Reasoning with Unreasonable People:
Focus on Disorders of Emotional Regulation

Presented by

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Disclosure

Neither Dr. Joseph W. Shannon, the presenting speaker, nor the activity planners of this program are aware of any actual, potential or perceived conflict of interest

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COURSE OBJECTIVES

Participants completing this program should be able to:

1. List several paths to achieving effective emotional communication.

2. Outline an effective strategy to reason with a person who has a disorder of mood, anxiety, OCD, anger, or personality.

3. Describe a strategy for reasoning or having a difficult conversation with a person who is experiencing pain, illness or vulnerability.

4. Describe a calming strategy including the practice of mindfulness for health professionals who are experiencing strong emotions.

Policies and Procedures

1. Questions are encouraged. However, please try to ask questions related to the topic being discussed. You may ask your question by clicking on "chat." Your questions will be communicated to the presenter during the breaks. Dr. Shannon will be providing registrants with information as to how to reach him by email for questions after the day of the live broadcast.

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All licensed health professionals are required to complete both sides. Please transmit by January 24th, 2015.

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Reasoning with Unreasonable People: Focus on Disorders of Emotional Regulation

Difficult conversations are inevitable in the helping professions. Telling a patient something they don't want to hear; confronting a colleague who's letting you or a patient down; saying "no" to a patient or family member's request; handling a complaint; giving an unwelcome instruction or suggestion to a patient, colleague or supervisee; and saying "no" to a supervisor's unreasonable expectation are but a few of the challenging situations that may confront the healthcare professional on a regular basis. Complicating any of these situations further is our own formidable resistance to engaging the other person. We want to protect ourselves from attack, or at least from embarrassment; we may not have a great track record for handling interpersonal conflict; we procrastinate because of anxiety, fear, fatigue and a host of other reasons; and we worry about making the situation worse if the conversation were to go terribly wrong, e.g., retaliation from the other person.

In this six-hour program, healthcare professionals will learn several strategies for communicating with difficult, challenging patients. Research indicates that the most challenging of people are those who have problems with irrational thinking, emotional dysregulation and/or impulse control. These disorders include: major mood disorders, obsessive-compulsive disorder (OCD), pathological anger, anxiety-based disorders and personality disorders.

As a result of completing this program, participants will be able to:

1. Discuss the symptoms and problematic beliefs associated with major depression, bipolar spectrum illness, anxiety-based disorders, OCD, anger mismanagement and selected personality disorders.
2. List effective pathways to reasoning with the highly emotional or otherwise unreasonable patient.
3. Describe and practice six key strategies for handling especially difficult conversations with these patients and their families.
4. Practice specific calming strategies applicable to both patient and caregiver who may be experiencing strong emotions.
5. Apply the above strategies to personal relationships as well.

AGENDA

7:30 AM - 9:00 AM	Registration, check-in
9:00 AM - 10:30 AM	Mental Illness and Core Schema
10:30 AM - 10:45 AM	Break
10:45 AM - 11:30 AM	Disorders of Emotional Regulation
11:30 AM - 12:30 PM	Lunch
12:30 PM - 2:30 PM	Disorders of Emotional Regulation (continued) Pathways to Effective Reasoning
2:30 PM - 2:45 PM	Break
2:45 PM - 4:00 PM	Model For Handling Difficult Conversations Strategies for Helping Patients with Strong Emotions Closure

I. Introduction: The Beliefs Which Can Impair Anyone

A. These core beliefs are called "schema." A schema is an extremely stable and enduring pattern of thinking that is learned in childhood or adolescence. We view ourselves, others and the world around us through our schema.

B. Research has revealed 16 specific types of problematic schema:

1. Dependence/Incompetence

"I'm not able to handle day-to-day responsibilities independently or competently."

"I must rely on others to take care of me because I am so inadequate/incompetent."

2. Subjugation

"I must defer to the advice, opinion and control of others to avoid negative consequences."

"I must ignore my own observations, desires and feelings and focus exclusively on those of others."

3. Self-sacrifice

"I must always focus on the needs of others; to do otherwise will make me feel guilty."

"Putting others first makes me feel useful/valid."

4. Vulnerability to Harm or Illness

"I am always vulnerable to a major catastrophe (financial, medical, emotional, etc.)."

"I must always take extraordinary precautions to protect myself."

B. 16 types of schema (cont)

5. Fear of Losing Control

"If I'm not careful, I will lose control over my own behavior, impulses, feelings, mind, body, self."

"To show strong emotion is losing control."

6. Emotional Deprivation

"I will never meet anyone who truly cares about me."

"My needs, feelings, expectations will never be fulfilled in a relationship; I am destined to be alone."

7. Abandonment/Loss

"All of my relationships are doomed to failure."

"Anyone who cares about me will ultimately abandon me."

"To be alone is to be abandoned."

8. Defectiveness/Unloveability

"I am a terribly damaged, flawed person."

"When others get close to me, they will see my flaws and ultimately reject me."

9. Mistrust/Abuse

"Others will intentionally betray or otherwise take advantage of me."

"Don't let others get close. They will see my vulnerabilities and use this to hurt me."

"Be wary of anyone who has power; they will use it to harm me in some way."

B. 16 types of schema (cont)

10. Social Isolation/Alienation

"I am so different from others that they could never accept me."

"I am so clearly superior to others that they could never meet my expectations."

11. Social Undesirability

"I am so physically unattractive, inept, stupid and unpopular that no one would ever want to be with me."

12. Shame/Embarrassment

"I possess certain characteristics that are both unacceptable and easily detected by others. I will always be seen as "less than" because of these characteristics."

"There is something fundamentally wrong with me or my family. I must always try to keep this hidden from others."

13. Perfectionism

"Whatever I do isn't good enough."

"Status, wealth, power trump all other values."

"Failure is unacceptable."

14. Failure to Achieve

"I am incapable of performing as well as my peers in any arena."

"What's the point of trying? I will always fail."

15. Self-Punishment

"I deserve to be treated harshly because I am such a disappointment to others."

B. 16 types of schema (cont)

16. Insufficient Limits/Entitlement

"I should be able to do or say whatever I want."

"I am more special than you. Therefore, I deserve special treatment always."

"I shouldn't have to play by the rules because I am so special/superior."

C. What makes schema so compelling?

1. We learn them as a result of interacting with major players in our life, most especially parents and significant peers.

2. Real life experiences can reinforce any belief making it more resilient.

3. We can distort reality such that it conforms with core schema, e.g.; negative interpretations and predictions of life events.

4. We can highlight or exaggerate information that conforms to the core schema, e.g., "Everyone in my class hated me."

5. We will engage in behaviors that confirm a deeply-held albeit distorted belief, e.g., "No one likes me." can lead to social isolation and withdrawal.

6. We will avoid situations that trigger painful schema, e.g., not accepting a promotion at work due to a core belief regarding "failure".

D. Rigidly-held beliefs (schema) cause problematic behaviors and negative emotions.

e.g., If you believe that you are always entitled to special treatment, you will behave in an aggressive, self-centered fashion. This will likely alienate, annoy or intimidate others. This increases the likelihood that others will not be all-that-interested in meeting your needs/expectations. Their "failure" to meet your needs will likely trigger anger and frustration in you.

E. Mentally-ill people typically hold an inordinately-high number of irrational or otherwise problematic schema. These problematic schema lead to especially pathological behavior which presents special challenges to the health care professional.

II. Overview of Disorders of Emotional Regulation

A. Depressive disorders

1. Disruptive mood dysregulation disorder
2. Major depressive disorder
3. Persistent depressive disorder (i.e., Dysthymia)
4. Premenstrual dysphoric disorder (PMDD)

B. Bipolar disorders

1. Cyclothymia
2. Bipolar II disorder
3. Bipolar I disorder

C. Anxiety disorders

1. Generalized anxiety disorder (GAD)
2. Agoraphobia
3. Panic disorder
4. Social anxiety disorder (social phobia)
5. Post-Traumatic Stress Disorder (P.T.S.D.)

D. Obsessive compulsive disorders

1. Body dysmorphic disorder
2. Excoriation disorder (skin-picking)
3. Hoarding disorder
4. Trichotillomania (hair-pulling disorder)
5. Perfectionism

E. Anger-management disorders

1. Aggressive behavior
2. Passive-Aggressive behavior

II. Overview of Disorders of Emotional Regulation (cont)

F. Selected Personality disorders

1. Anti-social (sociopathic)
2. Borderline
3. Histrionic
4. Narcissistic
5. Compulsive/Perfectionistic

III. Pathways to Effective Reasoning

A. Assuring that the person feels heard.

1. Active Empathic Listening
2. Emotional healing begins when the patient's feelings, observations and concerns are validated by the healthcare provider.

B. Focus on feelings.

1. What are the patient's emotional triggers/suppressors?
2. What feelings get triggered, e.g., anger?
3. What does the patient currently do to calm/soothe themself once triggered?

C. Focus on beliefs/schema.

1. What core beliefs are being triggered?

→ "I'm not good enough."
→ "I'm being abandoned."
→ "I'm entitled."

2. What makes these beliefs so compelling?

→ Reinforced by parents/peers?
→ Maintain patient's identity?

III. Pathways to Effective Reasoning (cont)

3. What can be done to challenge/change these beliefs?

→ Cognitive-behavioral psychotherapy?
→ Thought-stopping?
→ "Where's the evidence/data to support this belief?
→ "Is there evidence to support an alternative way of thinking about this situation?
→ "Can I change my narrative?"

D. Identify the patient's <u>core strengths</u>:

1. Resilience
2. Intrapersonal skills, e.g., self-soothing, distracting techniques
3. Interpersonal skills, e.g., easily connects with others in a group such as AA or NA group
4. <u>Emotion regulation skills</u>:

→ deep breathing; use of imagery
→ counting slowly from 1 to 10
→ the ice-cube strategy
→ waiting 24 hours before expressing anger

E. <u>Core emotional concerns</u>:

1. To feel understood
2. To feel appreciated
3. To be given the benefit of the doubt
4. To be treated as an equal
5. To be treated respectfully
6. To have the freedom to decide

F. <u>Beyond reason</u>:

1. Rage
2. Acute mania
3. Delirium
4. Substance-induced states

III. Pathways to Effective Reasoning (cont)

5. Psychosis
6. Dementia/Organic Brain Syndrome

IV. Model for Handling Especially-Difficult Conversations (Back, 2002, 2005, 2005)

A. State your positive intent.

1. Explain your purpose, highlighting the benefit to the other person.
2. Helpful for intent to convey empathy or to affirm other person in some way.

B. Tell the truth fast.

1. Get to the point quickly.
2. Be factual and specific.
3. Explain impact; i.e., negative consequences.

C. Listen and understand.

1. Invite reactions and inquire.
2. Listen intently; acknowledge the other person's feelings.
3. Check your understanding.

D. Find common ground.

→ Summarize your shared interest or goal. e.g., "We both want…"

E. Identify options and your action plan.

1. Identify possible courses of action and the pros and cons of each.
2. Agree on your approach – a plan of action for both of you.

F. Express appreciation.

1. Convey positive regard, i.e., thanks, admiration or appreciation. e.g., "This wasn't easy, and I appreciate your openness…"
2. "How are you feeling about our conversation…?"

IV. Model for Handling Especially-Difficult Conversations (cont)

G. Trouble-shooting:

1. Beforehand, adopt a positive mindset, or at least a neutral one. Do not come across as frustrated, angry or blaming. Be respectful and open.
2. If the person resists:

   a. Empathize with resistance.
   b. Repeat steps "A" through "F" in the face of continuing resistance.

3. If you're on the receiving end, open your mind.

V. Strategies for Helping Patients with Strong Emotions

A. Validate the feelings
e.g., "I can see that you're very upset…"

B. Cognitive restructuring
e.g., "I'm wondering if it would be helpful to look at the situation in a very different way…"

C. Exposure-Based treatments
e.g., Progressive Muscle Relaxation/Guided Imagery

D. Breathing techniques
e.g., training in deep, diaphragmatic breathing

E. Dialectical Behavioral Therapy (DBT)
e.g., Distracting techniques
e.g., Self-soothing techniques

F. Therapeutic Journaling
e.g., "changing the narrative"

G. Nutritional therapy
e.g., eliminating stimulants and sugar from diet

V. Strategies for Helping Patients with Strong Emotions (cont)

H. Pharmacotherapy
e.g., use of S.S.R.I.'s and anti-convulsants.

I. Individual psychotherapy/coaching

J. Group therapy and self-help groups
e.g., "consensual validation"

K. Aerobic exercise

L. Develop/nurture strong spiritual base

M. Humor
e.g., "Don't sweat the small stuff…"

VI. Questions, closure

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APPENDIX A

IDENTIFYING YOUR PROBLEMATIC SCHEMA

APPENDIX A: SCHEMA QUESTIONNAIRE*

Name _____ Date_____

Instructions: Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. When there is a conflict, base your answer on what you emotionally feel, not on what you rationally believe to be true.

If you desire, reword the statement so that the statement would be even more true of you. Then choose the highest rating from 1 to 6 that describes you during your life (including your revisions), and write the number in the space before the statement.

Rating Scale:

1 Does not fit me at all during my life.
2 True of me for a period during my life, but not for a major part.
3 True of me right now, but has not generally been true during my life.
4 Somewhat true of me for a major part of my life.
5 Mostly true of me for a major part of my life.
6 Describes me perfectly for most of my life.

Example:

I care about

__4__ I worry that people ∧ will not like me.

_____ 1. I do not feel capable of taking care of myself.

_____ 2. I need other people to take care of me.

_____ 3. I do not feel I can cope well with many of life's demands.

_____ 4. I believe that other people can take care of me better than I can take care of myself.

_____ 5. I have trouble tackling new tasks unless I have someone to guide me.

_____ 6. I think of myself as a passive, dependent person.

* Adapted from Jeffrey Young (1990)

_____ 7. I let other people have their way much of the time.

_____ 8. I think that if I do what I want, something bad will happen to me.

_____ 9. I feel I have no choice but to give in to other peoples' wishes.

_____ 10. I typically put others' needs before my own.

_____ 11. In relationships, I let the other person have primary control.

_____ 12. I find it difficult to be myself with other people.

_____ 13. I really don't know what I want out of life.

_____ 14. I can't express my anger because others will disapprove or leave me.

_____ 15. I feel the major decisions in my life were not really my own.

_____ 16. I feel guilty because I typically let people down or disappoint them.

_____ 17. I generally give more to other people than I get back in return.

_____ 18. I am a "people pleaser."

_____ 19. A lot of anger and resentment builds up inside of me that I don't express for fear of offending or alienating others.

_____ 20. I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.

_____ 21. I can't seem to escape the feeling that something bad is about to happen.

_____ 22. I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.

_____ 23. I see the world as a scary, dangerous place.

_____ 24. I worry about being attacked.

_____ 25. I am inordinately careful about money or else I might end up with nothing.

_____ 26. I take extraordinary precautions to avoid getting sick or hurt.

_____ 27. I worry that I'll lose all my money and become destitute.

_____ 28. I worry that I am seriously ill, even though nothing serious has been diagnosed by a physician.

_____ 29. I am an anxious, fearful person.

_____ 30. I prefer to take the secure or familiar way of doing things rather than risk the unexpected.

_____ 31. I obsess about the bad things happening in the world: crime, pollution, and so on.

_____ 32. I worry about losing control over my actions.

_____ 33. I often feel that I might go crazy.

_____ 34. I often feel that I'm going to have an anxiety attack.

_____ 35. I worry that I might start blushing or sweating in front of other people.

_____ 36. I often feel on the verge of crying uncontrollably.

_____ 37. I worry that I might not be able to resist my sexual urges.

_____ 38. I worry that I might seriously harm someone physically or emotionally if my anger gets out of control.

_____ 39. I feel that I must control my emotions and impulses or something bad is likely to happen.

_____ 40. No one is there to meet my needs.

_____ 41. I don't get enough love and attention.

_____ 42. I have no one to depend on for advice and emotional support.

_____ 43. I don't have anyone to nurture me, share themselves with me, or care deeply about everything that happens to me.

_____ 44. I don't have anyone who wants to get close to me and spend a lot of time with me.

_____ 45. I could disappear from the face of the earth and not really be missed.

_____ 46. My relationships are basically superficial.

_____ 47. I don't feel as if I am a special person to anyone.

_____ 48. No one really listens to me, understands me, or is tuned into my true needs and feelings.

_____ 49. I'm destined to be alone forever.

_____ 50. I worry that someone I love will die soon, even though there is little medical reason to support my concern.

_____ 51. I find myself clinging to people I'm close to.

_____ 52. I worry that people I feel close to will leave me or abandon me.

_____ 53. I feel that I lack a stable base of emotional support.

_____ 54. I don't feel that important relationships will last; I expect them to end.

_____ 55. I feel that many people are out to hurt me and take advantage of me.

_____ 56. I must protect myself from other people's attacks and put downs.

_____ 57. The best way for me to avoid being hurt is to attack first.

_____ 58. I feel that I must get revenge for the way people have treated me.

_____ 59. I feel that I cannot let my guard down in the presence of other people.

_____ 60. If someone acts nicely toward me, I assume that they must have a hidden agenda.

_____ 61. It is only a matter of time before someone betrays me.

_____ 62. Most people only think about themselves.

_____ 63. I have a great deal of difficulty trusting people.

_____ 64. I am quite suspicious of other people's motives.

_____ 65. I don't fit in.

_____ 66. I'm fundamentally different from other people.

_____ 67. I don't belong; I'm a loner.

_____ 68. I feel alienated from other people.

_____ 69. I feel isolated and alone.

_____ 70. No man/woman I desire could love me once he/she saw my defects.

_____ 71. No one I desire would want to stay close to me if he/she knew the real me.

_____ 72. I am inherently flawed and defective.

_____ 73. No matter how hard I try, I can't get a significant man/woman to respect me or feel that I am worthwhile.

_____ 74. I'm unworthy of the love, attention, and respect of others.

_____ 75. I'm not sexually attractive.

_____ 76. I'm too fat.

_____ 77. I'm ugly.

_____ 78. I can't carry on a decent conversation.

_____ 79. I'm dull and boring in social situations.

_____ 80. People I value wouldn't associate with me because of my social status (e.g., income, educational level, career).

_____ 81. I never know what to say socially.

_____ 82. People don't want to include me in their groups.

_____ 83. Almost nothing I do is as good as other people can do.

_____ 84. I'm incompetent.

_____ 85. Most other people are more capable than I am.

_____ 86. I screw up everything I try.

_____ 87. I'm inept.

_____ 88. I'm a failure.

_____ 89. If I trust my own judgment, I'll make the wrong decision.

_____ 90. I lack common sense.

_____ 91. My judgment cannot be relied upon.

_____ 92. I'm essentially a bad person.

_____ 93. I deserve to be punished.

_____ 94. I don't deserve pleasure or happiness.

_____ 95. When I make a mistake, I deserve strong criticism and punishment.

_____ 96. I can't let myself off the hook easily or make excuses for my mistakes.

_____ 97. I feel very guilty over mistakes I have made.

_____ 98. I can't seem to live up to my religious or moral principles in certain ways, no matter how hard I try.

_____ 99. I often feel guilty without knowing why.

_____ 100. I am humiliated by my failures and inadequacies.

_____ 101. I am too inferior or unacceptable to reveal my failings to other people.

_____ 102. If others found out about my defects, I could not face them.

_____ 103. I often feel embarrassed around other people because I don't measure up to them.

_____ 104. I am very self-conscious around other people.

_____ 105. I must be the best at what I do; I can't accept second best.

_____ 106. I strive to keep almost everything in perfect order.

_____ 107. I must look my best most of the time.

_____ 108. I try to do my best; I can't settle for "good enough."

_____ 109. I have so much to accomplish that there is almost no time to really relax.

_____ 110. Almost nothing I do is quite good enough; I can always do better.

_____ 111. I must meet all my responsibilities.

_____ 112. I feel there is constant pressure for me to achieve and get things done.

_____ 113. My relationships suffer because I push myself so hard.

_____ 114. My health is suffering because I put myself under so much pressure to do well.

_____ 115. I often sacrifice pleasure and happiness to meet my own standards.

_____ 116. I have a lot of trouble accepting “no” for an answer when I want something from other people.

_____ 117. I often get angry or irritable if I can’t get what I want.

_____ 118. I’m special and shouldn’t have to accept many of the restrictions placed on other people.

_____ 119. I hate to be constrained or kept from doing what I want.

_____ 120. I have great difficulty accepting aspects of my life that aren’t the way I want them to be, even though objectively my life is good.

_____ 121. I have great difficulty getting myself to stop drinking, smoking, overeating, or other problem behaviors.

_____ 122. I can’t seem to discipline myself to complete routine or boring tasks.

_____ 123. Often I allow myself to carry through on impulses and express emotions that get me into trouble or hurt other people.

APPENDIX B

PSYCHIATRIC DISORDERS INVOLVING EMOTIONAL DYSREGULATION

Disruptive Mood Dysregulation Disorder

I. Diagnostic Criteria **296.99 (F34.8)**

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.

B. The temper outbursts are inconsistent with developmental level.

C. The temper outbursts occur, on average, three or more times per week.

D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).

E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A-D.

F. Criteria A and D are present in a least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.

G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.

H. By history or observation, the age at onset of Criteria A-E is before 10 years.

I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.
Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).
Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

II. Other Data:

A. Associated symptoms:

1. Chronic irritability, agitation between outbursts of temper
2. May be a pre-cursor to pediatric onset bipolar disorder

B. Prevalence:

1. 2 to 5% of pediatric population
2. Typically diagnosed in male children
3. Strong co-morbity with Oppositional Defiant Disorder

III. Treatment:

A. Individual behavioral therapy
B. Family systems therapy
C. Pharmacotherapy targeted to specific symptoms, e.g., anti-depressant medication to address agitation/anxiety

Major Depressive Disorder

I. Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful).
Note: In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
Note: In children, consider failure to make expected weight gain.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.
Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

II. Other data:

A. Associated symptoms:

1. Suicidal ideation/behavior
2. Obsessive rumination, e.g., worrying about physical health
3. Psychosomatic illness, complaints
4. Substance abuse/dependency
5. Anxiety-based disorders, e.g., G.A.D.

B. Coding and Recording Procedures

The diagnostic code for major depressive disorder is based on whether this is a single or recurrent episode, current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a major depressive episode. Codes are as follows:

Severity/course specifier	Single episode	Recurrent episode
Mild (p. 188)	296.21 (F32.0)	296.31 (F33.0)
Moderate (p. 188)	296.22 (F32.1)	296.32 (F33.1)
Severe (p. 188)	296.23 (F32.2)	296.33 (F33.2)
With psychotic features (p. 186)	296.24 (F32.3)	296.34 (F33.3)

In partial remission (p. 188)	296.25 (F32.4)	296.35 (F33.41)
In full remission (p. 188)	296.26 (F32.5)	296.36 (F33.42)
Unspecified	296.20 (F32.9)	296.30 (F33.9)

C. Prevalence:

1. 7 to 10% across cultures
2. Females outnumber males 2:1

III. Treatment

A. Cognitive-behavioral psychotherapy
B. Nutritional counseling, e.g., eliminating white sugar and white flour form diet
C. Pharmacotherapy, e.g., use of anti-depressants
D. E.C.T., especially when severe vegetative symptoms persist in spite of more traditional treatment approaches

Persistent Depressive Disorder (Dysthymia)

I. Diagnostic Criteria **300.4 (F34.1)**

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.
Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating.
2. Insomnia or hypersomnia.
3. Low energy or fatigue.
4. Low self-esteem.
5. Poor concentration or difficulty making decisions.
6. Feelings of hopelessness.

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

II. Other data:

A. Associated symptoms:

1. Anxiety disorders, especially G.A.D.
2. Substance abuse disorders, especially alcohol abuse

B. Prevalence:

1. .5 to 1.5% of general population.
2. No gender differences in diagnosis

III. Treatment:

A. Supportive psychotherapy
B. Cognitive-behavioral psychotherapy
C. Short-term use of anti-depressant medication to address vegetative symptoms, e.g., problems with appetite or sleep.

Premenstrual Dysphoric Disorder

I. Diagnostic Criteria **625.4 (N94.3)**

A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before onset of menses, start to *improve* within a few days after the onset of menses, and become, *minimal* or absent in the week postmenses.

B. One (or more) of the following symptoms must be present:

1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
2. Marked irritability or anger or increased interpersonal conflicts.
3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.

C. One (or more) of the following symptoms must additionally be present, to reach a total of *five* symptoms when combined with symptoms from Criterion B above.

1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
2. Subjective difficulty in concentration.
3. Lethargy, easy fatigability, or marked lack of energy.
4. Marked change in appetite; overeating; or specific food cravings.
5. Hypersomnia or insomnia.
6. A sense of being overwhelmed or out of control.
7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," or weight gain.

Note: The symptoms in Criteria A-C must have been met for most menstrual cycles that occurred in the preceding year.

D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).

E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).

F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles.
Note: The diagnosis may be made provisionally prior to this confirmation.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).

II. Other data:

A. Associated symptoms:

1. Delusions (esp. paranoid) and hallucinations in the late luteal phase of the menstrual cycle
2. High-risk for suicidal ideation during pre-menstrual phase of cycle

B. Prevalence:

1. 2 to 6% of female population
2. Symptoms typically worsen as patient approaches menopause.

III. Treatment

A. Individual counseling (psycho-educational)
B. Pharmacotherapy, e.g., use of anti-depressant Zoloft to lessen symptoms

Cyclothymic Disorder

I. Diagnostic Criteria **301.13 (F34.0)**

A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.

B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.

C. Criteria for a major depressive, manic, or hypomanic episode have never been met.

D. The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

E. The systems are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

II. Other data:

A. Associated symptoms:

1. Essential feature is a chronic, fluctuating mood disturbance characterized by distinct periods of minor depression (dysthymia) and hypomania.
2. Clinician needs to R/o Bipolar II, Bipolar I and Schizoaffective disorders.

B. Prevalence:

1. 1 to 2% of the general population
2. No gender differences
3. Typically begins in early adolescence or young adult life

III. Treatment:

A. Cognitive-behavioral psychotherapy
B. Psycho-educational model, e.g., Miklowitz, 2011
C. Nutritional counseling
D. Pharmacotherapy, in perpetuity

Bipolar II Disorder

I. Diagnostic Criteria **296.89 (F31.81)**

For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode *and* the following criteria for a current or past major depressive episode:

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree.

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Major Depressive Episode (see description under "Bipolar I Disorder")

II. Other data:

A. Associated symptoms:

1. Impulsivity, e.g., sexual acting out, compulsive shopping, etc.
2. Suicidal gestures
3. Substance abuse

4. Increased mental acuity/creativity

B. Prevalence:

1. 1 to 2% of the general population
2. No gender differences
3. Adult onset = 85%; pediatric onset = 15%

III. Treatment:

A. Cognitive-behavioral psychotherapy
B. Psycho-educational model, e.g., Miklowitz, 2011
C. Nutritional counseling
D. Pharmacotherapy, in perpetuity

Bipolar I Disorder

I. Diagnostic Criteria

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g. feels rested after only 3 hour of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e,. purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.
Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful).
Note: In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
Note: In children, consider failure to make expected weight gain.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Coding and Recording Procedures
The diagnostic code for bipolar I disorder is based on type of current or most recent episode and its status with respect to current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a manic or major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a manic, hypomanic, or major depressive episode. Codes are as follows:

Bipolar I disorder	Current or most recent episode manic	Current or most recent episode hypomanic	Current or most recent episode depressed	Current or most recent episode unspecified
Mild (p. 154)	296.41 (F31.11)	NA	296.51 (F31.31)	NA
Moderate (p. 154)	296.42 (F31.12)	NA	296.52 (F31.32)	NA
Severe (p. 154)	296.43 (F31.13)	NA	296.53 (F31.4)	NA
With psychotic features (p.152)	296.44 (F31.2)	NA	296.54 (F31.5)	NA
In partial remission (p. 154)	296.45 (F31.73)	296.45 (F31.73)	296.55 (F31.75)	NA
In full remission (p. 154)	296.46 (F31.74)	296.46 (F31.74)	296.56 (F31.76)	NA
Unspecified	296.40 (F31.9)	296.40 (F31.9)	296.50 (F31.9)	NA

II. Other data:

A. Associated symptoms:

1. During manic episodes, individuals typically do not perceive themselves as ill and in need of treatment; they will become quite defensive and resist efforts to be treated.
2. During manic episodes, the individual can become hostile, physically threatening and delusional (paranoid); mood can shift very rapidly to anger or depression

B. Prevalence:

1. 1 to 2% of general population
2. No gender differences
3. Adult onset = 85%; pediatric onset = 15%

III. Treatment:

A. Cognitive-behavioral psychotherapy
B. Psycho-educational model, e.g., Miklowitz, 2011
C. Nutritional counseling
D. Pharmacotherapy, in perpetuity

Generalized Anxiety Disorder

I. Diagnostic Criteria **300.02(F41.1)**

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complains in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

II. Other data:

A. Associated symptoms:

1. Muscle tension, trembling or twitching; muscle aches/pains
2. Somatic symptoms, e.g., sweating, nausea, diarrhea, etc.

B. Prevalence:

1. 9% of general population
2. Females outnumber males 2:1
3. Highest among individuals of European descent
4. One third of disorder is biogenetic

III. Treatment:

A. Cognitive-behavioral psychotherapy
B. Pharmacotherapy, e.g., use of S.S.R.I.'s
C. Training in stress reduction/management

Agoraphobia

I. Diagnostic Criteria **300.22(F40.00)**

A. Marked fear or anxiety about two (or more) of the following five situations:

1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
3. Being in enclosed places (e.g., shops, theaters, cinemas).
4. Standing in line or being in a crowd.
5. Being outside of the home alone.

B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms, or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence).

C. The agoraphobic situations almost always provoke fear or anxiety.

D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.

E. The fear of anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder – for example, the symptoms are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder); and are not related exclusively to obsessions (as in obsessive-compulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder).

Note: Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

II. Other data:

A. Associated symptoms:

1. Not unusual for patient to become home-bound and dependent on others for services or assistance
2. Depression
3. Substance abuse; also abuse of prescription sedatives

B. Prevalence:

1. 1.7% of general population
2. Females outnumber males 2:1

III. Treatment:

A. Cognitive-behavioral psychotherapy
B. Pharmacotherapy, e.g., targeted use of benzodiazepines

Panic Disorder

I. Diagnostic Criteria **300.01 (F41.0)**

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:
Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").

2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).

II. Other data:

A. Associated symptoms:

1. Can occur nocturnally, e.g., being awakened from a sound sleep with a severe panic attack.
2. Will typically have constant or intermittent feelings of anxiety about broader physical or mental health concerns, e.g., over-reacting to minor symptoms.
3. Potential for drug or alcohol abuse to lessen the worry about having future panic attacks.

B. Prevalence:

1. Average age of onset is 20-24.
2. Individual can have long periods of remission between episodes of panic.
3. 2 to 3% of general population
4. Females outnumber males 2:1
5. Extremely rare in children younger than 14.
6. Ethnic/cultural differences: lowest incidence is in African, Asian and Latin countries.

III. Treatment:

A. Cognitive-behavioral psychotherapy
B. Pharmacotherapy
C. Training in stress reduction/management.

Social Anxiety Disorder (Social Phobia)

I. Diagnostic Criteria **300.23 (F40.10)**

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).
Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if: **Performance only:** if the fear is restricted to speaking or performing in public.

II. Other data:

A. Associated features:

1. Frequently have major problems with submissiveness or lack of assertiveness
2. Overly-rigid body posture, lack of eye-contact, may speak with an unusually soft voice
3. Tendency towards introversive, shy demeanor
4. Tend to live at home with their parents longer. Men may be delayed in marrying.
5. Substance abuse (to lessen anxiety) common.

B. Prevalence:

1. 7% of the general population
2. Females outnumber males 2.2 to 1.5

3. Cultural/Ethnic differences: lowest in Africans, Asians and Latinos; highest in Native Americans

III. Treatment:

A. Cognitive-Behavioral psychotherapy (individual and group)
B. Targeted pharmacotherapy, e.g., Propranolol, 10-80 mg/day
C. Training in specific social skills, e.g., initiating a conversation, turn-taking in conversation, giving and receiving compliments, etc.

Posttraumatic Stress Disorder

I. Diagnostic Criteria **309.81 (F43.10)**

Posttraumatic Stress Disorder

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies or pictures, unless the exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a

continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "my whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, gilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use the subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Posttraumatic Stress Disorder of Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.
   Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.
3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   Note: It may not be possible to ascertain that the frightening content is related to the traumatic event.
3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to reminders of the traumatic event(s).

C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

Persistent Avoidance of Stimuli

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).
2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

Negative Alterations in Cognitions

3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
4. Markedly diminished interest or participation in significant activities, including constriction of play.
5. Socially withdrawn behavior.
6. Persistent reduction in expression of positive emotions.

D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
2. Hypervigilance.
3. Exaggerated startle response.

4. Problems with concentration.
5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.

G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g. blackouts) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

II. Other data:

A. Associated symptoms:

1. Developmental regression, e.g., loss of language in young children
2. Paranoid ideation
3. Auditory hallucinations
4. Difficulty in regulating emotions, e.g., outbursts of anger/rage
5. Difficulty maintaining stable relationships, especially if dissociative symptoms are present

B. Prevalence:

1. 8.7% of the general population

2. No gender differences
3. Occupational, socio-cultural factors will influence likelihood, e.g., working as a "first-responder" in emergency situations.

III. Treatment:

A. Cognitive-behavioral and expressive psychotherapies
B. Group support and/or therapy
C. Neuro-feedback, e.g., E.M.D.R.
D. Targeted pharmacotherapy, e.g., short-term use of anti-psychotics.

Obsessive-Compulsive Disorder

I. Diagnostic Criteria **300.3 (F42)**

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
   Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in boy dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphillic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

II. Subtypes:

A. Body Dysmorphic Disorder, 300.7 (F45.22)

B. Excoriation Disorder (i.e., skin picking), 698.4 (L98.1)

C. Hoarding Disorder, 300.3 (F42)

D. Trichotillomania (i.e., hair-pulling), 312.39 (F63.3)

E. Perfectionism (see Compulsive Personality Disorder)

III. Other data:

A. Associated symptoms:

1. Dysfunctional beliefs:

    a. Inflated sense of responsibility
    b. Tendency to over-estimate threat
    c. Perfectionism
    d. Intolerance of uncertainty
    e. Over-importance of thoughts, e.g., believing that having a forbidden thought is as bad as acting on it.

2. Lack of insight/cognitive rigidity
3. Delusional beliefs, “If I don’t check the stove 30 times before I leave, the house will burn down.”

B. Prevalence:

1. 2% of the general population

2. No significant gender differences
3. Thought to be largely inherited but can be exacerbated by external factors, e.g., stress

III. Treatment:

A. Pharmacotherapy, in perpetuity
B. Cognitive-behavioral psychotherapy, e.g., Schwartz, 1996.

Selected Personality Disorders:

1. Anti-Social (Sociopathic) (301.7 or F60.2)

a. Diagnostic criteria:

1.) Failure to conform with social norms, rules and laws, as indicated by repeatedly performing acts that are grounds for arrest;
2.) Pathological lying, deceitfulness;
3.) Pervasive problems with judgment and impulse control;
4.) Chronic irritability, aggressiveness, e.g., repeated physical fights and assaults;
5.) Reckless regard for the safety of self or others;
6.) Consistent irresponsibility, e.g., not honoring financial agreements;
7.) Callous lack of remorse, e.g., indifference to the feelings of others.

b. Premorbid factors:

1). Diagnosis of Conduct Disorder or Oppositional Defiant Disorder before the age of 15;
2). Diagnosis of moderate to severe A.D.H.D.;
3). Chronic enuresis beyond the age of 4;
4). Fascination with fires and fire-starting;
5). Unprovoked cruelty to animals or other children;
6). Chronic substance abuse prior to age 18;
7). Frontal lobe head injury prior to age 15;
8). Quarrelsome, fractious or abrasive attitude, especially with authority figures;
9). Early fascination with firearms and other weapons;
10). Undiagnosed/untreated, severe P.T.S.D.

c. Co-morbid conditions:

1). Inflated self-appraisal which belies low self-esteem;
2). Tendency to lower their anxiety/insecurity by raising yours;
3). Recidivism, i.e., multiple arrests/imprisonments;
4). Cannot sustain monogamous relationships;
5). Irresponsible, abusive as parents;
6). Dishonorable discharges from armed services;
7). Depressed mood, generalized anxiety and an inability to tolerate boredom.

d. Prevalence:

1). 3 to 4% of the general population
2). Major gender differences: males outnumber females at a ratio of 4 to 1.
3). More prevalent among the poor and among males who abuse alcohol.

e. Films:

- "Public Enemy" (1932)
- "The Godfather" (1972)
- "Bad Influence" (1990) (The Rob Lowe character)
- "Mildred Pierce" (1945) (The Ann Blythe character)
- "Gun Crazy" (1950) (The Peggy Cummins character)
- "Bonnie and Clyde" (1967)

2. Borderline (301.83 or F60.3)

a. Diagnostic criteria:

1). Intolerant of being alone; will equate being alone with abandonment;
2). Pattern of unstable, intense interpersonal relationships characterized by splitting;
3). Profound identity confusion/disturbance;
4). Impulsive, self-damaging acts;
5). Recurrent suicidal threats, gestures;
6). Affective instability;
7). Chronic feelings of emptiness/boredom;
8). Inappropriate anger/rage;
9). Stress-related paranoid ideation/severe dissociative symptoms.

b. Premorbid factors:

1). Severe emotional dysregulation from birth;
2). Violent outbursts of temper triggered by real or perceived abandonment;
3). Self-damaging acts, e.g., self-mutilation;
4). Greater-than-average identity confusion;
5). A history of abuse/neglect prior to age 5;
6). Periods of dissociation beginning in early childhood;
7). Profound difficulty differentiating fantasy from reality;
8). Primitive ego defense mechanisms, most especially projection, splitting, denial and verbal/physical assaults;
9). Can take the family hostage, e.g., by threatening suicide;
10). Will elicit feelings of anger, frustration, exhaustion and guilt in parents.

c. Co-morbid conditions:

1). Attach unusual significance to transitional objects, e.g., pets and toys;
2). Major depressive disorders;
3). Anxiety disorders, e.g., O.C.D., hoarding;
4). P.T.S.D., especially related to sexual abuse;
5). Polysubstance abuse/dependency;
6). Psychosomatic illness, especially Fibromyalgia;
7). Eating disorders, especially compulsive over-eating (to fill the void);
8). Pre-mature death due to suicide.

d. Prevalence:

1). 4-6% of general population
2). Major gender differences; females outnumber males at a ratio of 4 to 1.
3). Lowest functioning, highest risk of suicide among the poor.

e. Films:

- "These Three" (1936) (The character of "Mary")
- "Dangerous" (1935)
- "Play Misty for Me" (1971)
- "Equus" (1978)
- "Misery" (1990)
- "The Talented Mr. Ripley" (2000)
- "Single White Female" (1992)

3. Histrionic (301.50 or F60.4)

a. Diagnostic criteria:

1). Pathological, pervasive need to be the center of attention;
2). Inappropriate, sexually flirtatious, provocative behavior;
3). Rapidly-changing, shallow expression of emotion;
4). Obsession with physical appearance;
5). Style of speech that is excessively impressionistic, lacking in detail;
6). Tendency towards being "theatrical"/"high-drama";
7). Easily influenced by others (i.e., suggestible);
8). Considers relationships to be more intimate than they really are.

b. Premorbid factors:

1). Will appear "normal" through early adolescence; they stop evolving psychologically at age 16/17;
2). Will show early signs of problems with impulse control; they tend to have great difficulty delaying gratification;

3). They have difficulty maintaining friendships due to their self-centeredness and pathological need for attention;
4). Overactive stimulus-seeking behavior from an early age that does not diminish with age;
5). Early onset psychosomatic issues, largely to get attention;
6). Pre-occupation with physical appearance.

c. Co-morbid conditions:

1). Depression, over not being the center of attention, or related to changes in physical appearance that come with aging;
2). Suicidal gestures/threats to get attention;
3). Psychosomatic illness;
4). Can also occur with borderline, narcissistic, anti-social and dependent personality disorders.

d. Prevalence: 2% of the general population; no gender differences

e. Films:

- "Gone with the Wind" (1939) (The characters of "Scarlet", "Prissy" and "Aunt Pittypat")
- "A Streetcar Named Desire" (1951) (The character of "Blanche Dubois")
- "The Bird Cage" (1999) (The Nathan Lane character)

4. Narcissistic Personality Disorder (301.81 or F60.81)

a. Diagnostic criteria:

1). Grandiose sense of self-importance, e.g., will exaggerate accomplishments or achievements to impress others;
2). Pre-occupied with fantasies of unlimited success, power, wealth, etc.; self-absorption in general;
3). Believes s/he is "special" and thus always entitled to special treatment;
4). Requires excessive admiration;
5). Exploitative of others;
6). Appalling lack of empathy yet will expect perfect empathy from others;
7). Pervasive feelings of envy towards others; may also believe that others envy them;
8). Displays arrogant, haughty behaviors towards others.

b. Premorbid factors:

1). Birth order: Oldest and only children more susceptible to developing NPD;
2). Over-indulgence by either or both parents;
3). Reluctance to share toys with other children;

4). Outbursts of temper when frustrated or thwarted in any way;
5). Overachievement in academics, sports or the arts;
6). Physical beauty or athletic prowess;
7). Unempathic beyond adolescence;
8). Strong tendency to distort the truth or lie to save face or to maintain a carefully-crafted public persona;
9). Arrogant, self-centered and inconsiderate demeanor;
10). Hypersensitivity to any criticism → self-esteem unusually vulnerable to "injury"

c. Co-morbid conditions:

1). Low vocational functioning (cannot handle criticism or defeat);
2). Low risk-taking;
3). Major and minor depressive disorders;
4). Bipolar spectrum illness, especially Bipolar I disorder;
5). Substance abuse, especially alcohol and cocaine.

d. Prevalence:

1). 6-8% of the general population
2). Major gender differences; males outnumber females 4 to 1.

e. Films:

- "Citizen Kane" (1941)
- "The Picture of Dorian Gray" (1945)
- "American Gigolo" (1979)
- "The Devil Wears Prada" (2004) (The Meryl Streep character)
- "Blue Jasmine" (2013) (The Cate Blanchett character)
- "Wall Street" (1988) (The Michael Douglas character)

5. Compulsive/Perfectionistic (301.4 or F60.5)

a. Diagnostic criteria:

1). Preoccupation with details, rules, lists, order, organization or schedules to the extent that the major point of the activity is lost;
2). Perfectionism that interferes with task completion (i.e., can't meet overly-rigid standards);
3). Excessive devotion to work to the exclusion of leisure activities;
4). Overconscientious, inflexible about matters of morality, ethics or values (not explained by cultural/religious identification);
5). Great difficulty discarding worn-out or worthless objects even when they have no sentimental value;
6). Great difficulty delegating responsibility to others;
7). Miserly spending style; money is hoarded for future emergencies;

8). Rigid, stubborn, critical demeanor; rarely gives compliments;
9). "Control freaks";
10). Uncomfortable with emotional display: "weakness".

b. Premorbid factors:

1). Gender: males outnumber females 2:1;
2). Birth order: 1st and only children;
3). Significant loss early in life;
4). Compulsive role models, e.g., a workaholic parent;
5). Cultural values, e.g., a culture that equates self-worth with productivity.

c. Co-morbid factors:

1). Anxiety-based disorders, especially O.C.D.;
2). Depressive disorders, especially dysthymia;
3). Substance abuse, especially alcohol;
4). Mid-life burnout and depression;
5). High achievement in academics, sports.

d. Prevalence: 2-8% of general population; males outnumber females 2:1.

e. Films:

- "Ordinary People" (1979) (The Mary Tyler Moore character)
- "The Remains of the Day" (1999) (The Anthony Hopkins character)

Appendix C

Exercises in Active Empathic Listening

Active Empathic Listening (AEL)

A. Definitions:

1. AEL is listening in such a way that the talker feels understood and cared about.

2. AEL focuses first on feelings: it helps the talker more specifically label his/her feelings, e.g., "You feel angry."

3. AEL focuses second on content: it helps the talker more specifically describe the sources or references to his/her feelings, e.g., "You feel angry and hurt because he didn't ask you to join him for the game."

4. AEL is respectful: it takes the talker as he/she is, accepts the feelings and content as the talker experiences them and doesn't try to change him/her or talk him/her out of the feelings as expressed.

5. AEL is for the talker: it focuses on what the talker wants to talk about, accepting that the talker is in charge of his/her own life.

B. What AEL is not:

1. AEL is not giving advice

2. AEL is not trying to talk the other out of expressed feelings.

3. AEL is usually not asking questions (exception: open-ended questions).

4. AEL is not telling how you would feel or act in the same situation, although you may do that later after you understand thoroughly.

C. Exercises: "Mirroring, Clarifying and Negotiation"

1. Mirroring:

a. Divide into dyads. Try to select someone with whom you have not had much association. One member of the pair is to be **A** and the other member is to be **B**. Please decide now who is to be **A** and who is to be **B**.

b. **A** now makes a statement to **B** either about him or herself, about **B**, or about the relationship between the two of you. Try to avoid statements such as: "It really is hot today" or "These chairs are quite uncomfortable". Say something about which you have some feelings and which can have meaning for both of you. For example: "I'm really quite uncomfortable about attempting this exercise" or "I think I will enjoy trying this exercise with you".

c. **B** repeats the statement back to **A** exactly as **A** said it. He or she is to use the exact words, tone, inflections, gestures, and posture. That is, he/she is to mirror that statement back to **A** as he/she perceived it.

d. Check your understanding of the exercise with each other. Are you both clear on the procedure? If so, continue with the exercise. If not, ask your instructor for assistance.

e. **A** now makes a second statement to **B**. **B** mirrors it.

f. **A** makes a third statement and **B** mirrors it.

g. Reverse the procedure. This time, **B** makes three statements to **A** and **after each one A** mirrors them back.

h. Process the experience with each other. What happened between you and your associate? Did you encounter any problems? What can you say about each other's voice, tone, pitch, inflections, volume, gestures and posture? How did you feel during the exercise? Are you clear on the meaning of mirroring?

i. Process the experience in the larger group, discussing and comparing experiences.

2. Clarifying:

a. Choose another associate. Again decide who is to be **A** and who is to be **B**.

b. **A** makes a statement to **B** similar to those made in Exercise 1a. The statement should still be about him or herself, about **B**, or about the relationship between the two of you.

c. **B** responds by saying, "What I think you mean is…" (or some similar phrase). Do not try to speculate about why either of you said what you did. **B** simply tells **A** what he/she thinks **A** meant by the statement. That is, he/she attempts to clarify the statement.

A is not to correct **B** if he/she thinks he/she is wrong. The point is that what **B** heard is what you got communicated, correctly or incorrectly.

d. Do you both have a clear understanding of the exercise? If so, continue. If not, ask your instructor for assistance.

e. **A** makes a second statement. **B** responds with, "What I think you mean is…"

f. **A** makes a third statement. **B** responds as before.

g. Now reverse the procedures. **B** makes three statements and after each **A** responds with, "What I think you mean is…"

h. Process the experience with each other. Did you find the exercise difficult? Did you find yourself attempting to get at why your partner said what he/she did? How did you decide what your partner meant in his/her statement? What part did voice, gestures, posture, etc. play in reaching your conclusions? How would you define clarifying?

i. Come together in the larger group and discuss the exercise as before.

3. Negotiating

a. For a new dyad. Decide who will be **A** and who will be **B**.

b. **A** says something to **B** with the same rules as before.

c. **B** responds with, "What I think you mean is…"

d. If **B** is correct in what he/she says, **A** can reply with, "Yes, that is exactly what I meant". If **B** is not correct, attempt to get at the exact meaning of what was said. The two of you are to negotiate until you are in agreement about what **A** really meant and **A** is able to respond to **B** with, "Yes, that is exactly what I meant".

e. If you are unclear about the procedures, ask for assistance. Otherwise, continue with the exercise.

f. Repeat steps 2, 3, and 4 twice more.

g. Now reverse the procedure with **B** initiating the statements and **A** responding to them. Do this three times.

h. Process the exercise as before. How did the original message change over time? What is meant by negotiating?

i. Discuss the exercise in the larger group.

Self-Test

1. "Unreasonable people" can include which of the following?
    a. People who show poor judgment
    b. People who have problems with impulse control
    c. People who have difficulty regulating their emotions, especially anger
    d. All of the above

2. Which of the following is not a psychiatric condition associated with unreasonable behavior?
    a. Borderline personality disorder
    b. Bipolar spectrum illness
    c. Avoidant personality disorder
    d. Anxiety-based disorders

3. Which of the following is not a type of problematic schema?
    a. Dependence/Incompetence
    b. Subjugation
    c. Vulnerability to harm or illness
    d. All of the above are types of problematic schema

4. The problematic schema "Mistrust/Abuse" involves all but which of the following?
    a. "Others will intentionally try to betray or otherwise take advantage of me."
    b. "Be wary of anyone who has power; they will use it to harm me."
    c. "It must destroy anyone that I come to trust."
    d. "Don't let others get close; they will see my vulnerabilities and use this to hurt me."

5. A person who has insufficient limits and a sense of entitlement:
    a. Believes they are more special than you.
    b. Believes they always deserve special treatment.
    c. Believes they don't have to play by the rules because they are so special.
    d. All of the above are true.

6. What makes a core belief/scheme so compelling?
    a. Many are biogenetic, in-born.
    b. We learn them as a result of interacting with major players in our life.
    c. Real-life experiences can reinforce any belief, making it more resilient.
    d. B and C are true.

7. Obsessive-compulsive disorders include all but which of the following?
    a. Hoarding disorder
    b. Chronic lateness or absenteeism
    c. Perfectionism
    d. Trichotillomania

8. Anger management problems include all but which of the following?
    a. Assertiveness
    b. Chronic passivity
    c. Inappropriate aggressive behavior
    d. Chronic passive-aggressiveness

9. Which of the following is a pathway to effective reasoning?
    a. Assuring that the person feels heard.
    b. Focus on the other person's feelings.
    c. Focus on the other person's beliefs/core schema.
    d. All of the above are effective pathways.

10. Which of the following is not a recommended strategy for dealing with highly emotional patients?
    a. Validate their feelings.
    b. Engage them in cognitive restructuring.
    c. Encourage a diet rich in carbohydrates and fats.
    d. Teach them to practice specific breathing techniques.