. When psychology programs fail to emphasize advocacy, students are likely to graduate without the confidence and tools necessary to advocate effectively. According to London (2010), a lack of confidence impacts motivation and the manner in which psychologists conceptualize problems and the need for change.

Finally, the third component, termed "unawareness," included lack of awareness of public advocacy issues as well as opportunities to advocate. Again, our results corroborate the findings of Myers and Sweeney (2004) that suggest a lack of awareness of advocacy issues is a significant barrier to participation in advocacy.

There are several limitations inherent in the design of the current study. For one, the sample was drawn from one university in the southeastern region of the United States. There may be issues with generalizability to the population of the United States as a whole. Additionally, the small sample size ($N = 86$) may further reduce applicability to the general population of professional psychologists. As such, the results should be interpreted within the context of existing within an exploratory framework. Further research is needed to examine characteristics in more diverse samples. Furthermore, the survey used was exploratory at best. Future studies ought to expand on the current template to include questions with greater variability in responses, as well as to include additional items or perceived barriers.

Participation in advocacy within the profession of psychology is essential because public policy drives professional functioning. The future of the field and of the people served by psychologists depends on advocacy efforts. Consequently, a careful consideration of the interaction among the three components identified in our study can provide valuable insight into improving advocacy within psychology. First, advocacy must become a valued asset to the field. As previous research has indicated, nearly half of psychologists admit that advocacy is not a priority (Kindsfater, 2008). Before the other barriers to advocacy can be addressed, psychologists need to perceive advocacy as an integral part of their profession. Once advocacy is valued, the lack of preparation and awareness can be addressed through graduate training programs and continuing education courses. Ideally, the increased valuation of advocacy, combined with the necessary tools and avenues to pursue it, will ignite motivation for psychologists to take their roles as advocates seriously.

Implications

Advocacy is a major component of psychology and mental health awareness. Although no significant trait or construct differ-

ences were found between participants who advocate within or outside their own field, this study did illustrate the essential need for advocacy training. This finding is crucial because it illustrates that lack of motivation or unwillingness to advocate is not primarily responsible for preventing advocacy; rather it is a deficiency in understanding or simply being aware of relevant issues. This lack of knowledge implies that the psychological community should seek to enlighten individual members not only about advocacy procedures, how they work, and the vast benefits that can emerge, but also about specific issues. Psychology students and professional practitioners are typically unaware of how much their individual contributions can actually help. People may not spend time or money advocating if they do not believe any results will emerge from their efforts. Hence, steps should be taken to highlight positive advocacy experiences and successful policy changes.

If professional psychologists actively supported relevant issues regarding mental health, the field of psychology would advance at a faster rate. To initiate this, implementing advocacy education in continuing education classes, mandatory seminars, and yearly conferences would compel psychologists to hear the relevant issues at hand. Professional psychologists may be overwhelmed with a heavy workload and not have time to individually research and participate in public policy advocacy. However, when made aware of significant concerns related to mental health, by nature, professional psychologists will be unable to ignore them.

As for spreading the importance of advocacy among professional facilities outside of the psychological field, companies can provide in-house training to employees to increase comfort and familiarity with the advocacy process. Because there are numerous areas in which individuals are interested, education can be provided according to the relevance of each specific institution. People in general are more likely to support issues that have meaning to them. Tailoring advocacy education in this manner may not only attract a greater amount of people but may also make the understanding of advocacy more simplistic.

Furthermore, there is a lack of awareness among society about which issues are most pertinent to be advocated for. It is therefore critical to provide timely information pertaining to relevant public policy issues for which the public can advocate. Creating public advocacy groups can also help disseminate information and increase opportunities for positive experiences. Increasing layman's confidence in advocacy can be accomplished by providing training opportunities via open workshops to create collaborative advocacy endeavors.

The findings presented in this study carry valuable implications for efforts aimed at enhancing participation in advocacy. Lating et al. (2009) suggest that the continued separation of professional and educational agendas in the training of psychologists may contribute to the profession's deficient involvement in advocacy. Specifically, psychology is the only major health profession to maintain an academic training model despite the creation of professional training programs. The lack of advocacy training appears to contribute to the development and maintenance of barriers such as lack of awareness of and lack of perceived competence in discussing public policy issues.

Efforts to increase psychologists' participation in public policy advocacy must begin early on and be integrated throughout their curricula. Pertinent public policy issues fit well into courses on ethics, diversity, assessment, and even intervention. Similarly, discussion about and training in the advocacy role may be reinforced through clinical training and supervision. In addition to incorporated teaching lessons, specific coursework in public policy advocacy might aid students in developing skills used to advocate, while increasing comfort, enhancing familiarity, and expanding knowledge of current issues.

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FINAL PAPER
ASSIGNMENT LE
PLEASE USE 5 SOURCES & THE ATTACHED BOOK SOURCE

Psychological Treatment Plan

It is recommended that students review the e-book *The Complete Adult Psychotherapy Treatment Planner* (Jongsma, Peterson, & Bruce, 2014) for additional assistance in completing this assignment. (ATTACHED)

Clinical and counseling psychologists utilize treatment plans to document a client's progress toward short- and long-term goals. The content within psychological treatment plans varies depending on the clinical setting. The clinician's theoretical orientation, evidenced-based practices, and the client's needs are taken into account when developing and implementing a treatment plan. Typically, the client's presenting problem(s), behaviorally defined symptom(s), goals, objectives, and interventions determined by the clinician are included within a treatment plan.

To understand the treatment planning process, students will assume the role of a clinical or counseling psychologist and develop a comprehensive treatment plan based on the same case study utilized for the Psychiatric Diagnosis assignment in PSY645. A minimum of five peer-reviewed resources must be used to support the recommendations made within the plan. The Psychological Treatment Plan must include the headings and content outlined below.

Behaviorally Defined Symptoms

- Define the client's presenting problem(s) and provide a diagnostic impression.
- Identify how the problem(s) is/are evidenced in the client's behavior.
- List the client's cognitive and behavioral symptoms.

Long-Term Goal

- Generate a long-term treatment goal that represents the desired outcome for the client.
  - This goal should be broad and does not need to be measureable.

Short-Term Objectives

- Generate a minimum of three short-term objectives for attaining the long-term goal.
  - Each objective should be stated in behaviorally measureable language. Subjective or vague objectives are not acceptable. For example, it should be stated that the objective will be accomplished by a specific date or that a specific symptom will be reduced by a certain percentage.

Interventions

- Identify at least one intervention for achieving each of the short-term objectives.
- Compare a minimum of three evidence-based theoretical orientations from which appropriate interventions can be selected for the client.

- Explain the connection between the theoretical orientation and corresponding intervention selected.
- Provide a rationale for the integration of multiple theoretical orientations within this treatment plan.
- Identify two to three treatment modalities (e.g., individual, couple, family, group, etc.) that would be appropriate for use with the client.

It is a best practice to include outside providers (e.g., psychiatrists, medical doctors, nutritionists, social workers, holistic practitioners, etc.) in the intervention planning process to build a support network that will assist the client in the achievement of treatment goals.

Evaluation

- List the anticipated outcomes of each proposed treatment intervention based on scholarly literature.
  - Be sure to take into account the individual's strengths, weaknesses, external stressors, and cultural factors (e.g., gender, age, disability, race, ethnicity, religion, sexual orientation, socioeconomic status, etc.) in the evaluation.
- Provide an assessment of the efficacy of evidence-based intervention options.

Ethics

- Analyze and describe potential ethical dilemmas that may arise while implementing this treatment plan.
- Cite specific ethical principles and any applicable law(s) for resolving the ethical dilemma(s).

The Psychological Treatment Plan

- Must be 8 to 10 double-spaced pages in length (not including title and references pages) and formatted according to APA style as outlined in the Ashford Writing Center (Links to an external site.).
- Must include a separate title page with the following:
  - Title of paper
  - Student's name
  - Course name and number
  - Instructor's name
  - Date submitted
- Must use at least five peer-reviewed sources in addition to the course text.
- Must document all sources in APA style as outlined in the Ashford Writing Center.
- Must include a separate references page that is formatted according to APA style as outlined in the Ashford Writing Center.

Attention Students: The Masters of Arts in Psychology program is utilizing the Pathbrite portfolio tool as a repository for student scholarly work in the form of signature assignments completed within the program. After receiving feedback for this

Psychological Treatment Plan, please implement any changes recommended by the instructor, go to Pathbrite (Links to an external site.), and upload the revised Psychological Treatment Plan to the portfolio. (Use the Pathbrite Quick-Start Guide to create an account if you do not already have one.) The upload of signature assignments will take place after completing each course. Be certain to upload revised signature assignments throughout the program as the portfolio and its contents will be used in other courses and may be used by individual students as a professional resource tool. See the Pathbrite (Links to an external site.) website for information and further instructions on using this portfolio tool.

Carefully review the Grading Rubric (Links to an external site.) for the criteria that will be used to evaluate your assignment.

COGNITIVE DEFICITS[1]

BEHAVIORAL DEFINITIONS

1. Client or client's family expresses concern about memory, concentration, "thinking," judgment, social behavior, or the ability to complete tasks.
2. Client receives negative feedback about school or work performance, when performance has typically been satisfactory.
3. Client makes frequent errors in everyday activities that were previously completed accurately.
4. Noticeable deterioration in everyday tasks such as keeping appointments, paying bills on time, recalling recent conversations, and processing mail.
5. Difficulty in recall of recent events.
6. Inappropriate or embarrassing social behavior, with history of effective social functioning.
7. Changes in driving safety not explained by visual problems.
8. Marked change in client's use of leisure time, with client reducing time spent on tasks requiring concentration (e.g., reading, woodworking, knitting, writing, puzzles, Internet searching).
9. Client reports higher levels of stress than usual when working on cognitively difficult tasks (e.g., organizing income tax information, making financial decisions, completing occupational tasks).

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[1] Content for this chapter was provided by Michele Rusin, coauthor with Arthur Jongsma of *The Rehabilitation Psychology Treatment Planner* (2001). Hoboken, NJ: Wiley.

LONG-TERM GOALS

1. Maintain effective functioning through the use of cognitive aids and strategies.
2. Adjust activities and responsibilities to level of cognitive capacity, cooperating with others who provide assistance or oversight.
3. Maintain physical and emotional health to maximize brain health and optimize cognitive performance.
4. Experience satisfaction in life while managing cognitive symptoms and resulting lifestyle changes.

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SHORT-TERM OBJECTIVES

1. Describe the history, nature, and severity of cognitive problems experienced. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Ask the client and (with authorization) the client's family/support system, about the types and duration of the client's cognitive problems, the temporal course (sudden, gradual, intermittent), and significant stressors occurring near the time of onset.
2. Ask the client and (with authorization) the client's family/support system about the client's use of prescribed and nonprescribed medications and substances (alcohol, street drugs, herbs).
3. Ask the client and (with authorization) the client's family/support system, and/or physician(s) about the patient's medical history, being attentive to conditions (e.g., hypothyroidism,

diabetes, hypertension, strokes, etc.) that might impact cognitive functioning.

2. Participate in a brief psychometric assessment to quantify cognitive and emotional functioning, and to screen for alcohol abuse. (4, 5, 6)

4. Administer tests to quantify patterns of cognitive performance (e.g., *Repeatable Battery for the Assessment of Neuropsychological Status*) or to screen for dementia/ cognitive impairment (e.g., *Mini Mental State Examination; Dementia Rating Scale-2; Memory Impairment Screen*), being attentive to the impact of age, educational level, and cultural background on the interpretation of scores.

5. Ask the client to complete inventories to assess depression (e.g., *Beck Depression Inventory-II; Geriatric Depression Scale*), anxiety (e.g., *Beck Anxiety Inventory; State-Trait Anxiety Inventory*), posttraumatic stress disorder (e.g., *Detailed Assessment of Posttraumatic Stress*), or general emotional status (*Symptom Checklist 90-R; Brief Symptom Inventory-18*).

6. Administer tests to screen for alcohol abuse (e.g., *CAGE* or *AUDIT*).

3. Give the therapist permission to speak with others about the types and durations of cognitive problems, while developing a treatment plan. (7)

7. With the client's authorization, talk with the client and family about initial impressions, and consult with the client's physician regarding symptoms, history, assessment results, and agree on a plan of care for the cognitive problem.

4. Cooperate with comprehensive evaluation procedures to assess

8. Initiate or support referral to health care professionals skilled

cognition and factors impacting cognitive problems. (8)

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (9, 10, 11, 12)

in providing an in-depth assessment of cognitive disorders (e.g., neurologist, rehabilitation medicine physician, neuropsychologist, rehabilitation psychologist). EBP

9. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
10. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
11. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
12. Assess for the severity of the level of impairment to the client's functioning to determine

	appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
⩔ 6. Client and/or family describe their understanding of the assessment results and recommendations. (13, 14)	13. Discuss evaluation results with the client and family members; provide them with education as the nature of the deficits found and treatment options. ⩔
	14. Assess the degree of the client's and family's realistic appraisal of the client's functioning by inquiring into their perception of the problem areas, the reason for the problems, and the typical clinical course; talk with the client and family about differences between their beliefs and what professionals are saying. ⩔
7. Agree to treatment of emotional disorders and/or substance dependence/abuse that may impact cognitive functioning. (15)	15. Develop and implement a treatment plan for depression, anxiety, and/ or substance abuse that might depress the client's cognition (see the Unipolar Depression, Anxiety, or Substance Abuse chapters in this *Planner*).
⩔ 8. Consistently use written records and/or alarms to remind self of commitments and planned activities. (16, 17)	16. To address all levels of memory problems, recommend use of written, visible external aids (e.g., day planners, memory books, calendars, dry erase boards) and/or alarms to cue the client to commitments and

planned activities; teach the client to use these aids.

17. Inquire about the client's use of written external memory aids, and reinforce consistent use.

9. Use computerized devices consistently to compensate for areas of cognitive weakness. (18, 19)

18. Assist the client with the selection of computerized external aids (e.g., GPS navigation systems, PDAs, smart phones) that match his/her preferences, budget, and ability to learn to use them; teach the client to use these aids.

19. Inquire into the client's use of computerized devices and reinforce use.

10. Use internal or covert cognitive strategies to increase effective task performance. (20, 21, 22, 23, 24)

20. For clients having mild impairments, demonstrate the use of repetition and enriched imagery (e.g., learning a person's name by repeating the name of the person during a conversation, and then associating their name with a physical feature (e.g., "Amy" has dark eyebrows that are "aiming" toward her nose).

21. For clients having mild impairments, demonstrate the use of clustering (e.g., organize grocery list items into groups: [4 fruits: bananas, blueberries, lemons, strawberries; 3 dairy items: butter, milk, yogurt; 2 bakery items: bagels, bread); remember these 3 groups, and then items within them, rather than trying to remember 9 random items) thereby focusing attention, enriching images, decreasing the cognitive load, and facilitating retrieval of information.

22. For clients having mild impairments, teach the peg word

	rhyme (1 is a bun, 2 is a shoe, etc.; see *How to Strengthen Memory by a New Process* by Sambrook) and demonstrate how use of the peg word system coupled with exaggerated imagery, enhances recall of information (e.g., learn cell phone number by developing a mental picture based upon the rhyme. For example, 573-8821 becomes a huge bee hive (5) reaching to heaven (7), with a tree (3) forming a slide down from heaven. Next are two gates (8, 8) behind which are an ornate shoe (2) with a sticky bun (1) inside.
	23. Recommend the client cue self silently (e.g., "Focus" "Stay on task") to maintain concentration and facilitate persistence.
	24. Inquire into the client's use of covert aids and reinforce use.
11. Use a systematic approach to problem-solving. (25)	25. Teach patient to use a systematic problem solving strategy (e.g., SOLVE: S = Situation specified; O = Options listed with pros and cons; L = Listen to others; V = Voice a choice, implement an option; E = evaluate the outcome) (see *Overcoming Grief and Loss After Brain Injury* by Niemeier and Karol).
12. Link new recurring activities to existing recurring activities. (26)	26. Suggest the client use a behavioral chaining strategy to add a new recurring activity to existing recurring activity (e.g., instruct client to review day planner at the end of each meal).
13. Accept and implement environmental changes to enhance everyday performance. (27)	27. Discuss ways to modify the client's environment (e.g., reduce clutter, reduce distractions, maintain consistent placement

of regularly used items, label locations of commonly used objects, identify one purse/wallet that the client will consistently use) to enhance functioning.

14. Participate in cognitive rehabilitation sessions and perform homework exercises. (28)

28. Refer the client for cognitive rehabilitation services to address deficits and learn coping skills.

15. Challenge self to accomplish cognitively difficult tasks that have been identified as "safe" by health care professionals. (29)

29. Work with the client to identify cognitively challenging, but reasonable activities (e.g., reading, puzzles, Mahjong, keeping up with sports) to build into the day.

16. Implement actions to enhance physical health. (30)

30. Talk with the client about the positive impact of a healthy lifestyle (e.g., aerobic exercise, healthy diet, adequate sleep) on maintaining and perhaps improving cognition; inquire into implementation of these behaviors.

17. Problem-solve with therapist around problems affecting adherence to treatment plan. (31)

31. Support and periodically reinforce the client's implementation of recommendations (e.g., adherence with medications, behavioral recommendations, participation in cognitive rehabilitation, use of strategies and aids, environmental modifications); problem-solve any obstacles to consistent treatment plan compliance.

18. Family members make adjustments to cope with the client's cognitive deficits. (32)

32. Educate family members that the client's cognitive changes are a family problem; talk about the most commonly encountered problems and ways to deal with them, work with family to identify coping resources, encourage caregivers to take

breaks, and recommend participation in recreational, social, and spiritual activities.

19. Client and family verbalize questions, anxiety, sadness, and other emotions triggered by this change in client's functioning. (33)

20. Express hope for the ability to experience satisfaction, love, and pleasure while managing the cognitive deficit. (34)

21. Participate in an evaluation of driving skills, accepting results and recommendations. (35, 36, 37, 38)

33. Assist the client and family members in working through grief, anger, and other emotions associated with the change in the client's functioning and their expectations for the future.

34. Work with the client and family to create reasonable expectations about the client's capacities and to bolster confidence in everyone's ability to have a satisfying life as they manage this problem.

35. Talk with the client and family members about the potential impact of the cognitive deficit on the client's driving safety.

36. Develop a plan with the client and family to informally assess the client's driving skills (e.g., have client navigate through empty parking lot, observing the client's ability to maintain appropriate speed, to keep vehicle within a lane, to pull car into a parking space, to observe posted signs).

37. Refer the client for an evaluation of driving skills administered by a professional trained to assess the impact of cognitive disorders on driving-related capacities.

38. Talk with the client and/or family about the state law governing responsibilities to report persons having medical conditions that affect driving skills; follow state laws and HIPAA in taking action (e.g., making a report directly to a

	state agency, discussing concerns about driving with the client's physician); suggest the client voluntarily surrender his/her license and promise to not drive.
22. Utilize public transportation, or accept transportation with family and friends. (39)	39. Assist the client in identifying alternate transportation resources (e.g., public transportation, handicapped-accessible public transportation, volunteer drivers, friends, extended family); if applicable, recommend supervision while the client learns to use these services.
23. Consider the advice of professionals and others in selecting "safe" activities in which to invest one's time. (40)	40. Work with the health care team and family to identify which activities are safe and what restrictions are necessary; provide counsel to the client regarding deciding which activities one is free to engage in, which may require supervision or partial restrictions, and which must be abandoned.
24. Family and client implement restrictions in a way that preserves client's experience of choice, while reducing confrontation. (41)	41. When possible, offer safe options for daily activities (e.g., provide small amounts of spending money for client to carry in a wallet, provide credit card with a low spending limit, review checks written by the client prior to mailing them); create impediments to the client engaging in dangerous behavior (e.g., keeping the client's car keys, disconnecting the car battery), if necessary.
25. Family members respond with empathy to the client's experience and allow the client to manage responsibilities and problems that are within his/her capacity. (42)	42. Educate family members about the positive effect of empathic responding and emotional support; describe the negative impact on functioning if excessive instrumental support

is provided, or the client is being "over-helped."

26. Seek out reputable sources of information, advice, and support related to the underlying disease/injury. (43)

27. In consultation with an attorney, complete legal documents regarding proxy decision making and other legal issues. (44)

28. Verbalize an understanding of the Americans with Disabilities Act and ways to request accommodations in academic, work, or community settings. (45)

29. Identify and apply for benefits triggered by disability. (46)

43. Refer the client and family to resources to enhance coping effectiveness through education, skills-building, and emotional support; suggest written materials, web-based resources (see the Bibliotherapy Suggestions in Appendix A), and community support groups.

44. Talk with the client and family about the impact of cognitive impairment on a person's ability to make legally binding decisions (e.g., contracts, advance directives, power of attorney designations, will); refer the client/family to attorneys with expertise in these areas (e.g., elder law).

45. Talk with the client and family about the Americans with Disabilities Act and inform as to how this act allows the client to obtain accommodations at school, work, or in other settings.

46. Educate the client and family about potential financial support benefits (e.g., disability insurance benefits, Social Security Disability, activation of long-term care policy benefits) and how to apply for them.

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	294.9	Cognitive Disorder, NOS
	294.10	Dementia of the Alzheimer's Type, Without Behavioral Disturbance
	294.11	Dementia of the Alzheimer's Type, With Behavioral Disturbance
	290.40	Vascular Dementia Uncomplicated
	290.41	Vascular Dementia With Delirium
	290.42	Vascular Dementia With Delusions
	290.43	Vascular Dementia With Depressed Mood
	294.1x	Dementia Due to (Axis III Disorder)
	_____	_____
	_____	_____
Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
799.59	R41.9	Unspecified Neurocognitive Disorder
294.11	F02.81	Probable Major Neurocognitive Disorder Due to (specify disorder), With Behavioral Disturbance
294.10	F02.80	Probable Major Neurocognitive Disorder Due to (specify disorder), Without Behavioral Disturbance
331.9	G31.9	Possible Major Neurocognitive Disorder Due to (specify disorder)
331.83	G31.84	Mild Neurocognitive Disorder Due to (specify disorder)
290.40	F01.51	Probable Major Vascular Neurocognitive Disorder With Behavioral Disturbance
290.40	F01.50	Probable Major Vascular Neurocognitive Disorder Without Behavioral Disturbance
331.9	G31.9	Possible Major Vascular Neurocognitive Disorder
331.83	G31.84	Mild Vascular Neurocognitive Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition
294.8	F06.8	Other Specified Mental Disorder Due to Another Medical Condition

294.10	F02.80	Major Neurocognitive Disorder Due to Another Medical Condition, Without Behavioral Disturbance
294.11	F02.81	Major Neurocognitive Disorder Due to Another Medical Condition, With Behavioral Disturbance
291.2	F10.27	Alcohol-Induced Major Neurocognitive Disorder, Nonamnestic-Confabulatory Type, With Moderate or Severe Alcohol Use Disorder
291.1	F10.26	Alcohol-Induced Major Neurocognitive Disorder, Amnestic-Confabulatory Type, With Moderate or Severe Alcohol Use Disorder
291.89	F10.288	Alcohol-Induced Mild Neurocognitive Disorder, With Moderate or Severe Use Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EBT indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

DEPENDENCY

BEHAVIORAL DEFINITIONS

1. Resists becoming self-sufficient, consistently relying on parents to provide financial support, housing, or caregiving.
2. A history of many intimate relationships with little, if any, space between the ending of one and the start of the next.
3. Strong feelings of panic, fear, and helplessness when faced with being alone as a close relationship ends.
4. Feelings easily hurt by criticism and preoccupied with pleasing others.
5. Inability to make decisions or initiate actions without excessive reassurance from others.
6. Frequent preoccupation with fears of being abandoned.
7. All feelings of self-worth, happiness, and fulfillment derive from relationships.
8. Involvement in at least two relationships wherein he/she was physically abused but had difficulty leaving the relationship.
9. Avoids disagreeing with others for fear of being rejected.

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LONG-TERM GOALS

1. Develop confidence in capability of meeting own needs and of tolerating being alone.
2. Achieve a healthy balance between independence and dependence.

3. Decrease dependence on relationships while beginning to meet own needs, build confidence, and practice assertiveness.
4. Break away permanently from any abusive relationships.
5. Emancipate self from emotional and economic dependence on parents.
6. Embrace the recovery model's emphasis on accepting responsibility for treatment decisions as well as the expectation of being able to live, work, and participate fully in the community.

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SHORT-TERM OBJECTIVES

1. Describe the style and pattern of emotional dependence in relationships. (1)
2. Verbalize an increased awareness of own dependency. (2, 3)
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)

THERAPEUTIC INTERVENTIONS

1. Explore the client's history of emotional dependence extending from unmet childhood needs to current relationships.
2. Develop a family genogram to increase the client's awareness of family patterns of dependence in relationships and assess how he/she is repeating them in the present relationship.
3. Assign the client to read *Co-dependent No More* by Beattie or *Women Who Love Too Much* by Norwood; process key ideas.
4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the

"problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
8. Explore the client's family of origin for experiences of emotional abandonment.

4. Verbalize insight into the automatic practice of striving to meet other people's expectations. (8, 9, 10)

9. Assist the client in identifying the basis for his/her fear of disappointing others (or assign "Taking Steps Toward Independence" from the *Adult Psychotherapy Homework Planner* by Jongsma).
10. Read with the client the fable entitled "The Bridge" in *Friedman's Fables* by Friedman; process the meaning of the fable.

5. List positive things about self. (11, 12)

11. Assist the client in developing a list of his/her positive attributes and accomplishments (or assign "Acknowledging My Strengths" from the *Adult Psychotherapy Homework Planner* by Jongsma).
12. Assign the client to institute a ritual of beginning each day with 5 to 10 minutes of solitude where the focus is personal affirmation.

6. Identify and replace distorted automatic thoughts associated with assertiveness, being alone, or acting independently. (13, 14, 15, 16)

13. Explore and clarify the client's fears or other negative feelings associated with being more independent.
14. Use the cognitive restructuring process (i.e., teaching the connection between thoughts, feelings, and actions; identifying relevant automatic thoughts and their underlying beliefs or biases; challenging the biases; developing alternative positive perspectives; testing biased and alternative beliefs through behavioral experiments) to assist the client in replacing negative automatic thoughts associated with assertiveness, being alone, or not meeting others' needs.
15. Reinforce the client for developing and implementing positive, reality-based messages

	to replace the distorted, negative self-talk associated with independent behaviors (or assign "Replacing Fears With Positive Messages" from the *Adult Psychotherapy Homework Planner* by Jongsma).
	16. Assign the client a homework exercise (e.g., "Journal and Replace Self-Defeating Thoughts" from the *Adult Psychotherapy Homework Planner* by Jongsma) in which he/she identifies fearful self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments; review and reinforce success, providing corrective feedback toward improvement.
7. Verbalize a decreased sensitivity to criticism. (17, 18, 19)	17. Explore the client's sensitivity to criticism and help him/her develop new ways of receiving, processing, and responding to it.
	18. Assign the client to read books on assertiveness (e.g., *Your Perfect Right: Assertiveness and Equality in Your Life and Relationships* by Alberti and Emmons).
	19. Verbally reinforce the client for any and all signs of assertiveness and independence.
8. Increase saying no to others' requests. (20)	20. Assign the client to say no without excessive explanation for a period of one week and process this with him/her.
9. Report incidents of verbally stating own opinion. (21, 22)	21. Train the client in assertiveness or refer him/her to a group that will facilitate and develop his/her assertiveness skills via lectures and assignments.

22. Assign the client to speak his/her mind for one day, and process the results with him/her.

10. Identify own emotional and social needs and ways to fulfill them. (23, 24)

23. Ask the client to compile a list of his/her emotional and social needs and ways that these could possibly be met; process the list (or assign "Satisfying Unmet Emotional Needs" from the *Adult Psychotherapy Homework Planner* by Jongsma).

24. Ask the client to list ways that he/she could start taking care of himself/herself; then identify two to three that could be started now and elicit the client's agreement to do so. Monitor for follow-through and feelings of change about self.

11. Report examples of receiving favors from others without feeling the necessity of reciprocating. (25)

25. Assign the client to allow others to do favors for him/her and to receive without giving. Process progress and feelings related to this assignment.

12. Verbalize an increased sense of self-responsibility while decreasing sense of responsibility for others. (26, 27, 28)

26. Assist the client in identifying and implementing ways of increasing his/her level of independence and making own decisions in day-to-day life (or assign "Making Your Own Decisions" from the *Adult Psychotherapy Homework Planner* by Jongsma).

27. Assist the client in not accepting responsibility for others' actions or feelings; recommend the client read *Taking Responsibility: Self-Reliance and the Accountable Life* by Branden.

28. Facilitate conjoint session with the client's significant other with focus on exploring ways to

increase independence within the relationship.

13. Verbalize an increased awareness of boundaries and when they are violated. (29, 30, 31)

29. Assign the client to keep a daily journal regarding boundaries for taking responsibility for self and others and when he/she is aware of boundaries being broken by self or others.

30. Assign the client to read the book *Boundaries: Where You End and I Begin* by Katherine and process key ideas.

31. Ask the client to read the chapter on setting boundaries and limits in the book *A Gift to Myself* by Whitfield and complete the accompanying survey on personal boundaries; process the key ideas and results of the survey.

14. Increase the frequency of verbally clarifying boundaries with others. (32)

32. Reinforce the client for implementing boundaries and limits for self.

15. Increase the frequency of making decisions within a reasonable time and with self-assurance. (33, 34, 35, 36)

33. Confront the client's tendency toward decision avoidance and encourage his/her efforts to implement proactive decision making.

34. Teach the client problem-resolution skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating outcome, and readjusting plan as necessary).

35. Use modeling and role-playing with the client to apply the problem-solving approach to his/her avoidance of decision-making (or assign "Applying

	Problem-Solving to Interpersonal Conflict" from the *Adult Psychotherapy Homework Planner* by Jongsma); encourage implementation of action plan, reinforcing success and redirecting for failure.
	36. Give positive verbal reinforcement for each timely thought-out decision that the client makes.
16. Participate in marital and/or family therapy. (37)	37. Conduct or refer to marital and/or family therapy toward the goal of altering entrenched dysfunctional marital and/or family system patterns that support the client's dependency.
17. Attend an Al-Anon group. (38)	38. Refer the client to Al-Anon or another appropriate self-help group to reinforce efforts to break the dependency cycle with a chemically dependent partner.
18. Develop a plan to end the relationship with abusive partner, and implement the plan with therapist's guidance. (39, 40, 41)	39. Assign the client to read *The Verbally Abusive Relationship* by Evans; process key ideas and insights.
	40. Refer the client to a safe house that provides counseling services to abused women.
	41. Refer the client to a domestic violence program and monitor and encourage his/her continued involvement in the program.

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.4	Dysthymic Disorder
	995.81	Physical Abuse of Adult, Victim
	_____	_____
	_____	_____
Axis II:	301.82	Avoidant Personality Disorder
	301.83	Borderline Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.4	F34.1	Persistent Depressive Disorder
995.81	Z69.11	Encounter for Mental Health Services for Victim of Spouse or Partner Violence, Physical
301.82	F60.6	Avoidant Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.6	F60.7	Dependent Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

DISSOCIATION

BEHAVIORAL DEFINITIONS

1. The existence of two or more distinct personality states that recurrently take full control of one's behavior.
2. An episode of the sudden inability to remember important personal identification information that is more than just ordinary forgetfulness.
3. Persistent or recurrent experiences of depersonalization; feeling as if detached from or outside of one's mental processes or body during which reality testing remains intact.
4. Persistent or recurrent experiences of depersonalization; feeling as if one is automated or in a dream.
5. Depersonalization sufficiently severe and persistent as to cause marked distress in daily life.

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LONG-TERM GOALS

1. Integrate the various personalities.
2. Reduce the frequency and duration of dissociative episodes.
3. Resolve the emotional trauma that underlies the dissociative disturbance.
4. Reduce the level of daily distress caused by dissociative disturbances.
5. Regain full memory.

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SHORT-TERM OBJECTIVES

1. Identify each personality and have each one tell its story. (1, 2, 3)

2. Complete psychological testing designed to further understand the nature and extent of dissociative experiences and personality. (4)

3. Cooperate with a referral to a neurologist to rule out organic factors in amnestic episodes. (5)

THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.

2. Without undue encouragement or leading, probe and assess the existence of the various personalities that take control of the client.

3. Conduct a functional analysis of the variables associated with dissociative states and their resolution including thoughts, feelings, actions, interpersonal variables, consequences, and secondary gains.

4. Conduct or refer for psychological testing of dissociation (e.g., *The Dissociative Experiences Scale*) and/or abnormal and normal personality features and traits (e.g., MMPI-2).

5. Refer the client to a neurologist for evaluation of any organic cause for memory loss experiences.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Complete a psychotropic medication evaluation with a physician. (10)
6. Take prescribed psychotropic medications responsibly at times ordered by the physician. (11)
7. Participate in a therapy to address personal and interpersonal vulnerabilities to dissociation. (12)
8. Identify the key issues that trigger a dissociative state. (13, 14, 15)

10. Arrange for an evaluation of the client for a psychotropic medication prescription.
11. Monitor and evaluate the client's psychotropic medication prescription for compliance, effectiveness, and side effects.
12. In clients whose dissociation appears functionally related to a clinical syndrome (e.g., PTSD) or personality disorder (e.g., Borderline Personality Disorder), conduct or refer to evidence-based treatment of the disorder (e.g., cognitive processing therapy or dialectical behavior therapy, respectively).
13. Explore the feelings and traumatic circumstances that trigger the client's dissociative state (see the Childhood Trauma and Sexual Abuse Victim chapters in this *Planner*).
14. Explore the client's sources of emotional pain or trauma, and feelings of fear, inadequacy, rejection, or abuse (or assign "Describe the Trauma" from the *Adult Psychotherapy Homework Planner* by Jongsma).
15. Assist the client in accepting a connection between his/her dissociating and avoidance of facing emotional conflicts/issues and painful emotions (e.g., experiential avoidance).

9. Decrease the number and duration of personality changes. (16, 17)

16. Facilitate integration of the client's personality by supporting and encouraging him/her to stay focused on reality rather than escaping through dissociation (or assign "Staying Focused on the Present Reality" from the *Adult Psychotherapy Homework Planner* by Jongsma).

17. Emphasize to the client the importance of a here-and-now focus on reality rather than a preoccupation with the traumas of the past and dissociative phenomena associated with that fixation. Reinforce instances of here-and-now behavior.

10. Practice relaxation and deep breathing as means of reducing anxiety that serves as a trigger for dissociation. (18, 19, 20)

18. Teach the client calming techniques (e.g., progressive muscle relaxation, breathing-induced relaxation, calming imagery, cue-controlled relaxation, applied relaxation) as part of a tailored strategy for reducing chronic and acute physiological tension that triggers dissociation.

19. Role-play the use of relaxation and cognitive coping to visualized stress-provoking scenes, moving from low- to high-stress scenes. Assign the implementation of calming techniques in his/her daily life when facing these trigger situations; process the results, reinforcing success and problem-solving obstacles.

20. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation*

and Stress Reduction Workbook by Davis, Robbins-Eshelman, and McKay; *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow).

11. Identify, challenge, and replace self-talk that produces negative emotional reactions with self-talk that facilitates a better regulation of emotions. (21, 22, 23)

21. Explore the client's self-talk that mediates his/her strong negative/painful feelings and actions (e.g., "I can't face this"); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more realistic and regulated response. Combine new self-talk with calming skills as part of developing coping skills to manage negative emotions.

22. Role-play the use of relaxation and cognitive coping to visualized emotion-provoking scenes, moving from low- to high-challenge scenes. Assign the implementation of calming techniques in his/her daily life when facing trigger situations; process the results, reinforcing success and problem-solving obstacles.

23. Assign the client a homework exercise in which he/she identifies biased self-talk and generates alternatives that help moderate emotional reactions; review while reinforcing success, providing corrective feedback toward improvement.

12. Verbalize acceptance of brief episodes of dissociation as not being the basis for panic, but only as passing phenomena. (24, 25, 26, 27, 28)

24. Teach the client to be calm and matter-of-fact in the face of brief dissociative phenomena so as to not accelerate anxiety symptoms, but to stay focused on reality.

25. Use an ACT approach to help the client experience and accept the presence of painful/troubling thoughts and feelings without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).

26. Teach mindfulness meditation to help the client change his/her relationship with painful thoughts and/or feelings, building acceptance of them without undue reactivity (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).

27. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.

28. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (e.g., *Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems* by Follette and Pistorello).

13. Discuss the period preceding memory loss and the period after memory returns. (14, 29)

14. Explore the client's sources of emotional pain or trauma, and feelings of fear, inadequacy, rejection, or abuse (or assign "Describe the Trauma" from the *Adult Psychotherapy Homework Planner* by Jongsma).

29. Arrange and facilitate a session with the client and significant others to assist him/her in regaining lost personal information.

14. Utilize photos and other memorabilia to stimulate recall of personal history. (30, 31)

30. Calmly reassure the client to be patient in seeking to regain lost memories.

31. Review pictures and other memorabilia to gently trigger the client's memory recall.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.90	Alcohol Dependence
	300.14	Dissociative Identity Disorder
	300.12	Dissociative Amnesia
	300.6	Depersonalization Disorder
	300.15	Dissociative Disorder NOS
	_____	_____
	_____	_____
Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
300.14	F44.81	Dissociative Identity Disorder
300.6	F48.1	Depersonalization/Derealization Disorder
300.15	F44.9	Unspecified Dissociative Disorder
300.15	F44.89	Other Specified Dissociative Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EATING DISORDERS AND OBESITY

BEHAVIORAL DEFINITIONS

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (i.e., body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Persistent preoccupation with body image related to grossly inaccurate assessment of self as overweight.
4. Undue influence of body weight or shape on self-evaluation.
5. Strong denial of the seriousness of the current low body weight.
6. In postmenarcheal females, amenorrhea (i.e., the absence of at least three consecutive menstrual cycles).
7. Escalating fluid and electrolyte imbalance resulting from eating disorder.
8. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
9. Recurrent episodes of binge eating (a large amount of food is consumed in a relatively short period of time and there is a sense of lack of control over the eating behavior).
10. Eating much more rapidly than normal.
11. Eating until feeling uncomfortably full.
12. Eating large amounts of food when not feeling physically hungry.
13. Eating alone because of feeling embarrassed by how much one is eating.
14. Feeling disgusted with oneself, depressed, or very guilty after eating too much.
15. An excess of body weight, relative to height, that is attributed to an abnormally high proportion of body fat (Body Mass Index of 30 or more).

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LONG-TERM GOALS

1. Restore normal eating patterns, healthy weight maintenance, and a realistic appraisal of body size.
2. Stabilize medical condition with balanced fluid and electrolytes, resuming patterns of food intake that will sustain life and gain weight to a normal level.
3. Terminate the pattern of binge eating and purging behavior with a return to eating normal amounts of nutritious foods.
4. Terminate overeating and implement lifestyle changes that lead to weight loss and improved health.
5. Develop healthy cognitive patterns and beliefs about self that lead to positive identity and prevent a relapse of the eating disorder.
6. Develop healthy interpersonal relationships that lead to alleviation and help prevent the relapse of the eating disorder.
7. Develop coping strategies (e.g., feeling identification, problem-solving, assertiveness) to address emotional issues that could lead to relapse of the eating disorder.

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SHORT-TERM OBJECTIVES

1. Honestly describe the pattern of eating including types, amounts, and frequency of food consumed or hoarded. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the historical course of the disorder including the amount, type, and pattern of the client's food intake (e.g., too little food, too much food, binge eating, or hoarding food);

	perceived personal and interpersonal triggers and personal goals.
	3. Compare the client's calorie consumption with an average adult rate of 1,900 (for women) to 2,500 (for men) calories per day to determine over- or undereating.
	4. Measure the client's weight and assess for minimization and denial of the eating disorder behavior and related distorted thinking and self-perception of body image.
2. Describe any regular use of unhealthy weight control behaviors. (5)	5. Assess for the presence of recurrent inappropriate purging and nonpurging compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise; monitor on an ongoing basis.
3. Complete psychological tests designed to assess and track eating patterns and unhealthy weight-loss practices. (6)	6. Administer psychological instruments to the client designed to objectively assess eating disorders (e.g., the *Eating Inventory; Stirling Eating Disorder Scales*; or *Eating Disorders Inventory-3*); give the client feedback regarding the results of the assessment; readminister as indicated to assess treatment response.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)	7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees

with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with a complete medical evaluation. (11)	11. Refer the client to a physician for a medical evaluation to assess negative consequences of failure to maintain adequate body weight and overuse of compensatory behaviors; stay in close consultation with the physician as to the client's medical condition.
6. Cooperate with a nutritional evaluation. (12)	12. Refer the client to a nutritionist experienced in eating disorders for an assessment of nutritional rehabilitation; coordinate recommendations into the care plan.
7. Cooperate with a dental exam. (13)	13. Refer the client to a dentist for a dental exam to assess the possible damage to teeth from purging behaviors and/or poor nutrition.
8. Cooperate with a psychotropic medication evaluation by a physician and, if indicated, take medications as prescribed. (14, 15)	14. Assess the client's need for psychotropic medications (e.g., SSRIs); arrange for a physician to evaluate for and then prescribe psychotropic medications, if indicated.
	15. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects.
9. Cooperate with admission to inpatient treatment, if indicated. (16)	16. Refer the client for hospitalization, as necessary, if his/her weight loss becomes severe and physical health is jeopardized, or if he/she is a danger to self or others due to a severe psychiatric disorder (e.g., severely depressed and suicidal).
10. Verbalize an accurate understanding of how eating disorders develop. (17)	17. Teach the client a model of eating disorders development that includes concepts such as sociocultural pressures to be

thin, overvaluation of body shape and size in determining self-image, maladaptive eating habits (e.g., fasting, binging, overeating), maladaptive compensatory weight management behaviors (e.g., purging, exercise), and resultant feelings of low self-esteem (see *Overcoming Binge Eating* by Fairburn; *The Eating Disorders Sourcebook: A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders* by Costin).

11. Verbalize an understanding of the rationale for and goals of treatment. (18, 19)

18. Discuss a rationale for treatment consistent with the model being used including how cognitive, behavioral, interpersonal, lifestyle, and/or nutritional factors can promote poor self-image, uncontrolled eating, and unhealthy compensatory actions, and how changing them they can build physical and mental health-promoting eating practices.

19. Assign the client to read psychoeducational chapters of books or treatment manuals on the development and treatment of eating disorders or obesity that are consistent with the treatment model (e.g., *Overcoming Binge Eating* by Fairburn; *Overcoming Your Eating Disorders: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder-Workbook* by Apple and Agras; *The LEARN Program for Weight Management* by Brownell for weight loss).

12. Keep a journal of food consumption. (20)

13. Establish regular eating patterns by eating at regular intervals and consuming optimal daily calories. (21, 22, 23)

14. Attain and maintain balanced fluids and electrolytes, as well as resumption of reproductive functions. (24, 25)

15. Identify and develop a list of high-risk situations for unhealthy eating or weight loss practices. (26, 27)

20. Assign the client to self-monitor and record food intake (or assign "A Reality Journal: Food, Weight, Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material to reinforce and facilitate motivation to change.

21. Establish an appropriate daily caloric intake for the client and assist him/her in meal planning.

22. Establish healthy weight goals for the client per the Body Mass Index (BMI), the Metropolitan Height and Weight Tables, or some other recognized standard.

23. Monitor the client's weight (e.g., weekly) and give realistic feedback regarding body weight.

24. Monitor the client's fluid intake and electrolyte balance; give realistic feedback regarding progress toward the goal of balance.

25. Refer the client back to the physician at regular intervals if fluids and electrolytes need monitoring due to poor eating patterns.

26. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client's uncontrolled eating and/or compensatory weight management behaviors.

27. Direct and assist the client in construction of a hierarchy of

	high-risk internal and external triggers for uncontrolled eating and/or compensatory weight management behaviors.
16. Learn and implement skills for managing urges to engage in unhealthy eating or weight loss practices. (28)	28. Teach the client tailored skills to manage high-risk situations including distraction, positive self-talk, problem-solving, conflict resolution (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise), or other social/ communication skills; use modeling, role-playing, and behavior rehearsal to work through several current situations.
17. Participate in exercises to build skills in managing urges to use maladaptive weight control practices. (29)	29. Assign homework exercises that allow the client to practice and strengthen skills learned in therapy; select initial high-risk situations that have a high likelihood of being a successful coping experience for the client; prepare and rehearse a plan for managing the risk situation; review/process the real life implementation by the client, reinforcing success while providing corrective feedback toward improvement.
18. Identify, challenge, and replace self-talk and beliefs that promote the anorexia or bulimia. (30, 31, 32)	30. Conduct Phase One of Cognitive Behavioral Therapy (see *Cognitive Behavior Therapy and Eating Disorders* by Fairburn) to help the client understand the adverse effects of binging and purging; assigning self-monitoring of weight and eating patterns and establishing a regular pattern of eating (use "A Reality Journal: Food, Weight,

Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material.

31. Conduct Phase Two of Cognitive Behavioral Therapy (CBT) to shift the focus to eliminating dieting, reducing weight and body image concerns, teaching problem-solving, and doing cognitive restructuring to identify, challenge, and replace negative cognitive messages that mediate feelings and actions leading to maladaptive eating and weight control practices (or assign "How Fears Control My Eating" from the *Adult Psychotherapy Homework Planner* by Jongsma).

32. Conduct Phase Three of CBT to assist the client in developing a maintenance and relapse prevention plan including self-monitoring of eating and binge triggers, continued use of problem-solving and cognitive restructuring, and setting short-term goals to stay on track.

19. To begin to resolve bulimic behavior, identify important people in the past and present, and describe the quality, good and poor, of those relationships. (33)

33. Conduct Interpersonal Therapy (see "Interpersonal Psychotherapy for Bulimia Nervosa" by Fairburn) beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships, highlighting themes that may be supporting the eating disorder (e.g., interpersonal disputes, role transition conflict, unresolved grief, and/or interpersonal deficits).

20. Verbalize a resolution of current interpersonal problems and a resulting termination of bulimia. (34, 35, 36, 37)

34. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss.

35. For disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.

36. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role and taking steps to gain mastery over the new role.

37. For interpersonal deficits, help the client develop new interpersonal skills and relationships.

21. Parents and adolescent with anorexia agree to participate in all three phases of family-based treatment of anorexia. (38, 39, 40)

38. Conduct Phase One (sessions 1–10) of Family-Based Treatment (see *Treatment Manual for Anorexia Nervosa: A Family-Based Approach* by Lock et al.) by confirming with the family their intent to participate and strictly adhere to the treatment plan, taking a history of the eating disorder, clarifying that the parents will be in charge of weight restoration of the client, establishing healthy weight

goals, and asking the family to participate in the family meal in session; establish with the parents and a physician a minimum daily caloric intake for the client and focus them on meal planning; consult with a physician and/or nutritionist if fluids and electrolytes need monitoring due to poor nutritional habits.

39. Conduct Phase Two of Family-Based Treatment (FBT) (sessions 11–16) by continuing to closely monitor weight gain and physician/nutritionist reports regarding health status; gradually return control over eating decisions back to the adolescent as the acute starvation is resolved and portions consumed are nearing what is normally expected and weight gain in demonstrated.

40. Conduct Phase Three of FBT (sessions 17–20) by reviewing and reinforcing progress and weight gain; focus on adolescent development issues; teach and rehearse problem-solving and relapse prevention skills.

22. State a basis for positive identity that is not based on weight and appearance but on character, traits, relationships, and intrinsic value. (41)

41. Assist the client in identifying a basis for self-worth apart from body image by reviewing his/her talents, successes, positive traits, importance to others, and intrinsic spiritual value.

23. Follow through on implementing the five aspects of the LEARN program to achieve weight loss. (42, 43)

42. Assign the client to read the LEARN manual (see *The LEARN Program for Weight Management* by Brownell) and then review the five aspects of the program (i.e., Lifestyle,

Exercise, Attitudes, Relationships, and Nutrition), that will be emphasized over the next 12 weeks.

43. In weekly sessions, systematically work through the five aspects of the LEARN program manual (Lifestyle, Exercise, Attitudes, Relationships, and Nutrition), applying each component to the client's life to establish new behavioral patterns designed to achieve weight loss.

24. Verbalize an understanding of relapse prevention and the distinction between a lapse and a relapse. (44, 45)

44. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of distress, urges, or to avoid, and relapse with the decision to return to the cycle of maladaptive thoughts and actions (e.g., feeling anxious, binging, then purging).

45. Identify with the client future situations or circumstances in which lapses could occur.

25. Implement relapse prevention strategies for managing possible future anxiety symptoms. (46, 47, 48)

46. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previous external or internal cues that arise) to prevent relapse.

47. Develop a "maintenance plan" with the client that describes how the client plans to identify challenges, use knowledge and skills learned in therapy to manage them, and maintain positive changes gained in therapy.

48. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains and

adjust to life without the eating disorder.

26. Attend an eating disorder group. (49)

49. Refer the client to a support group for eating disorders.

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.1	Anorexia Nervosa
	307.51	Bulimia Nervosa
	307.50	Eating Disorder NOS
	xxx.xx	Binge Eating Disorder
	316	Psychological Symptoms Affecting Axis III Disorder (e.g., obesity)
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.1	F50.02	Anorexia Nervosa, Binge-Eating/Purging Type
307.1	F50.01	Anorexia Nervosa, Restricting Type
307.51	F50.2	Bulimia Nervosa
278.00	E66.9	Overweight or Obesity
307.50	F50.9	Unspecified Feeding or Eating Disorder
307.59	F50.8	Other Specified Feeding or Eating Disorder
301.6	F60.7	Dependent Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EBP indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

EATING DISORDERS AND OBESITY

BEHAVIORAL DEFINITIONS

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (i.e., body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Persistent preoccupation with body image related to grossly inaccurate assessment of self as overweight.
4. Undue influence of body weight or shape on self-evaluation.
5. Strong denial of the seriousness of the current low body weight.
6. In postmenarcheal females, amenorrhea (i.e., the absence of at least three consecutive menstrual cycles).
7. Escalating fluid and electrolyte imbalance resulting from eating disorder.
8. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
9. Recurrent episodes of binge eating (a large amount of food is consumed in a relatively short period of time and there is a sense of lack of control over the eating behavior).
10. Eating much more rapidly than normal.
11. Eating until feeling uncomfortably full.
12. Eating large amounts of food when not feeling physically hungry.
13. Eating alone because of feeling embarrassed by how much one is eating.
14. Feeling disgusted with oneself, depressed, or very guilty after eating too much.
15. An excess of body weight, relative to height, that is attributed to an abnormally high proportion of body fat (Body Mass Index of 30 or more).

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LONG-TERM GOALS

1. Restore normal eating patterns, healthy weight maintenance, and a realistic appraisal of body size.
2. Stabilize medical condition with balanced fluid and electrolytes, resuming patterns of food intake that will sustain life and gain weight to a normal level.
3. Terminate the pattern of binge eating and purging behavior with a return to eating normal amounts of nutritious foods.
4. Terminate overeating and implement lifestyle changes that lead to weight loss and improved health.
5. Develop healthy cognitive patterns and beliefs about self that lead to positive identity and prevent a relapse of the eating disorder.
6. Develop healthy interpersonal relationships that lead to alleviation and help prevent the relapse of the eating disorder.
7. Develop coping strategies (e.g., feeling identification, problem-solving, assertiveness) to address emotional issues that could lead to relapse of the eating disorder.

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SHORT-TERM OBJECTIVES

1. Honestly describe the pattern of eating including types, amounts, and frequency of food consumed or hoarded. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the historical course of the disorder including the amount, type, and pattern of the client's food intake (e.g., too little food, too much food, binge eating, or hoarding food);

	perceived personal and interpersonal triggers and personal goals.
	3. Compare the client's calorie consumption with an average adult rate of 1,900 (for women) to 2,500 (for men) calories per day to determine over- or undereating.
	4. Measure the client's weight and assess for minimization and denial of the eating disorder behavior and related distorted thinking and self-perception of body image.
2. Describe any regular use of unhealthy weight control behaviors. (5)	5. Assess for the presence of recurrent inappropriate purging and nonpurging compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise; monitor on an ongoing basis.
3. Complete psychological tests designed to assess and track eating patterns and unhealthy weight-loss practices. (6)	6. Administer psychological instruments to the client designed to objectively assess eating disorders (e.g., the *Eating Inventory; Stirling Eating Disorder Scales*; or *Eating Disorders Inventory-3*); give the client feedback regarding the results of the assessment; readminister as indicated to assess treatment response.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)	7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees

with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with a complete medical evaluation. (11)

11. Refer the client to a physician for a medical evaluation to assess negative consequences of failure to maintain adequate body weight and overuse of compensatory behaviors; stay in close consultation with the physician as to the client's medical condition.

6. Cooperate with a nutritional evaluation. (12)

12. Refer the client to a nutritionist experienced in eating disorders for an assessment of nutritional rehabilitation; coordinate recommendations into the care plan.

7. Cooperate with a dental exam. (13)

13. Refer the client to a dentist for a dental exam to assess the possible damage to teeth from purging behaviors and/or poor nutrition.

8. Cooperate with a psychotropic medication evaluation by a physician and, if indicated, take medications as prescribed. (14, 15)

14. Assess the client's need for psychotropic medications (e.g., SSRIs); arrange for a physician to evaluate for and then prescribe psychotropic medications, if indicated.

15. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects.

9. Cooperate with admission to inpatient treatment, if indicated. (16)

16. Refer the client for hospitalization, as necessary, if his/her weight loss becomes severe and physical health is jeopardized, or if he/she is a danger to self or others due to a severe psychiatric disorder (e.g., severely depressed and suicidal).

10. Verbalize an accurate understanding of how eating disorders develop. (17)

17. Teach the client a model of eating disorders development that includes concepts such as sociocultural pressures to be

thin, overvaluation of body shape and size in determining self-image, maladaptive eating habits (e.g., fasting, binging, overeating), maladaptive compensatory weight management behaviors (e.g., purging, exercise), and resultant feelings of low self-esteem (see *Overcoming Binge Eating* by Fairburn; *The Eating Disorders Sourcebook: A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders* by Costin).

11. Verbalize an understanding of the rationale for and goals of treatment. (18, 19)

18. Discuss a rationale for treatment consistent with the model being used including how cognitive, behavioral, interpersonal, lifestyle, and/or nutritional factors can promote poor self-image, uncontrolled eating, and unhealthy compensatory actions, and how changing them they can build physical and mental health-promoting eating practices.

19. Assign the client to read psychoeducational chapters of books or treatment manuals on the development and treatment of eating disorders or obesity that are consistent with the treatment model (e.g., *Overcoming Binge Eating* by Fairburn; *Overcoming Your Eating Disorders: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder-Workbook* by Apple and Agras; *The LEARN Program for Weight Management* by Brownell for weight loss).

12. Keep a journal of food consumption. (20)

13. Establish regular eating patterns by eating at regular intervals and consuming optimal daily calories. (21, 22, 23)

14. Attain and maintain balanced fluids and electrolytes, as well as resumption of reproductive functions. (24, 25)

15. Identify and develop a list of high-risk situations for unhealthy eating or weight loss practices. (26, 27)

20. Assign the client to self-monitor and record food intake (or assign "A Reality Journal: Food, Weight, Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material to reinforce and facilitate motivation to change.

21. Establish an appropriate daily caloric intake for the client and assist him/her in meal planning.

22. Establish healthy weight goals for the client per the Body Mass Index (BMI), the Metropolitan Height and Weight Tables, or some other recognized standard.

23. Monitor the client's weight (e.g., weekly) and give realistic feedback regarding body weight.

24. Monitor the client's fluid intake and electrolyte balance; give realistic feedback regarding progress toward the goal of balance.

25. Refer the client back to the physician at regular intervals if fluids and electrolytes need monitoring due to poor eating patterns.

26. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client's uncontrolled eating and/or compensatory weight management behaviors.

27. Direct and assist the client in construction of a hierarchy of

	high-risk internal and external triggers for uncontrolled eating and/or compensatory weight management behaviors.
16. Learn and implement skills for managing urges to engage in unhealthy eating or weight loss practices. (28)	28. Teach the client tailored skills to manage high-risk situations including distraction, positive self-talk, problem-solving, conflict resolution (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise), or other social/ communication skills; use modeling, role-playing, and behavior rehearsal to work through several current situations.
17. Participate in exercises to build skills in managing urges to use maladaptive weight control practices. (29)	29. Assign homework exercises that allow the client to practice and strengthen skills learned in therapy; select initial high-risk situations that have a high likelihood of being a successful coping experience for the client; prepare and rehearse a plan for managing the risk situation; review/process the real life implementation by the client, reinforcing success while providing corrective feedback toward improvement.
18. Identify, challenge, and replace self-talk and beliefs that promote the anorexia or bulimia. (30, 31, 32)	30. Conduct Phase One of Cognitive Behavioral Therapy (see *Cognitive Behavior Therapy and Eating Disorders* by Fairburn) to help the client understand the adverse effects of binging and purging; assigning self-monitoring of weight and eating patterns and establishing a regular pattern of eating (use "A Reality Journal: Food, Weight,

Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material.

31. Conduct Phase Two of Cognitive Behavioral Therapy (CBT) to shift the focus to eliminating dieting, reducing weight and body image concerns, teaching problem-solving, and doing cognitive restructuring to identify, challenge, and replace negative cognitive messages that mediate feelings and actions leading to maladaptive eating and weight control practices (or assign "How Fears Control My Eating" from the *Adult Psychotherapy Homework Planner* by Jongsma).

32. Conduct Phase Three of CBT to assist the client in developing a maintenance and relapse prevention plan including self-monitoring of eating and binge triggers, continued use of problem-solving and cognitive restructuring, and setting short-term goals to stay on track.

19. To begin to resolve bulimic behavior, identify important people in the past and present, and describe the quality, good and poor, of those relationships. (33)

33. Conduct Interpersonal Therapy (see "Interpersonal Psychotherapy for Bulimia Nervosa" by Fairburn) beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships, highlighting themes that may be supporting the eating disorder (e.g., interpersonal disputes, role transition conflict, unresolved grief, and/or interpersonal deficits).

20. Verbalize a resolution of current interpersonal problems and a resulting termination of bulimia. (34, 35, 36, 37)

34. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss.

35. For disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.

36. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role and taking steps to gain mastery over the new role.

37. For interpersonal deficits, help the client develop new interpersonal skills and relationships.

21. Parents and adolescent with anorexia agree to participate in all three phases of family-based treatment of anorexia. (38, 39, 40)

38. Conduct Phase One (sessions 1–10) of Family-Based Treatment (see *Treatment Manual for Anorexia Nervosa: A Family-Based Approach* by Lock et al.) by confirming with the family their intent to participate and strictly adhere to the treatment plan, taking a history of the eating disorder, clarifying that the parents will be in charge of weight restoration of the client, establishing healthy weight

goals, and asking the family to participate in the family meal in session; establish with the parents and a physician a minimum daily caloric intake for the client and focus them on meal planning; consult with a physician and/or nutritionist if fluids and electrolytes need monitoring due to poor nutritional habits.

39. Conduct Phase Two of Family-Based Treatment (FBT) (sessions 11–16) by continuing to closely monitor weight gain and physician/nutritionist reports regarding health status; gradually return control over eating decisions back to the adolescent as the acute starvation is resolved and portions consumed are nearing what is normally expected and weight gain in demonstrated.

40. Conduct Phase Three of FBT (sessions 17–20) by reviewing and reinforcing progress and weight gain; focus on adolescent development issues; teach and rehearse problem-solving and relapse prevention skills.

22. State a basis for positive identity that is not based on weight and appearance but on character, traits, relationships, and intrinsic value. (41)

41. Assist the client in identifying a basis for self-worth apart from body image by reviewing his/her talents, successes, positive traits, importance to others, and intrinsic spiritual value.

23. Follow through on implementing the five aspects of the LEARN program to achieve weight loss. (42, 43)

42. Assign the client to read the LEARN manual (see *The LEARN Program for Weight Management* by Brownell) and then review the five aspects of the program (i.e., Lifestyle,

Exercise, Attitudes, Relationships, and Nutrition), that will be emphasized over the next 12 weeks.

43. In weekly sessions, systematically work through the five aspects of the LEARN program manual (Lifestyle, Exercise, Attitudes, Relationships, and Nutrition), applying each component to the client's life to establish new behavioral patterns designed to achieve weight loss.

24. Verbalize an understanding of relapse prevention and the distinction between a lapse and a relapse. (44, 45)

44. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of distress, urges, or to avoid, and relapse with the decision to return to the cycle of maladaptive thoughts and actions (e.g., feeling anxious, binging, then purging).

45. Identify with the client future situations or circumstances in which lapses could occur.

25. Implement relapse prevention strategies for managing possible future anxiety symptoms. (46, 47, 48)

46. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previous external or internal cues that arise) to prevent relapse.

47. Develop a "maintenance plan" with the client that describes how the client plans to identify challenges, use knowledge and skills learned in therapy to manage them, and maintain positive changes gained in therapy.

48. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains and

adjust to life without the eating disorder.

26. Attend an eating disorder group. (49)

49. Refer the client to a support group for eating disorders.

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.1	Anorexia Nervosa
	307.51	Bulimia Nervosa
	307.50	Eating Disorder NOS
	xxx.xx	Binge Eating Disorder
	316	Psychological Symptoms Affecting Axis III Disorder (e.g., obesity)
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.1	F50.02	Anorexia Nervosa, Binge-Eating/Purging Type
307.1	F50.01	Anorexia Nervosa, Restricting Type
307.51	F50.2	Bulimia Nervosa
278.00	E66.9	Overweight or Obesity
307.50	F50.9	Unspecified Feeding or Eating Disorder
307.59	F50.8	Other Specified Feeding or Eating Disorder
301.6	F60.7	Dependent Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EB indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

IMPULSE CONTROL DISORDER

BEHAVIORAL DEFINITIONS

1. A tendency to act too quickly without careful deliberation, resulting in numerous negative consequences.
2. Loss of control over aggressive impulses resulting in assault, self-destructive behavior, or damage to property.
3. Deliberate and purposeful fire-setting on more than one occasion.
4. Persistent and recurrent maladaptive gambling behavior.
5. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.
6. Recurrent pulling out of one's hair resulting in noticeable hair loss.
7. Desire to be satisfied almost immediately and a decreased ability to delay pleasure or gratification.
8. A history of acting out in at least two areas that are potentially self-damaging (e.g., spending money, sexual activity, reckless driving, addictive behavior).
9. Overreactivity to mildly aversive or pleasure-oriented stimulation.
10. A sense of tension or affective arousal before engaging in the impulsive behavior (e.g., kleptomania, pyromania).
11. A sense of pleasure, gratification, or release at the time of committing the ego-dystonic, impulsive act.
12. Difficulty waiting for things—that is, restless standing in line, talking out over others in a group, and the like.

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LONG-TERM GOALS

1. Reduce the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out.
2. Reduce thoughts that trigger impulsive behavior and increase self-talk that controls behavior.
3. Learn to stop, listen, and think before acting.

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SHORT-TERM OBJECTIVES

1. Identify the impulsive behaviors that have been engaged in over the last six months. (1)
2. List the reasons or rewards that lead to continuation of an impulsive pattern. (2, 3)
3. Disclose any history of substance use that may contribute to and complicate the treatment of Impulse Control Disorder. (4)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM*

THERAPEUTIC INTERVENTIONS

1. Review the client's behavior pattern to assist him/her in clearly identifying, without minimization, denial, or projection of blame, his/her pattern of impulsivity.
2. Explore whether the client's impulsive behavior is triggered by anxiety and maintained by anxiety relief rewards; assess for bipolar manic disorder or ADHD.
3. Ask the client to make a list of the positive things he/she gets from impulsive actions and process it with the therapist.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the

diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. List the negative consequences that accrue to self and others as a result of impulsive behavior. (9, 10, 11)

6. Identify impulsive behavior's antecedents, mediators, and consequences. (12, 13)

7. Participate in imaginal exposure sessions to decrease the urge to act impulsively. (14, 15)

9. Assign the client to write a list of the negative consequences that have occurred because of impulsivity (or assign "Recognizing the Negative Consequences of Impulsive Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).

10. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others.

11. Confront the client's denial of responsibility for the impulsive behavior or the negative consequences (or assign "Accept Responsibility for Illegal Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).

12. Ask the client to keep a log of impulsive acts (time, place, feelings, thoughts, what was going on prior to the act, and what was the result); process log content to discover triggers and reinforcers (or assign "Impulsive Behavior Journal" from the *Adult Psychotherapy Homework Planner* by Jongsma).

13. Explore the client's past experiences to uncover his/her cognitive, emotional, and situational triggers to impulsive episodes.

14. Assist the client in composing a script describing a typical situation in which impulsive behavior occurs, the urge to act, physical symptoms, expected negative consequences, and, finally, resisting the urge.

8. Participate in an *in vivo* exposure treatment procedure. (16, 17, 18, 19)

15. Use the client's script in an imaginal exposure session in which the client is relaxed and the script is read repeatedly.
16. Direct and assist the client in construction of a hierarchy of feared internal and external impulsive behavior cues.
17. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client's impulsive actions.
18. Select initial exposures (imaginal or *in vivo*) to the internal and/or external impulsive behavior cues that have a high likelihood of being a successful experience for the client; include response prevention and do cognitive restructuring within and after the exposure (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa; or *Treatment of Obsessive-Compulsive Disorder* by McGinn and Sanderson).
19. Assign the client a homework exercise in which he/she repeats the exposure to the internal and/or external impulsive behavior cues using response prevention and restructured cognitions between sessions and records responses (or assign "Reducing the Strength of Compulsive Behaviors" in the *Adult Psychotherapy Homework Planner* by Jongsma); review during next session, reinforcing success and providing corrective feedback toward improvement (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa).

9. Verbalize a clear connection between impulsive behavior and negative consequences to self and others. (10, 20)

10. Before acting on behavioral decisions, frequently review them with a trusted friend or family member for feedback regarding possible consequences. (21, 22)

11. Utilize cognitive methods to control trigger thoughts and reduce impulsive reactions to those trigger thoughts. (13, 23, 24)

10. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others.

20. Reinforce the client's verbalized acceptance of responsibility for and connection between impulsive behavior and negative consequences.

21. Conduct a session with the client and his/her partner to develop a contract for receiving feedback prior to impulsive acts.

22. Brainstorm with the client who he/she could rely on for trusted feedback regarding action decisions; use role-play and modeling to teach how to ask for and accept this help.

13. Explore the client's past experiences to uncover his/her cognitive, emotional, and situational triggers to impulsive episodes.

23. Teach the client cognitive methods (thought-stopping, thought substitution, reframing, etc.) for gaining and improving control over impulsive urges and actions.

24. Use the cognitive restructuring process (i.e., teaching the connection between thoughts, feelings, and actions; identifying relevant automatic thoughts and their underlying beliefs or biases; challenging the biases; developing alternative positive perspectives; testing biased and alternative beliefs through behavioral experiments) to assist the client in replacing negative automatic

thoughts associated with education and his/her ability to learn.

12. Use relaxation exercises to control anxiety, urges, and reduce consequent impulsive behavior. (25, 26, 27)

25. Teach the client relaxation skills (e.g., progressive muscle relaxation, imagery, diaphragmatic breathing, verbal cues for deep relaxation), how to discriminate better between relaxation and tension, as well as how to apply these skills to coping with situations associated with impulsive urges (e.g., see *Progressive Relaxation Training* by Bernstein and Borkovec).

26. Assign the client homework each session in which he or she practices relaxation exercises daily for at least 15 minutes and applies the technique to impulsive trigger situations; review the exercises, reinforcing success while providing corrective feedback toward improvement.

27. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *Mastery of Your Anxiety and Worry—Workbook* by Craske and Barlow).

13. Utilize behavioral strategies to manage urges for impulsive action. (28, 29, 30)

28. Teach the use of positive behavioral alternatives to cope with impulsive urges (e.g., talking to someone about the urge, taking a time out to delay any reaction, calling a friend or family member, engaging in physical exercise, leaving credit cards with a family member, creating needed item shopping lists to avoid impulsive buying, avoiding use of police and fire scanners, etc.).

29. Review the client's implementation of behavioral coping strategies to reduce urges and tension; reinforce success and redirect for failure.

30. Teach the client covert sensitization in which he/she imagines a negative consequence (e.g., going to jail) whenever the desire to act impulsively appears (e.g., the desire to steal); assign as homework; review, reinforcing success and problem-solving obstacles until internalized by the client.

14. List instances where "stop, listen, think, and act" has been implemented, citing the positive consequences. (31, 32)

31. Using modeling, role-playing, and behavior rehearsal, teach the client how to use "stop, listen, and think" before acting in several current situations.

32. Review and process the client's use of "stop, listen, think, and act" in day-to-day living and identify the positive consequences.

15. Describe any history of manic or hypomanic behavior related to a mood disorder. (33)

33. Assess the client for a mood disorder that includes manic episodes with a lack of judgment over impulsive behavior and its consequences (see the Bipolar Disorder—Mania chapter in this *Planner*).

16. Identify situations in which there has been a loss of control over aggressive impulses resulting in destructive or assaultive behavior. (34)

34. Explore the client's history of explosive anger management problems; include this as presenting problem if there have been several such episodes of aggressiveness grossly out of proportion to any precipitating psychosocial stressor (see the Anger Control Problems chapter in this *Planner*).

17. Comply with the recommendations from a physician evaluation regarding the

35. Refer the client to a physician for an evaluation for a psychotropic medication prescription.

necessity for psychopharmacological intervention. (35, 36)

36. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness; consult with the prescribing physician at regular intervals.

18. Implement a reward system for replacing impulsive actions with reflection on consequences and choosing wise alternatives. (37, 38)

37. Assist the client in identifying rewards that would be effective in reinforcing himself/herself for suppressing impulsive behavior.

38. Assist the client and significant others in developing and putting into effect a reward system for deterring the client's impulsive actions.

19. Learn and implement problem-solving skills to reduce impulsive behavior. (39, 40)

39. Teach the client problem-resolution skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating outcome, and readjusting plan as necessary).

40. Use modeling and role-playing with the client to apply the problem-solving approach to his/her urge for impulsive action (or assign "Problem-Solving: An Alternative to Impulsive Action" from the *Adult Psychotherapy Homework Planner* by Jongsma); encourage implementation of action plan, reinforcing success and redirecting for failure.

20. Read recommended material on overcoming impulsive behavior. (41)

41. Recommend the client read material on coping with impulsive urges (e.g., *Stop Me Because I Can't Stop Myself: Taking Control of Impulsive Behavior* by Grant and Fricchione; *Overcoming Impulse*

Control Problems: A Cognitive-Behavioral Therapy Program—Workbook by Grant, Donahue, and Odlaug).

21. Attend a self-help recovery group. (42)

42. Refer the client to a self-help recovery group (e.g., 12-step program, ADHD group, Rational Recovery, etc.) designed to help terminate self-destructive impulsivity; process his/her experience in the group.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.34	Intermittent Explosive Disorder
	312.32	Kleptomania
	312.31	Pathological Gambling
	312.39	Trichotillomania
	312.30	Impulse Control Disorder NOS
	312.33	Pyromania
	310.1	Personality Change Due to Axis III Disorder
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.34	F63.81	Intermittent Explosive Disorder
312.32	F63.81	Kleptomania
312.31	F63.0	Gambling Disorder
312.39	F63.2	Trichotillomania
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
312.33	F63.1	Pyromania
310.1	F07.0	Personality Change Due to Another Medical Condition
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.