Treatment planner
Directions for using this treatment planning tool:

This treatment planner is designed to be used as part of clinical treatment throughout our work with patients. It will be initially used on new patients as part of the Psychological Assessment form. A treatment plan is a work in progress, and should evolve as the clinician continuously assesses adequate and realistic goals for patients. Psychological treatment is most effective when following a clear modality, and is driven by patient conceptualization. This tool is designed to give you the flexibility to either choose a pre-determined modality (e.g. if scientifically proven to work for certain populations) or to create a plan based on your modality of preference (e.g. Interpersonal or Cognitive-Behavioral).

The treatment modalities suggested below are by no means comprehensive, and will continue to be edited over time. They also should not be seen as limiting of the clinician’s own creativity in determining appropriate plans for complex patients. Some of the sections have additional information that could help with conceptualization or psychotropic medication considerations.

Once the information-gathering portion of the assessment is completed, and a diagnosis has been formed, the clinician will direct themselves to the section of the treatment plan that matches the patient’s diagnosis. DSM-5 codes should be available for a majority of commonly used diagnoses. More than one section can be used at one time. The assessing clinician will determine a number of treatment goals deemed appropriate for the patient’s diagnosis, as well as matching interventions that would help patient reach these goals.
Treatment Considerations for All Patients:

1. Strengths: What are the patient’s coping skills and protective factors?
2. Support: To what extent is the patient involved in his/her social environment?
3. Barriers to progress: What are the patient’s triggers and risk factors?
4. Modality: Which psychological framework will you use to conceptualize and treat the patient?
5. Frequency: How often and for how long should the patient be seen for optimal benefits?
6. Goals: What are the symptoms and signs to look for to measure improvement, and what are the steps to get there?

Coping Skills and Protective Factors:
Religion/spirituality
Relationship with family
Strong social support
Strong community support
Involvement in church
Good premorbid functioning
High access to resources
Strong intellectual abilities
Stable employment
Good bodily habitus

Barriers to Progress:
Relational problems
Problems related to family upbringing
Problems related to primary support group
Child physical abuse
Child sexual abuse
Child neglect
Child psychological abuse
Adult maltreatment and neglect problems
Spouse or partner violence
Spouse or partner neglect
Educational problems
Housing and economic problems
Problems related to living in a residential institution
Problems related to living alone
Religious or spiritual problem
Personal history of psychological trauma
Personal history of self-harm
Unavailability or inaccessibility of healthcare facilities
Non-adherence to medical treatment
Overweight or obesity
Malingering
Wandering associated with a mental disorder
Borderline intellectual functioning
DSM-5 Neurodevelopmental Disorders Cluster

AD/HD
Attention deficit/hyperactivity disorder
314.01 Combined presentation
314.00 Predominantly inattentive presentation
314.01 Predominantly hyperactive/impulsive presentation

Treatment Objectives:
1. Sustain attention and concentration for consistently longer periods of time and reduce impulsive behavior.
2. Take stimulant medication as prescribed to decrease inattention and impulsivity.
3. Teacher will implement classroom accommodations to reduce distractions and increase on-task behavior.
4. Patients and/or teachers successfully use behavior management strategies to increase desirable behaviors and reduce undesirable behaviors.
5. Sustain attention and concentration for consistently longer periods of time.
6. Increase the frequency of on-task behaviors.
7. Demonstrate marked improvement in impulse control.
8. Regularly take medication as prescribed to decrease impulsivity, hyperactivity, and distractibility
9. Work with family to set firm, consistent limits and maintain appropriate boundaries.
10. Improve self-esteem.
11. Develop positive social skills to help maintain lasting peer friendships.

Treatment Plan ADHD:

Objective 1: Take medication as prescribed by Primary Care Provider.
   • Arrange for medication evaluation by primary care physician.
   • Monitor patient for medication usage; Assess compliance, effectiveness, side effects.
   • Consult with prescribing physician regularly

Objective 2: Delay instant gratification in favor of achieving meaningful long-term goals.
   • Teach the patient meditational and self control strategies (e.g., “Stop, Look, Listen, and Think”) to inhibit impulsive behavior and achieve long term goals.
   • Increasing structure in the home to help patient learn to delay gratification (e.g., completing chores before seeing friends).

Objective 3: Identify and use a variety of effective reinforcers to increase positive and reduce negative behaviors.
   • Identify a variety of positive reinforcers or rewards to maintain the patient’s interest and motivation in achieving desired goals/changes in behavior.
   • Use basic behavior management principles to implement changes in behaviors.

Objective 4: Patient will comply with the implementation of behavior management strategies to reduce the frequency of inattentive, impulsive, and non-compliant behaviors.
   • Design a reward and/or contingency contract system to reinforce the patient’s desired behavior and reduce inappropriate behaviors.

Objective 5: Teachers implement classroom accommodations to reduce distractions and increase attention.
• Provide seating arrangement to minimize distractions; close to teacher; away from
door, windows, and distracting classmates.
• Provide advance cues when patient is about to transition from one task to another.
• Provide reinforcement for complying with seat work and other academic activities
requiring on-task behavior.

Objective 6: Patient implement system to enhance task completion.
• Design a “Day Planner” system to insure that patient is aware of all daily needed
tasks
• Break daily tasks into smaller units with breaks between units.
• Use rewards to increase task completion at appropriate level of accuracy.

In addition to including the type of information just presented, clinicians should attempt to
introduce measurable/quantifiable aspects of the patient behavior into the treatment plan. For
example:
• Completes necessary tasks at home, school, or work daily 90% of the time.
• Takes medication 100% of the time.
• By 03/15/2016 scores on Conner’s ADHD Index within the normal range.
Schizophrenic Spectrum and Other Psychotic Disorders Cluster

295.90 Schizophrenia
295.70 Schizoaffective disorder, specify if Bipolar Type or Depressive Type
297.1 Delusional Disorder
295.70 Substance/Medication-Induced Psychotic Disorder
Psychotic Disorder Due to another medical condition
293.81 With delusions
293.82 With hallucinations
298.9 Unspecified Schizophrenia Spectrum and other Psychotic Disorder
295.40 Schizophreniform Disorder

Treatment Objectives:
1. Reduce acute symptomatology.
2. Encourage compliance with medications.
3. Encourage patient to understand and accept that meds may not always be able to control symptoms.
5. Reduce irrational beliefs.
6. Help patient develop better coping skills.
7. Develop discharge plan for coping with everyday life, including living arrangements, work, etc.
8. Promote socialization.

Treatment Plan for Schizophrenia Spectrum Disorder:
1. Develop treatment plan, discuss with patient, and agree on target problem.
2. Refer patient for medical and psychiatric evaluations.
3. Evaluate need for hospitalization, and resolve patient fears of being hospitalized.
4. When medication is prescribed, confirm that prescription has been filled and meds are taken on a regular schedule. Assign patient to keep journal.
5. If necessary, refer to psychiatrist or prescriber for dosage adjustment and control of side effects.
6. Instruct patient on dangers of mixing prescribed medication with other drugs.
7. Teach patient to counter destructive thoughts and urges with positive self-talk drawing on past successful experience with the activities of daily living.
8. Explore and confront patient's irrational belief system. Point out rational beliefs and consequences.
9. Coach patient in taking an active interest in his appearance. Teach patient the importance of grooming and hygiene.
10. Produce genogram to help understand family interactions and stressors
11. Involve patient's family in treatment and act as family consultant to help them understand and deal with the patient.
12. Lessen family anxiety and teach new skills for interaction with the patient.
13. Assign patient to expand daily journal to include thoughts, feelings, and behavior.
14. Regularly review journal with patient and identify triggers that result in aberrant behavior.
15. Teach patient stress reduction or relaxation technique to control trigger points.
16. Refer to self-help group to learn and practice socialization.
17. Teach social skills training
18. If patient is severely disturbed, refer to residential treatment center or group home.
19. Refer patient for vocational training.
20. Do reality testing and encourage patient to focus on real world rather than fantasies.
22. Teach patient laws of anxiety--not dangerous, not permanent, avoidance increases anxiety.
23. Explain principles of assertiveness to replace aggression.
24. Help patient to overcome denial and fully accept illness.
25. Develop termination plan and discuss issues associated with termination, e.g., dependency and separation
DSM-5 Cluster: Bipolar and Related Disorders

BIPOLAR DISORDER I
Current or most recent episode manic
296.41 Mild
296.42 Moderate
296.43 Severe
296.44 With psychotic features
296.45 In partial remission
296.46 In full remission
296.40 unspecified

Current or most recent episode hypomanic
296.45 In partial remission
296.46 In full remission
296.40 unspecified

Current or most recent episode depressed
296.51 Mild
296.52 Moderate
296.53 Severe
296.54 With psychotic features
296.55 In partial remission
296.56 In full remission
296.50 unspecified

296.7 Current or most recent episode unspecified

Treatment Objectives-Manic Episode
1. Control pressurized speech.
2. Reduce psychomotor agitation.
3. Increase ability to maintain concentration.
4. Curtail potentially destructive activities.
5. Restore normal sleep pattern.
6. Reduce grandiosity.
7. Increase ability to focus on a single thought or task.

Treatment Objectives-Depressive Episode
1. Reduce persistent depression.
2. Restore interest in former pleasurable activities.
3. Restore normal eating pattern.
4. Restore normal sleep pattern.
5. Eliminate feelings of worthlessness, guilt.
6. Improve energy level.
7. Eliminate or control suicidal ideations.
BIPOLAR II DISORDER
296.89 Bipolar II Disorder
Specify if hypomanic, depressed, in partial remission, in full remission, mild, moderate, severe.

Treatment Objectives-Depressive Episode
1. Reduce persistent depression.
2. Restore interest in former pleasurable activities.
3. Restore normal eating pattern.
4. Restore normal sleep pattern.
5. Eliminate feelings of worthlessness, guilt.
6. Improve energy level.
7. Eliminate or control suicidal ideations.

Treatment Objectives-Hypomanic Episode
1. Control pressurized speech.
2. Reduce psychomotor agitation.
3. Increase ability to maintain concentration.
4. Curtail potentially destructive activities.
5. Restore normal sleep pattern.
6. Reduce grandiosity.
7. Increase ability to focus on a single thought or task.

CYCLOTHYMIC DISORDER
301.13 Cyclothymic Disorder
Specify if: with anxious distress

Treatment Objectives:
1. Diminish grandiosity.
2. Restore normal sleep pattern.
3. Reduce pressurized speech.
4. Control flight of ideas.
5. Increase ability to concentrate.
6. Ease psychomotor agitation.
7. Eliminate pleasurable activities with negative consequences.
8. Ease depression.
9. Restore interest in activities.
10. Restore normal eating patterns, weight.
11. Restore normal sleep patterns.
12. Reduce fatigue.
15. Control suicidal ideations.
17. Prevent relapse.

Treatment Plan for Bipolar Disorders:
1. Perform a diagnostic evaluation
2. Evaluate the safety of the patient and others and determine a treatment setting (inpatient/outpatient…)

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3. Establish and maintain a therapeutic alliance
4. Monitor treatment response
5. Provide education to the patient and to the family
6. Enhance treatment compliance
7. Promote awareness of stressors and regular patterns of activity and sleep
8. Work with the patient to anticipate and address early signs of relapse
9. Evaluate and manage functional impairments
10. Assess for risk of suicide, homicide, and violence
11. Assess for substance use disorders and comorbid mental health disorder

**Psychotropic Medication Management with primary Care Provider:**

**Acute treatment:**

1. **Manic or mixed episodes**
   
   The first-line pharmacological treatment for more severe manic or mixed episodes is the initiation of either lithium plus an antipsychotic or valproate plus an antipsychotic. For less ill patients, monotherapy with lithium, valproate, or an antipsychotic such as olanzapine may be sufficient.

2. **Depressive episodes**
   
   The first-line pharmacological treatment for bipolar depression is the initiation of either lithium or lamotrigine. Antidepressant monotherapy is not recommended.

3. **Rapid cycling**
   
   The initial treatment for patients who experience rapid cycling should include lithium or valproate; an alternative treatment is lamotrigine. For many patients, combinations of medications are required.
DSM-5 Cluster: Depressive Disorders

PERSISTENT DEPRESSIVE DISORDER
300.4 Persistent Depressive disorder (Dysthymia)
Specify if: in partial remission; in full remission; early onset; late onset; with pure dysthymic syndrome; with persistent major depressive episode; with intermittent major depressive episodes, with current episode; with intermittent major depressive episodes, without current episode.

Also use for
309.0 Adjustment disorder with depressed mood
309.28 Adjustment disorder with mixed anxiety and depressed mood
309.9 Unspecified adjustment disorder

Treatment Objectives:
1. Reduce the symptoms of depression.
2. Restore patient to former level of functioning.
3. Prevent relapse.

MAJOR DEPRESSIVE DISORDER
Major depressive disorder
Single episode
296.21 Mild
296.22 Moderate
296.23 Severe
296.24 With psychotic features
296.25 In partial remission
296.26 In full remission
296.20 unspecified
Recurrent Episode
296.31 Mild
296.32 Moderate
296.33 Severe
296.34 With psychotic features
296.35 In partial remission
296.36 In full remission
296.30 unspecified

311 Unspecified Depressive Disorder

Treatment Objectives:
1. Reduce persistent depression.
2. Restore interest in former pleasurable activities.
3. Restore normal eating pattern.
4. Restore normal sleep pattern.
5. Eliminate feelings of worthlessness, guilt.
6. Improve energy level.
7. Eliminate or control suicidal ideations.
8. Alleviate depressed mood and return to previous level of effective functioning.
9. Develop the ability to recognize, accept, and cope with feelings of depression.
10. Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation of depression symptoms

**Treatment Plan for Depressive Disorders**

1. Describe the signs and symptoms of depression that are experienced.
2. Explore how depression is experienced in patient's day-to-day living.
3. Encourage sharing feelings of depression in order to clarify them and gain insight as to causes.
4. Verbally express understanding of the relationship between depressed mood and repression of feelings that is, anger, hurt, sadness, and so on.
5. Encourage patient to share feelings of anger regarding pain inflicted on her in childhood that contributes to current depressed state.
6. Explain a connection between previously unexpressed (repressed) feelings of anger (and helplessness) and current state of depression.
7. Identify cognitive self-talk that is engaged in to support depression.
8. Assist in developing awareness of cognitive messages that reinforce hopelessness and helplessness.
9. Replace negative and self-defeating self-talk with verbalization of realistic and positive cognitive messages. Help the patient keep a daily record that lists each situation associated with the depressed feelings and the dysfunctional thinking that triggered the depression. Then use logic and reality to challenge each dysfunctional thought for accuracy, replacing it with a positive, accurate thought.
10. Assign patient to keep a daily journal of experiences, automatic negative thoughts associated with experiences and the depressive affect that result from that distorted interpretation. Process journal material to diffuse destructive thinking patterns and replace with alternate, realistic, positive thoughts.
11. Make positive statements regarding self and ability to cope with stresses of life.
12. Reinforce positive, reality-based cognitive messages that enhance self-confidence and increase adaptive action.
13. Assign patient to write at least one positive affirmation statement daily regarding him/her and the future.
14. Decrease frequency of negative self-descriptive statements and increase frequency of positive self-descriptive statements.
15. Reinforce patient's positive statements made about self.
16. Assign patient to write at least one positive affirmation statement daily regarding him/her and the future.
17. Implement a regular exercise regimen as a depression reduction technique (behavioral activation).
18. Develop and reinforce a routine of physical exercise to stimulate depression-reducing hormones.
DSM-5 Cluster: Anxiety Disorders

GENERALIZED ANXIETY DISORDER
300.02 Generalized Anxiety Disorder
Also use for:
309.24 Adjustment disorder with anxiety
309.28 Adjustment disorder with mixed anxiety and depressed mood
309.9 Unspecified adjustment disorder

Treatment Objectives:

1. Reduce pervasive worry.
2. Diminish and eliminate symptoms of anxiety: restlessness, fatigue, lack of concentration, irritability, somatization, and sleep disturbance.
3. Reduce anxiety and improve coping skills
4. Restore patient to optimum level of functioning.

Treatment Plan for Generalized Anxiety Disorder:

1. Clinician will assess for symptoms of anxiety and confirm diagnosis:
   a. Tests and other evaluations
      i. BAI-Zung-others
2. Clinician will consider medication recommendation to PCP
   a. buspirone for tension, worry, and psychic symptoms,
   b. benzos for somatic and adrenergic symptoms,
   c. antidepressants for concurrent depressive undertones
3. Clinician will socialize patient to treatment
   a. Patient will understand that they have an illness.
   b. This treatment will teach patient how to relax, and improve their ability to deal with stress.
4. Clinician will implement relaxation Training
   a. progressive muscle relaxation,
   b. breathing relaxation,
   c. guided imagery,
   d. meditation
5. Clinician will guide patient to assess and confront avoidance using exposure and other techniques
   a. compose hierarchy of avoided behaviors,
   b. assess SUDs,
   c. confront behaviors
6. Clinician will use desensitization by pairing exposure with relaxation, in an effort to reduce anxious response
7. Clinician will monitor worries and assign “worry time” for patient
   a. patient is required to worry for a specific time at a specific time and place
8. Clinician will perform a cognitive evaluation of the nature of worrying
   a. Increase understanding that patient views worrying as a hypervigilant strategy to avoid bad outcomes.
   b. Challenge distorted cognitive thoughts
9. Clinician may use other techniques for countering worry and rumination
   a. behavioral activation
   b. interpersonal interventions
      i. assertiveness,
ii. attending to others instead of complaining

c. Stress-reduction and problem-solving training
   i. time management,
   ii. positive self-rewards

10. Clinician will assess the need to phase out treatment
AGORAPHOBIA
300.22 Agoraphobia

Treatment Objectives:

1. Diminish fear of being trapped in a place or situation.
2. Diminish fear of embarrassment over panic attack.
3. Diminish fear that help may not be available in certain places or situations.
4. Eliminate avoidance of fearful places.
5. Eliminate need for companion in confronting certain places or situations.
6. Restore patient to optimum level of functioning.
7. Prevent relapse.

Information about the disorder:
Treatment options for agoraphobia and panic disorder are similar.

Cognitive behavioral treatments:
1. Exposure treatment can provide lasting relief to the majority of patients with panic disorder and agoraphobia. Disappearance of residual and subclinical agoraphobic avoidance, and not simply of panic attacks, should be the aim of exposure therapy.
2. Systematic desensitization may also be used.
3. Cognitive restructuring has also proved useful in treating agoraphobia. This treatment uses thought replacing with the goal of replacing one's irrational, counter-factual beliefs with more accurate and beneficial ones.
4. Relaxation techniques are often useful skills for the agoraphobic to develop, as they can be used to stop or prevent symptoms of anxiety and panic.

Psychopharmacological treatments:
1. Anti-depressant medications most commonly used to treat anxiety disorders are mainly in the SSRI (selective serotonin reuptake inhibitor) class and include sertraline, paroxetine and fluoxetine.
2. Benzodiazepine tranquilizers, MAO inhibitors and tricyclic antidepressants are also commonly prescribed for treatment of agoraphobia.

Alternative treatments:
1. Eye movement desensitization and reprogramming (EMDR) has shown poor results. As such, EMDR is only recommended in cases where cognitive-behavioral approaches have proven ineffective or in cases where agoraphobia has developed following trauma.
2. Many people with anxiety disorders benefit from joining a self-help or support group (telephone conference call support groups or online support groups being of particular help for completely housebound individuals). Stress management techniques and various kinds of meditation practices as well as visualization techniques can help people with anxiety disorders calm themselves and may enhance the effects of therapy.
3. Service to others can distract from the self-absorption that tends to go with anxiety problems.
4. Aerobic exercise may have a calming effect.
5. Since caffeine, certain illicit drugs, and even some over-the-counter cold medications can aggravate the symptoms of anxiety disorders, they should be avoided.

Treatment Plan for Agoraphobia:
Clinician will allow patient to:
1. Express phobic fear and focus on recounting the precise stimuli for it.
2. Develop examples of circumstances that cause anxiety.
3. Become capable in relaxation and breathing exercises.
4. Recognize a non-threatening, pleasant setting that can sponsor relaxation using guided imagery.
5. Collaborate with systematic desensitization to the anxiety-activating stimulus.
6. Experience in vivo desensitization to the stimulus
7. Come across the phobic stimulus and omit feelings of control, calmness, and comfort.
8. Recognize symbolic significance that the phobic stimulus may have as a basis for fear.
9. Express the separate realities of the irrationally feared object or situation and the emotionally painful experience from the past that has been evoked by the phobic stimulus.
10. Share the feelings associated with past emotionally painful situation that is connected to the phobia.
11. Acknowledge the cognitive beliefs and messages that mediate the anxiety response.
12. Express positive, healthy, and rational self-talk that decreases fear and allows the behavioral encounter with avoided stimuli.
13. Use behavioral and cognitive strategies that decrease or eliminate irrational anxiety.
15. Responsibly take prescribed psychotropic medication to alleviate phobic anxiety.
16. Describe the history and nature of the panic symptoms.
17. Recognize any secondary gain that accrues due to modification of life related to panic.
18. Express acknowledgement that panic symptoms do not bring on mental illness, loss of control over self, or heart attack.
19. Rehearse positive self talk that comforts self of the aptitude to endure anxiety symptoms without grave consequences.
20. Use deep muscle relaxation and breathing exercises to stop panic symptoms.

Clinician will use Strategies or Interventions for Individuals with Panic-Phobia or Agoraphobia Problems:
1. Talk about and evaluate the phobic anxiety, its intensity, and the triggering stimuli.
2. Run a fear survey to further measure the extent and extensiveness of phobic responses.
3. Guide and aid in developing a hierarchy of anxiety producing circumstances linked with the phobic response.
   a. Educate in progressive relaxation methods.
   b. Use biofeedback systems to assist relaxation skills.
   c. Coach in guided imagery for anxiety relief
   d. Guide systematic desensitization procedures to lessen phobic response.
   e. Appoint and or escort client in a vivo desensitization contact with phobic stimulus.
   f. Evaluate and verbally support advancement toward overcoming anxiety.
4. Clarify possible symbolic meaning of the phobia stimulus.
5. Explain and distinguish between the irrational fear and past emotional pain.
6. Strengthen insights into past emotional pain and present anxiety.
7. Recognize the erroneous schemes and related automatic thoughts that set off anxiety response.
8. Teach in modifying core schemes using cognitive reformation techniques.
Treatment Objectives:
1. Reduce frequency of panic attacks.
2. Restore patient to optimum level of functioning.
3. Prevent recurrence of panic attacks.

Information about disorder:

CBT Interventions:
Cognitive-behavioral therapy generally targets these maintaining factors and places less emphasis on determining the origins of panic disorder for a particular patient. Cognitions hypothesized to maintain panic disorder include catastrophic misinterpretations of physical symptoms (e.g., the belief that palpitations signal an impending heart attack) (for example, see references 167 and 168). Therefore, many versions of CBT seek to identify and change mistaken beliefs about physical symptoms and their consequences.

Techniques are aimed at 1) weakening or extinguishing learned associations between stimuli (both internal and external) and panic and 2) creating opportunities for learning and strengthening nonanxious responses. All forms of CBT conceptualize avoidance behavior as a maintaining factor in panic disorder, either because it prevents patients from disconfirming their anxious beliefs or because it prevents habituation of fear responses. Thus, confronting feared stimuli and situations is an essential part of CBT for panic disorder.

Therapy begins with one or more psychoeducation sessions that serve to identify the patient’s symptoms and areas of impairment, provide accurate information about the nature and purpose of anxiety and fear, conceptualize the patient’s experiences in terms of the CBT model, and outline a rationale and plan for treatment.

A major goal of psychoeducation for panic disorder is conveying that panic symptoms result from the body’s natural fear response and are not dangerous.

Self-monitoring is another core component of CBT. Patients monitor their panic attacks using techniques such as keeping a daily diary. They are asked to record the date, time, location, and any perceived triggers of the panic attack. They also may be asked to record the physical symptoms, anxious thoughts, and behavioral responses that occurred during the attack. Patients are informed that this will help to assess the frequency and nature of their panic attacks and to provide data regarding the relationship of panic symptoms to potential triggers.

Another component of CBT is exposure to fear cues. Patients with panic disorder can experience panic attacks in response to internal and external cues (169). The most common internal fear cues are bodily sensations (e.g., heart racing, dizziness, shortness of breath). Common external fear cues include situations in which having a panic attack would be embarrassing or in which escape would be difficult (e.g., public places, enclosed spaces).

Internal fear cues are addressed through interoceptive exposure. Interoceptive exposure involves exposing the patient to feared bodily sensations in a systematic way, until he or she no longer responds fearfully to those sensations. Feared bodily sensations are provoked using a series of exercises such as running in place (to induce heart pounding), spinning in a chair or while standing up (to induce dizziness), and hyperventilation or breathing through a straw (to induce light-headedness or shortness of breath).
External fear cues are targeted through situational exposure, which involves confronting situations or activities that commonly provoke fear. Situational exposure can include a wide variety of exercises such as driving on a highway, riding in an elevator, or visiting a grocery store or shopping mall.

Cognitive restructuring focuses on identifying and countering erroneous beliefs that contribute to panic disorder. Patients with panic disorder commonly interpret panic symptoms in a catastrophic manner (e.g., as signs of an impending heart attack or fainting spell). They also typically underestimate their ability to cope with panic attacks

**Psychodynamic psychotherapy**

The goal of psychodynamic psychotherapy is to achieve remission of panic disorder symptoms through a therapeutic process that encourages exploration of feelings and past and present traumatic experiences. The core principles of psychodynamic psychotherapy are 1) the appreciation that much of mental life is unconscious, 2) childhood experiences in concert with genetic and constitutional factors shape adult personality, and 3) individual symptoms and behaviors may serve multiple functions.

Acute stressors, or “life events,” occur just prior to panic disorder onset. According to psychodynamic theory, the psychological meaning of these events as well as symptoms, behaviors, and coping styles are determined by complex forces that may be unavailable to the patient’s conscious awareness uncover and understand the thoughts and feelings associated with panic symptoms as well as the unconscious psychological meanings of these panic symptoms, issues that are theorized to be related to separation, autonomy, self-esteem, anger, or aggression. Understanding of transference and interpretation are used to elucidate these issues as well as related interpersonal conflicts.

Panic-focused psychodynamic psychotherapy is based on the postulate that panic symptoms carry a specific emotional significance that the patient must confront before remission of the panic symptoms can occur. According to this theoretical model, patients with panic disorder are conceptualized as having difficulty separating from important attachment figures and perceiving themselves as autonomous, which is thought to motivate agoraphobic avoidance. The combination of perceiving their environment and relationships as overly dangerous and themselves as inadequate and lacking autonomy triggers high levels of anxiety that perpetuate panic and agoraphobic avoidance. Panic symptoms in turn are thought to reinforce conflicted interpersonal relationships in which the patient feels excessively dependent on significant others and frightened of losing them. Panic-focused psychodynamic psychotherapy focuses on the transference as a mutative therapeutic agent and does not require behavioral exposure to agoraphobic situations. It helps patients to confront the emotional significance of their physical symptoms and recognize that their fears of upcoming catastrophe reflect an internal emotional state rather than reality. Through these techniques, PFPP encourages patients to function more autonomously and may help patients with panic disorder to achieve a greater sense of personal efficacy, yielding improved function and symptomatic relief.

**Specific pharmacological interventions:**

1. Selective serotonin reuptake inhibitors or SNRIs are likely to be the best choice of pharmacotherapy for many patients with panic disorder, though SSRIs have a larger evidence base and are more likely to be chosen as a first-line treatment. Because they have no liability for abuse, SSRIs, SNRIs, and TCAs are also preferable to benzodiazepines in individuals with current or prior substance use disorders.

2. Although consideration must be given to potential side effects of benzodiazepines (e.g., sedation, memory difficulties, increased rates of falls or motor vehicle accidents), one advantage of benzodiazepines is their earlier onset of action as compared to antidepressants benzodiazepines may be useful for patients with very distressing or impairing symptoms in whom rapid symptom control is critical. Furthermore, several studies suggest that the short-term (4–6 week) addition of benzodiazepines...
(alprazolam and clonazepam) to antidepressants produces a more rapid therapeutic response. Consequently, benzodiazepines may be used along with antidepressants to help control symptoms until the antidepressant takes effect, followed by slow tapering of the benzodiazepine.

3. To reduce the possibility of physiological dependence, psychiatrists sometimes prescribe benzodiazepines on an as-needed (p.r.n.) basis. Unfortunately, this practice has a number of adverse effects. Irregular use promotes fluctuating blood levels that may aggravate anxiety. One study also showed worse CBT outcomes in participants using benzodiazepines on a p.r.n. basis compared to those taking benzodiazepines on a regular schedule and those not taking benzodiazepines.

4. The data support the efficacy of alprazolam in treating multiple dimensions of illness (i.e., preventing panic attacks, reducing anticipatory anxiety and avoidance) in patients with panic disorder. However, because of its short half-life, frequent (3–4 times daily) dosing is required, which creates practical difficulty for many patients and results in more rapid and profound withdrawal symptoms with missed doses. Some psychiatrists to prefer clonazepam over other benzodiazepines for the long-term maintenance treatment of panic disorder, largely because of the ease of clonazepam dosing.

Treatment Plan for Panic Disorder:
1. Clinician will help patient weaken or extinguish learned associations between stimuli (both internal and external) and panic using the following techniques:
   - Internal fear cues will be addressed through interoceptive exposure
   - External fear cues are targeted through situational exposure, which involves confronting situations or activities that commonly provoke fear.
   - Cognitive restructuring focuses on identifying and countering erroneous beliefs that contribute to panic disorder
2. Clinician will create opportunities for learning and strengthening nonanxious responses.
3. Clinician will use psychoeducation sessions that serve to identify the patient’s symptoms and areas of impairment, provide accurate information about the nature and purpose of anxiety and fear, conceptualize the patient’s experiences in terms of the CBT model, and outline a rationale and plan for treatment.
4. Clinician will convey that panic symptoms result from the body’s natural fear response and are not dangerous.
5. Patient will monitor their panic attacks using techniques such as keeping a daily diary. She/he will be asked to record the date, time, location, and any perceived triggers of the panic attack.
6. Patients may also be asked to record the physical symptoms, anxious thoughts, and behavioral responses that occurred during the attack. Patients are informed that this will help to assess the frequency and nature of their panic attacks and to provide data regarding the relationship of panic symptoms to potential triggers.
**SOCIAL ANXIETY DISORDER**

*300.23 Social Anxiety Disorder*

Specify if: performance only

**Treatment Objectives:**

1. Diminish and eliminate fear of embarrassment or humiliation in social interactions.
2. Control and eliminate panic attacks.
3. Eliminate need for avoidance of social interactions.
4. Restore patient to optimum level of functioning to prevent relapse.

**Treatment Plan for Social Anxiety Disorder:**

1. Clinician will teach patient normal and adaptive function of anxiety
2. Patient will learn more about social anxiety as a disorder through psychoeducation
3. Clinician will allow patient to build skills to manage anxiety including
   a. Observing social anxiety
   b. Use ABC sheets to track time, symptoms, and situation
   c. Learning relaxation tools, like deep breathing and progressive muscle relaxation
   d. Challenge maladaptive thoughts to create “realistic thinking”.
   e. Use ABC sheets to determine whether thoughts are based on facts
   f. Listing fears from least scary to scariest
   g. Using exposure to face fearful stimuli, starting with the least scary
   h. Eliminate subtle avoidance and safety behaviors (include substance abuse)
   i. Meeting new people in safe environment
   j. Practicing skills and teaching ways of expecting and preventing relapse
SPECIFIC PHOBIA
300.29 Specific Phobia
Code for Animal, Natural Environment, Blood-Injection-Injury, Situational, or Other

Treatment Objectives:
1. Diminish excessive fear of object or situation.
2. Decrease anxiety when exposed to object or situation.
3. Eliminate need to avoid or endure object or situation.
4. Eliminate interference with ADLs.
5. Restore patient to optimum level of functioning.

Overview of Evidence-Based Treatment for Specific Phobia in Adults
Psychosocial interventions—and exposure-based treatments in particular—are considered the empirically-supported treatments of choice for specific phobia.

A-Exposure-Based Treatment
1. Exposure to feared objects
2. Exposure to situations, interoceptive cues (e.g., internal physical sensations)
3. A combination of both
4. The patient remains in the situation for a sufficient duration to learn that the feared consequences do not occur and that they can tolerate the fear and anxiety.
5. Self-help and self-administered therapies can be equally effective
6. Sessions are spaced close together, perhaps expanding the spacing of sessions as treatment progresses
7. Allow the client has enough time to consolidate the extinction learning that occurs across sessions, either within a single day or distributed across several days

B-Variations of In Vivo Exposure Therapy
Virtual Reality Exposure Therapy
Eye Movement Desensitization and Reprocessing (EMDR)
1- Process cognitions related to an anxiety-provoking or traumatic event and decondition the client’s fear of the conditioned stimulus. It includes brief imaginal exposures to the feared object or situation while the client engages in rapid eye movements guided by the clinician.

Applied Tension (AT) and Applied Relaxation (AR)
1-variations of standard in vivo exposure intended to counteract the vasovagal fainting response that is unique to BII phobias.
2-In AT, the clients are instructed to tense all the muscles of their body while being exposed to phobic stimuli
3-AR involves teaching the client to use progressive muscle relaxation, alternately tensing and releasing specific muscle groups, in the context of gradual exposure to the feared stimulus.

C- Cognitive Therapy
1-Challenging patient’s beliefs, expectations, or predictions about the likelihood or consequences of harm related to encountering the feared object or situation in order to reduce anxiety and avoidance behavior.

D- Pharmacotherapy
1-Antidepressant medication (escitalopram, paroxetine) for specific phobia both produced only modest treatment gains compared to placebo and did not include a follow-up period
2- Benzos and anxiolitics increase risk for relapse
3-An exception to this appears to be the use of d-cycloserine (DCS), a partial agonist of the N-methyl-D aspartate (NMDA) glutamatergic receptor, which has been shown in several animal and human clinical studies to accelerate fear reduction during exposure
Treatment Plan for Phobias:

1. A comprehensive, multimodal assessment is recommended to generate a thorough case conceptualization
2. Clinician will identify any factors that may facilitate or complicate treatment, and
3. Clinician will establish a baseline from which to measure treatment effectiveness.
4. Clinician will work with patient to prioritize and select goals for treatment: typically the most distressing or impairing problem should be addressed first
5. Clinician should give priority to addressing problems that put the client’s health at risk, such as when necessary medical or dental treatments are being avoided.
6. Clinician will socialize the client to treatment
7. Clinician will use psychoeducation to emphasize that the goal of treatment is not to completely eliminate anxiety but to minimize the associated distress and avoidance through systematically confronting the feared stimuli
8. Clinician will identify issues of motivation or compliance that can be accounted for in the treatment plan and monitored throughout.
9. Clinician will use self-report measures, such as SUDS ratings and questionnaire-based measures, which should be collected in the initial assessment and can be incorporated throughout treatment to track session by session change.
DSM-5 Cluster: Obsessive-Compulsive and Related Disorders

OBSESSIVE-COMPULSIVE DISORDER
300.3 Obsessive-Compulsive Disorder
Specify if: with good or fair insight, with poor insight, or with absent insight/delusional beliefs

Treatment Objectives:

1. Ameliorate obsessional thoughts, impulses, and images that cause anxiety or distress.
2. Eliminate the excessive and unrealistic compulsions that interfere with the patient's ADLs.
3. Restore patient to optimal level of functioning.

Information about treatment modality:

Choosing treatment modality: CBT, SRIs, or combination

- CBT alone, consisting of exposure and response prevention, is recommended as initial treatment for a patient who is not too depressed, anxious, or severely ill to cooperate with this treatment modality, or who prefers not to take medications and is willing to do the work that CBT requires
- An SRI alone is recommended for a patient who is not able to cooperate with CBT, has previously responded well to a given drug, or prefers treatment with an SRI alone

Choosing psychopharmacological treatment

- Because the SSRIs have a less troublesome side-effect profile than clomipramine, an SSRI is preferred for a first medication trial

Choosing a specific form of psychotherapy

- CBT that relies primarily on behavioral techniques such as exposure and response prevention (ERP) is recommended because it has the best evidentiary support
- Psychodynamic psychotherapy may still be useful in helping patients overcome their resistance to accepting a recommended treatment by illuminating their reasons for wanting to stay as they are (e.g., best adaptation, secondary gains). It may also be useful in addressing the interpersonal consequences of the OCD symptoms

Treatment plan for Obsessive Compulsive Disorder:

1. Clinician will establish therapeutic alliance
2. Clinician will determine adequate therapeutic modality and will implement chosen psychotherapy modality
3. Clinician will make recommendations to PCP to implement psychopharmacological treatment
4. Clinician will regularly rate severity of symptoms using YBOCS to determine improvement over time
5. Clinician will evaluate safety of patient and others, and determine the need for hospitalization
6. Clinician will rule-out co-occurring disorders
7. Clinician will coordinate with other care providers and family members to enhance patient care
8. Clinician will rule-out neurobiological reasons for behavior, using a neurology referral if needed
9. Clinician will teach patient biological versus behavioral causes of OCD
10. Patient will assist clinician in determining a list of avoided behaviors, and rate them in ascending order
11. Exposure and response prevention will be implemented in a therapeutic setting
   a. Start with lowest number and encourage exposure to feared stimulus until physiological symptoms of fear subside
   b. Repeat successful tasks to build up confidence in abilities, and gradually move up to more difficult tasks
   c. Use SUDs to determine level of distress and accommodation to the fearful stimulus
12. Acquired skills will be generalized by patient to a variety of different settings, in ascending level of difficulty.
BODY DYSMORPHIC DISORDER
300.7 Body Dysmorphic Disorder (specify if with muscle dysmorphia)

Treatment Objectives:

1. Eliminate preoccupation with real or imagined flaw.
2. Eliminate time spent worrying about the defect.
3. Resolve conflicts that trigger or exacerbate obsession with the defect.
4. Reduce need for perfection and accept body as it is.
5. Eliminate excessive checking and grooming.
6. Develop improved social skills.
7. Control delusions.
8. Reduce and eliminate depression.
9. Restore optimum level of functioning.

Treatment plan for Body Dysmorphic Disorder:

Clinician will implement cognitive restructuring techniques

1. Clinician will teach client to challenge mind-reading
2. Clinician will use Mindfulness/Meta-Cognitive Therapy.
   a. Patient will learn to accept the presence of distorted thoughts and uncomfortable feelings without over-responding to them with avoidant and compulsive behaviors, which actually reinforce and worsen the thoughts and feelings,
3. Clinician will use Exposure and Response Prevention. BDD and obsessive-compulsive disorder (OCD) have distinct similarities. Patients who have BDD or OCD typically engage in ritualistic behaviors to avoid anxiety. To stop avoidance, patients create a hierarchy of situations that cause them anxiety, and give each situation a rating of 0—causes no anxiety or avoidance—to 100—causes intense anxiety and avoidance—working up to the situation that causes the most concern. While in the situation, patients also gather evidence about their beliefs.

Clinician will implement behavioral techniques:

1. Patient will decrease the number of times they do the behavior per day. Instead of checking the mirror 12 times a day, try reducing it to eight times.
2. Patient will spend less time on the behavior. If you typically look in the mirror for 20 minutes, reduce the time to 10 minutes.
3. Patient will delay the behavior. If you have the desire to check yourself in the mirror, consider postponing it. The more you delay a behavior, the less likely you are to rely on it in the future.
4. The patient will make it tougher to do the behavior. Some patients cut their hair throughout the day to get it just perfect. To avoid this, stop carrying scissors with you, have a loved one keep them or get rid of them altogether.
5. Clinician will use Mirror Retraining: patients learn to pay attention to their appearance in a new, non-judgmental way, learning to give neutral and positive feedback
6. Clinician will encourage active participation
7. Clinician will encourage social support and a healthy lifestyle
8. Clinician will discourage cosmetic procedures
Clinician will make medication recommendations to PCP as needed: Research has found that SSRIs are tremendously helpful for patients with BDD. These antidepressants—which include Prozac, Paxil, Celexa, Lexapro, Zoloft, Anafranil and Luvox—are also commonly prescribed for depression, OCD and social anxiety disorder, all of which share similarities with BDD.

Clinician will pay attention to and rule out co-occurring disorders
DSM-5 cluster: Trauma and stressor-related disorders

POSTTRAUMATIC STRESS DISORDER
309.81 Posttraumatic stress disorder
309.9 Unspecified Trauma and Stressor-Related Disorder
V-Codes: Child Sexual abuse; Spouse or Partner Violence, Sexual; Adult Sexual Abuse by Nonspouse or Nonpartner

Treatment Objectives:

1. Eliminate stressors associated with the traumatic event.
2. Relieve distress associated with the event. Manage
   i. Intrusive thoughts
   ii. Avoidance
   iii. Alterations in cognition/mood
   iv. Alterations in arousal/reactivity
3. Break pattern of avoidance and reduce emotional response to environmental cues
4. Eliminate pattern of alternating between thinking about and avoiding thinking about the trauma
5. Help patients assimilate experience into current assumptions
6. Return patient to premorbid level of functioning.
7. Prevent recurrence of symptoms.

Treatment plan for PTSD:
1. Assessment:
   a. Initial evaluation of trauma and associated symptoms
   b. Tests and other evaluations
   c. Consideration of medications
2. Socialization to treatment (explaining PTSD-reliving the trauma/avoiding it/signs of physical stress)
3. Anxiety management training (breathing relaxation, progressive muscle relaxation, visualization, thought-stopping, distraction)
4. Exposure:
   a. Imaginal exposure to trauma memories and to related cues: re-telling story with progressive amount of details, and ongoing measuring of SUDS
   b. In-vivo exposure to avoided situations
5. Cognitive restructuring: over-generalization, all or nothing thinking, and personalization
6. Coping with life problems: living situation, physical health, substance dependence
7. Phasing out treatment
ACUTE STRESS DISORDER

308.3 Acute Stress Disorder

Also use for:

309.3 Adjustment disorder with disturbance of conduct
309.4 Adjustment disorder with mixed disturbances of emotions and conduct
309.9 Unspecified adjustment disorder

Treatment Objectives:

1. Reduce patient's arousal symptoms: sleep disturbance, irritability, concentration, vigilance, restlessness.
2. Manage dissociative symptoms: Restore realization and personalization.
3. Eliminate avoidance symptoms: people, places, things, or activities.
4. Manage negative mood
5. Reduce intrusive symptoms (involuntary distressing memories, distressing dreams, and flashbacks)
6. Restore patient to optimal level of functioning.

Additional information:

Cognitive behavior therapies may speed recovery and prevent PTSD when therapy is given over a few sessions beginning 2–3 weeks after trauma exposure

Psychodynamic Modality:
One controlled trial of psychodynamic therapy versus hypnotherapy or desensitization versus no therapy showed all interventions were superior to the control condition (no treatment) in decreasing avoidance and intrusive symptoms
1- Clinician will investigate patient’s defenses and coping skills as they are a product of their biopsychosocial development and will focus on the meaning of the trauma for the individual in terms of prior psychological conflicts and developmental experience and relationships, as well as the particular developmental time of the traumatic occurrence(s). Clinician will examine the person’s overall capacity to cope with memories of traumatic event(s) and their triggers and the coping style they use to manage these memories
2- Clinician will focus on the effect of traumatic experience on the individual’s prior self-object experiences, overwhelmed self-esteem, altered experience of safety, and loss of self-cohesiveness and self-observing functions and will help the person identify and maintain a functional sense of self in the face of trauma
3- Clinician will address the subjective and interpersonal sustaining factors of the illness (e.g., shattered assumptions about attachments, issues of trust), as well as the changes in beliefs and world view and the widely altered threat perceptions often seen in chronic PTSD
4- Issues of transference could be explored to help the patient understand conscious and unconscious concerns surrounding the meaning of recent and more remote traumatic events in his or her life as they appear in the treatment
5- Awareness of countertransference will be used as a central component of treatment of traumatic experience as the therapist’s emotional response on hearing the patient describe the traumatic events can either facilitate or disrupt the therapeutic alliance, making ongoing attention to countertransference of particular importance in treating patients with ASD

Treatment Plan for Acute Stress Disorder:
1. Assess exposure to a traumatic event and establishing a diagnosis of ASD or PTSD
2. Encourage acutely traumatized persons to first rely on their inherent strengths, their existing support networks, and their own judgment may also reduce the need for further intervention
3. Evaluate the safety of patients and others
4. Determine treatment setting
5. Establish and maintaining a therapeutic alliance
6. Coordinate treatment effort with other providers
7. Monitor treatment response
8. Provide education
   a. Early supportive interventions, psychoeducation, and case management appear to be helpful in acutely traumatized individuals, because these approaches promote engagement in ongoing care and may facilitate entry into evidence-based psychotherapeutic and psychopharmacological treatments.
9. Enhance medication adherence by emphasizing to the patient
   • when and how often to take the medicine,
   • the expected time interval before beneficial effects of treatment may be noticed,
   • the necessity to take medication even after feeling better,
   • the need to consult with the physician before discontinuing medication, and
   • steps to take if problems or questions arise
10. Increase understanding of, and adaptation to, the psychosocial effects of the disorder
11. Evaluating and managing physical health and functional impairments
Dissociative Disorders Cluster

DISSOCIATIVE DISORDERS
300.14 Dissociative Identity Disorder
300.12 Dissociative Amnesia
300.6 Depersonalization/Derealization disorder
300.15 Unspecified Dissociative disorder
Somatic Symptoms and Related Disorders

300.82 Somatic Symptoms Disorder
300.7 Illness Anxiety Disorder
300.11 Conversion Disorder
300.19 Factitious Disorder
300.82 Unspecified Somatic Symptom and Related Disorder

Treatment Objectives:

1. Make patient aware of factitious nature of symptoms (for factitious disorder).
2. Explore the think between emotional symptoms and physical symptoms.
3. Eliminate need for hospitalization.
4. Acknowledge need for "sick role."
5. Reduce pathological behaviors.
6. Restore patient to optimum level of functioning.
7. Prevent relapse.

Treatment Plan for Somatic Symptoms Disorders:

Psychosocial interventions

1. Cognitive-behavioral psychotherapy strategies may be specifically helpful in reducing distress and high medical use. A strong relationship between the patient and the primary care physician can assist in long-term management.

2. Psychosocial interventions that focus on maintaining social and occupational function despite chronic medical symptoms may be helpful.

3. Recent studies have shown that cognitive-behavioral therapy reduces depressive symptoms in people with somatic diseases and should be used by clinician if symptoms of depression are present.

4. Psychoeducation can be helpful by letting the patient know that physical symptoms may be exacerbated by anxiety or other emotional problems. However, be careful because patients are likely to resist suggestions that their condition is due to emotional rather than physical problems.

5. The primary care physician should inform the patient that the symptoms do not appear to be due to a life-threatening, disabling, medical condition and should schedule regular visits for reassessment and reinforcement of the lacking severity of ongoing symptoms.

6. The patient also may be told that some patients with similar symptoms have had spontaneous improvement, implying that spontaneous improvement may occur. However, clinician should accept the patient's physical symptoms and not pursue a goal of symptom resolution.

7. Indeed, regular, noninvasive, medical assessment reduces anxiety and limits health care–seeking behavior; this may be facilitated by regularly scheduled visits with the patient's primary care physician. Clinician can work with PCP on facilitating that connection.

8. Clinician will encourage patients to remain active and limit the effect of target symptoms on the quality of life and daily functioning.
9. Clinician will encourage family members not to become preoccupied with the patient's physical symptoms or medical care. Family members should direct the patient to report symptoms to their primary care physician.
DSM-5 Cluster: Feeding and Eating Disorders

ANOREXIA NERVOSA

307.1 Anorexia Nervosa
Specify whether: Restricting type; Binge-eating/purging type

Treatment Objectives:

1. Normalizing eating
2. Restoring normal body weight
3. Improve family system

Treatment Plan Anorexia:

CBT for Anorexia Nervosa:

Phase I: Orientation to CBT, Engagement, and Motivation

1. Clinician will introduce patient to the Structure and Rationale of CBT
2. Clinician will focus on building a therapeutic alliance
3. Clinician will start CBT sessions that have an explicit internal structure that includes weight assessment and discussion of weight status, review of self-monitoring and between-session work
4. Clinician will let patient know that this approach to treatment recognize that EDs are multidetermined and that different factors are involved in the development and maintenance of the disorder
5. Clinician will establish a regular schedule for monitoring weight during treatment.
6. Working between Sessions will be used by clinician to offer the patient the opportunity to experiment with changes in the context of a supportive therapeutic environment
7. Self-Monitoring will include recording social and emotional experiences and situations that contextualize the ED
8. Assessing and Enhancing Motivation will emphasize the importance of acknowledging the ego-syntonic nature of extreme thinness and self-control and the desperation that is associated with “choosing” AN as a solution. Therapist is encouraged to explicitly acknowledge the difficulties of making real changes in one’s life and remind them not to “attach surplus meaning to resistance.”

PHASE II: Core Cognitive and Behavioral Interventions for AN

1. Clinician will establish weight gain protocol and meal planning
2. Clinician will use behavioral experimentation between sessions
3. Clinician will help with identifying and challenging Dysfunctional Thoughts
4. Clinician will aim at preventing Weight Loss after Minimum Target Weight Has Been Achieved
5. Clinician will address Body Image Disturbance
6. Clinician will combat excessive exercise. No exercise until a minimum target weight has been achieved for 1 month

PHASE III: Schema-Based Cognitive Therapy and Related Clinical Issues

1. Clinician will share general Outline of Schema-Based CBT
2. Patient will develop Affect Regulation and Interpersonal Effectiveness Skills
3. Clinician will use the therapeutic relationship to address maladaptive thoughts and schemas

PHASE IV: Ending Treatment and Relapse Prevention

Below is a list of possible interventions that may assist in the work around ending treatment.

1. Case summary: Ask your patient to write her own case summary, highlighting what was especially useful, what was difficult, etc.
2. Risks for relapse: Ask your patient to write about the risks that she sees on the horizon. In that regard it is also useful to have her identify cues that will tell her she is off course or at risk for relapsing and have her prepare a plan for how to minimize or avert such risk.
3. Goal Setting: Patients can prepare a list of goals for the coming month, 3 months, 1 year.
4. Encourage patients to review CBT materials from therapy and keep a folder of the materials that seem most relevant.
5. Have your patient project forward to when she is an old woman. As she reflects on the life she imagines, how does she want to be remembered (by the therapist, friends, or family)? What does she want her legacy to be? Throughout this discussion, you can link your patient’s desires to the year’s work of CBT.
6. Ask your patient to write about past relapses and to be as detailed as possible about the patterns that were central to relapsing; discuss with her how she can handle things differently this time.
7. Review specific processes of CBT interventions, such as food diaries, Dysfunctional Thought Record, and problem solving. Find out how the patient is using these instruments at the end of treatment and discuss how she can maximize their utility for transitioning out of treatment.
8. Role playing: Use this technique to anticipate and work through any anticipated difficult situations.
9. Explore what the patient thinks it would mean if she were to relapse. Does it mean that treatment didn’t work? If so, it may make her less likely to seek help when she needs it. It may be useful to use the analogy of a shower here (e.g., “You get dirty after a shower, but that doesn’t mean the shower didn’t work; moreover, getting dirty isn’t so scary when you know how to shower”).
10. Emphasize growth potential of slips.
11. Letting up on perfectionism and acceptance
12. Anticipating the loss
13. Acceptance that a successful intervention does not always prevent relapse
BULIMIA NERVOSA
307.51 Bulimia Nervosa

Treatment Objectives:
1. Restore healthy eating patterns.
2. Eliminate preoccupation with weight and body size.
3. Eliminate purging and other compensatory actions.
4. Reduce need to be perfect.
5. Develop new coping styles and improve interpersonal relationships.
6. Manage mood intolerance
7. Address low self-esteem

Information about the disorder:
The cognitive-behavioral theory proposes that binge eating is largely a product of these patients’ distinctive form of dietary restraint (attempts to restrict their eating), which may or may not be accompanied by actual dietary restriction (true undereating in a physiological sense). Additional mechanisms (mood intolerance, clinical perfectionism, core low self-esteem, and major interpersonal difficulties) may also be maintaining the maladaptive behavior.

Treatment Plan for Bulimia Nervosa:

Cognitive Behavioral Modality
Stage 1:
1. Engage the patient in treatment and the process of change
2. Jointly create a formulation of the processes maintaining the ED
3. Establish real-time life monitoring using thought and action records
4. Provide education, and to introduce two important procedures, “weekly weighing” and “regular eating.”
5. Involve significant others

Stage 2:
1. Review progress
2. Identify barriers to change
3. Modify the formulation as needed
4. Assess for other disorders
5. Plan Stage 3

Stage 3:
It is the main body of treatment, and addresses the key mechanisms that are maintaining the patient’s ED
a. The overevaluation of shape and weight and its various expressions including body-checking and avoidance
b. Dietary restraint
c. Event- or mood-related changes in eating (including mood intolerance)
d. Undereating and being underweight
e. Clinical perfectionism, core low self-esteem, and major interpersonal difficulties

Stage 4:
(1) Ensure that the changes made in treatment are maintained over the following months, and
(2) Minimize the risk of relapse in the long term.

Interpersonal Modality:
IPT is delivered in three phases:
1. Identifying the problem area(s) that will be the target for treatment.
2. Working on the target problem area(s).
3. Consolidating gains made during treatment and preparing patients for future work on their own.

1. An assignment of the “sick role” serves several functions, including granting the patient the permission to recover, delineating recovery as a responsibility of the patient, and allowing the patient to be relieved of other responsibilities in order to recover.

2. Therapy will focus on identifying and altering current dysfunctional interpersonal patterns related to ED features.

3. Clinician will conduct an “interpersonal inventory” with the patient and, in doing so, develops an interpersonal formulation that specifically relates to the patient’s ED. In the interpersonal formulation the clinician will link the patient’s ED to at least one of the four interpersonal problem areas:
   - Interpersonal deficits
   - Interpersonal role disputes
   - Role transitions
   - Grief

Therapeutic Techniques used for Interpersonal Therapy:
- Therapeutic Stance
- Focusing on Goals
- Making Connections
- Redirecting Issues Related to ED Symptoms

General Therapeutic Techniques
- Encourage acceptance of painful affects
- Teach the patient how to use affect in interpersonal relationships
- Help the patient experience suppressed affects

Psychodynamic Therapy Modality:
1. Working Through Projection and Projective Identification
2. Exploring the Psychological Meaning of Food and Eating
3. Confronting Narcissistic Self-Sufficiency
4. Facing Down Excessive Shame and Guilt
Sleep-wake disorders cluster

SLEEP DISORDER
780.52 Insomnia disorder
780.54 Hypersomnolence disorder
327.23 Obstructive Sleep Apnea Hypopnea
327.42 Rapid eye movement sleep behavior disorder
307.47 Nightmare disorder
780.59 Unspecified Sleep-Wake disorder

Treatment Objectives:

1. Primary Goals:
   a. Improvement in sleep quality and/or time.
   b. Improvement of insomnia-related daytime impairments such as improvement of energy, attention or memory difficulties, cognitive dysfunction, fatigue, or somatic symptoms.

2. Other Goals:
   a. Improvement in an insomnia symptom (SOL (sleep onset latency), WASO (wake after sleep onset), # awakenings) such as:
      i. SOL <30 minutes and/or
      ii. WASO <30 minutes and/or
      iii. Decreased frequency of awakenings or other sleep complaints
      iv. TST (total sleep time) >6 hours and/or sleep efficiency >80% to 85%.
   b. Formation of a positive and clear association between the bed and sleeping
   c. Improvement in sleep related psychological distress

Note: Rule out other mental disorders, general medical conditions, and drug abuse.

Information about the disorder:

Psychological and Behavioral Therapies:

Psychological and behavioral interventions are effective and recommended in the treatment of chronic primary and comorbid (secondary) insomnia.

• These treatments are effective for adults of all ages, including older adults, and chronic hypnotic users.
• These treatments should be utilized as an initial intervention when appropriate and when conditions permit.

Initial approaches to treatment should include at least one behavioral intervention such as stimulus control therapy or relaxation therapy, or the combination of cognitive therapy, stimulus control therapy, sleep restriction therapy with or without relaxation therapy—otherwise known as cognitive behavioral therapy for insomnia (CBT-I).

Multicomponent therapy (without cognitive therapy) is effective and recommended therapy in the treatment of chronic insomnia.

Other common therapies include sleep restriction, paradoxical intention, and biofeedback therapy.

Although all patients with chronic insomnia should adhere to rules of good sleep hygiene, there is insufficient evidence to indicate that sleep hygiene alone is effective in the treatment of chronic insomnia. It should be used in combination with other therapies.

When an initial psychological/behavioral treatment has been ineffective, other psychological/behavioral therapies, combination CBT-I therapies, combined treatments (see below), or occult comorbid disorders may next be considered.
Pharmacological Treatment:

Short-term hypnotic treatment should be supplemented with behavioral and cognitive therapies when possible. (Consensus)

When pharmacotherapy is utilized, the choice of a specific pharmacological agent within a class, should be directed by: (1) symptom pattern; (2) treatment goals; (3) past treatment responses; (4) patient preference; (5) cost; (6) availability of other treatments; (7) comorbid conditions; (8) contraindications; (9) concurrent medication interactions; and (10) side effects.

For patients with primary insomnia (psychophysiologic, idiopathic or paradoxical ICSD-2 subtypes), when pharmacologic treatment is utilized alone or in combination therapy, the recommended general sequence of medication trials is:

- Short-intermediate acting benzodiazepine receptor agonists (BZD or newer BzRAs) or ramelteon: examples of these medications include zolpidem, eszopiclone, zaleplon, and temazepam
- Alternate short-intermediate acting BzRAs or ramelteon if the initial agent has been unsuccessful
- Sedating antidepressants, especially when used in conjunction with treating comorbid depression/anxiety: examples of these include trazodone, amitriptyline, doxepin, and mirtazapine
- Combined BzRA or ramelteon and sedating antidepressant
- Other sedating agents: examples include anti-epilepsy medications (gabapentin, tiagabine) and atypical antipsychotics (quetiapine and olanzapine)

These medications may only be suitable for patients with comorbid insomnia who may benefit from the primary action of these drugs as well as from the sedating effect.

Over-the-counter antihistamine or antihistamine/analgesic type drugs (OTC “sleep aids”) as well as herbal and nutritional substances (e.g., valerian and melatonin) are not recommended in the treatment of chronic insomnia due to the relative lack of efficacy and safety data.

Older approved drugs for insomnia including barbiturates, barbiturate-type drugs and chloral hydrate are not recommended for the treatment of insomnia.

The following guidelines apply to prescription of all medications for management of chronic insomnia:

- Pharmacological treatment should be accompanied by patient education regarding: (1) treatment goals and expectations; (2) safety concerns; (3) potential side effects and drug interactions; (4) other treatment modalities (cognitive and behavioral treatments); (5) potential for dosage escalation; (6) rebound insomnia.
- Patients should be followed on a regular basis, every few weeks in the initial period of treatment when possible, to assess for effectiveness, possible side effects, and the need for ongoing medication.
- Efforts should be made to employ the lowest effective maintenance dosage of medication and to taper medication when conditions allow.
- Medication tapering and discontinuation are facilitated by CBT-I.
- Chronic hypnotic medication may be indicated for long-term use in those with severe or refractory insomnia or chronic comorbid illness. Whenever possible, patients should receive an adequate trial of cognitive behavioral treatment during long-term pharmacotherapy.

Long-term prescribing should be accompanied by consistent follow-up, ongoing assessment of effectiveness, monitoring for adverse effects, and evaluation for new onset or exacerbation of existing comorbid disorders

Long-term administration may be nightly, intermittent (e.g., three nights per week), or as needed.

Combined Treatments:

The use of combined therapy (CBT-I plus medication) should be directed by (1) symptom pattern; (2) treatment goals; (3) past treatment responses; (4) patient preference; (5) cost; (6) availability of other treatments; (7) comorbid conditions; (8) contraindications; (9) concurrent medication interactions; and (10) side effects.

Combined therapy shows no consistent advantage or disadvantage over CBT-I alone. Comparisons to long-term pharmacotherapy alone are not available.
Treatment Plan Insomnia:

Types of cognitive behavioral therapies:

1. Stimulus control is designed to extinguish the negative association between the bed and undesirable outcomes such as wakefulness, frustration, and worry. These negative states are frequently conditioned in response to efforts to sleep as a result of prolonged periods of time in bed awake. The objectives of stimulus control therapy are for the patient to form a positive and clear association between the bed and sleep and to establish a stable sleep-wake schedule.
   a. Instructions: Go to bed only when sleepy; maintain a regular schedule; avoid naps; use the bed only for sleep; if unable to fall asleep (or back to sleep) within 20 minutes, remove yourself from bed—engage in relaxing activity until drowsy then return to bed—repeat this as necessary. Patients should be advised to leave the bed after they have perceived not to sleep within approximately 20 minutes, rather than actual clock-watching which should be avoided.

2. Relaxation training such as progressive muscle relaxation, guided imagery, or abdominal breathing, is designed to lower somatic and cognitive arousal states which interfere with sleep. Relaxation training can be useful in patients displaying elevated levels of arousal and is often utilized with CBT.
   a. Instructions: Progressive muscle relaxation training involves methodical tensing and relaxing different muscle groups throughout the body. Specific techniques are widely available in written and audio form.

3. Cognitive Behavioral Therapy for Insomnia or CBT-I is a combination of cognitive therapy coupled with behavioral treatments (e.g., stimulus control, sleep restriction) with or without relaxation therapy. Cognitive therapy seeks to change the patient’s overvalued beliefs and unrealistic expectations about sleep. Cognitive therapy uses a psychotherapeutic method to reconstruct cognitive pathways with positive and appropriate concepts about sleep and its effects. Common cognitive distortions that are identified and addressed in the course of treatment include: “I can’t sleep without medication,” “I have a chemical imbalance,” “If I can’t sleep I should stay in bed and rest,” “My life will be ruined if I can’t sleep.”

4. Multicomponent therapy [without cognitive therapy] utilizes various combinations of behavioral (stimulus control, relaxation, sleep restriction) therapies, and sleep hygiene education. Many therapists use some form of multimodal approach in treating chronic insomnia.

5. Sleep restriction initially limits the time in bed to the total sleep time, as derived from baseline sleep logs. This approach is intended to improve sleep continuity by using sleep restriction to enhance sleep drive. As sleep drive increases and the window of opportunity for sleep remains restricted with daytime napping prohibited, sleep becomes more consolidated. When sleep continuity substantially improves, time in bed is gradually increased, to provide sufficient sleep time for the patient to feel rested during the day, while preserving the newly acquired sleep consolidation. In addition, the approach is consistent with stimulus control goals in that it minimizes the amount of time spent in bed awake helping to restore the association between bed and sleeping.
   a. Instructions (Note, when using sleep restriction, patients should be monitored for and cautioned about possible sleepiness):
      i. Maintain a sleep log and determine the mean total sleep time (TST) for the baseline period (e.g., 1-2 weeks)
      ii. Set bedtime and wake-up times to approximate the mean TST to achieve a >85% sleep efficiency (TST/TIB × 100%) over 7 days; the goal is for the total time in bed (TIB) (not <5 hours) to approximate the TST.
iii. Make weekly adjustments: 1) for sleep efficiency (TST/TIB × 100%) >85% to 90% over 7 days, TIB can be increased by 15-20 minutes; 2) for SE <80%, TIB can be further decreased by 15-20 minutes.

iv. Repeat TIB adjustment every 7 days.

6. Paradoxical intention is a specific cognitive therapy in which the patient is trained to confront the fear of staying awake and its potential effects. The objective is to eliminate a patient’s anxiety about sleep performance.

7. Biofeedback therapy trains the patient to control some physiologic variable through visual or auditory feedback. The objective is to reduce somatic arousal.

8. Sleep hygiene therapy involves teaching patients about healthy lifestyle practices that improve sleep. It should be used in conjunction with stimulus control, relaxation training, sleep restriction or cognitive therapy.
   a. Instructions include, but are not limited to, keeping a regular schedule, having a healthy diet and regular daytime exercise, having a quiet sleep environment, and avoiding napping, caffeine, other stimulants, nicotine, alcohol, excessive fluids, or stimulating activities before bedtime.
SEXUAL DYSFUNCTION
302.74 Delayed Ejaculation
302.72 Erectile disorder
302.73 Female orgasmic disorder
302.72 Female sexual interest/arousal disorder
302.76 Genito-pelvic pain/penetration disorder
302.71 Male hypoactive sexual desire disorder
302.75 Premature ejaculation
302.70 Unspecified sexual dysfunction
DSM-5 Substance-Related and Addictive Disorder Cluster

PATHOLOGICAL GAMBLING
312.31 Gambling Disorder
Specify if: Episodic, persistent; in early remission, in sustained remission; mild, moderate, severe.

Treatment Objectives:
1. Control anger and anxiety over idea of curtailing gambling.
2. Reframe denial/magical thinking/superstition with reality.
3. Use new ways of coping with distress that do not include gambling
4. Determine family connections with gambling.
5. Strengthen family support and improve interaction.
6. Confront lying and criminal behavior.
7. Confront destructive impact on all activities of daily living (ADLs).
8. Prevent relapse.

Treatment Plan for Pathological Gambling:
The treatment included two components, cognitive therapy and relapse prevention.
The cognitive therapy included four targets:
1. Understanding the concept of randomness: The therapist explained the concept of chance — that each turn is independent, that no strategies exist to control the outcome, that there is a negative expectation of return, and that it is impossible to predict the outcome of the game.
2. Understanding the erroneous beliefs held by gamblers: This component mainly addressed the difficulty individuals had understanding the principle of independence among random events. The therapist explained how the illusion of control contributes to forming gambling habits and corrected the mistaken beliefs held by the gambler, such as believing that you can use past events to make a better prediction or a sound bet.
3. Awareness of inaccurate perceptions: The participant was informed that incorrect perceptions prevail during gambling.
4. Cognitive corrections of erroneous perceptions: The therapist corrected inadequate verbalizations and faulty beliefs using a recording of the patient’s vocal expressions made during a session of imaginary gambling, such as: “If I lose four times in a row, I’m sure to win next time.”

The relapse prevention component was adapted from the model for alcoholics.
1. The possibility of relapse will be discussed with patient, and they learn to become aware of high-risk situations and thoughts that might lead them to start gambling again.
2. Patients can be asked to describe past relapses and identify high-risk situations and flawed thoughts associated with these situations.
3. The clinician will help patients correct these perceptions to help avoid relapses.
Substance-Related and Addictive Disorders

Alcohol-related disorders:
Alcohol use disorder
  305.00 Mild
  303.90 Moderate
  303.90 Severe
303.00 Alcohol Intoxication
291.81 Alcohol Withdrawal
291.9 Unspecified Alcohol-related disorder

Caffeine-related disorders:
305.90 Caffeine Intoxication

Cannabis-related disorders:
Cannabis use disorder
  305.20 Mild
  304.30 Moderate
  304.30 Severe
292.89 Cannabis Intoxication
292.0 Cannabis Withdrawal
292.9 Unspecified Cannabis-related disorder

Hallucinogen-related disorders

Inhalant-related disorders

Opioid-related disorders:
Opioid use disorder
  305.50 Mild
  304.00 Moderate
  304.00 Severe
292.89 Opioid intoxication
292.0 Opioid withdrawal
292.9 Unspecified opioid-related disorders

Sedative-hypnotic-, or anxiolitic-related disorder:
Sedative-hypnotics use disorder
  305.50 Mild
  304.00 Moderate
  304.00 Severe
292.89 Sedative-hypnotics intoxication
292.0 Sedative-hypnotics withdrawal
292.9 Unspecified Sedative-hypnotics-related disorders

Stimulant-related disorders:
Stimulant use disorder
  Mild
    305.70 Amphetamine-type substance
    305.60 Cocaine-type substance
    305.70 Other or unspecified stimulant
  Moderate
    304.40 Amphetamine-type substance
    304.20 Cocaine-type substance
    304.40 Other or unspecified stimulant
  Severe
304.40 Amphetamine-type substance
304.20 Cocaine-type substance
304.40 Other or unspecified stimulant

292.89 Stimulant intoxication
292.0 Stimulant withdrawal

Tobacco-related disorders

Other or unknown substance related disorders
Specify if: mild, moderate, or severe
Specify if: in early remission, in sustained remission
Specify if: in a controlled environment
Specify if: with perceptual disturbances

Treatment Objectives:
2. Recognize and accept abuse as a disease.
3. Refer to AA, NA, or rational recovery group.
4. Sustain sobriety.
5. Increase quality of life.
7. Reduce/eliminate shame/guilt.
8. Identify people, places, and things that trigger abuse.

Treatment Plan Substance-related disorders:
1. Discuss treatment plan and agree on target problems.
2. Cultivate therapeutic alliance or collaborative relationship with patient to instill trust and enhance outcome of treatment.
3. Explain possible need for hospitalization.
4. Refer for or administer a Substance Abuse Screening to accurately identify chemical dependency.
5. Assess possible homicidal or suicidal effects of substance dependence. If homicidal, notify authorities. If actively suicidal, hospitalize immediately. If patient has suicidal ideations, but no plan, enter into suicide pact.
6. Refer patient for psychiatric evaluation and/or hospitalization if required.
7. Refer patient for medical evaluation to identify physical problems caused by or exacerbated by substance use.
8. Create genogram to better understand interactions of family members.
10. Explore level of distressed thinking or denial, and assess patient's level of cognitive and intellectual functioning that contributes to substance use.
11. Help patient overcome denial by looking at the facts of substance use and the problems they have caused.
12. Discuss importance of medication regimen.
13. Evaluate patient for possible dual diagnosis and treat other symptoms, e.g., anxiety, depression, social phobia, etc. See appropriate treatment plan.
14. Refer for acupuncture if appropriate.
15. Explore past patterns of substance use in relation to life stressors.
16. Refer patient to twelve-step program (NA or AA) or to rational recovery group if NA/AA is rejected.
17. Explain mourning process and help patient mourn substance of choice.
18. Identify person, place, and thing triggers that may cause backsliding or relapse.
19. Assign patient to maintain a daily journal of his/her feelings and reactions.
20. Teach patient relaxation techniques, hypnosis, or creative visualization to cope with feelings. Provide audiotape for home use.
21. Investigate family conflicts and identify enablers that aid in patient's substance use.
22. Investigate ritualistic behaviors related to substance use and teach patient more rational behaviors.
23. Explore and identify the effects of substance use on the patient's social, family, occupational, and other relations.
24. Conduct family sessions or refer to family therapist.
25. Refer family to Alanon for support.
26. Assign books on substance disorders as homework.
27. Review issues of shame and guilt that may cause or contribute to substance use and dependence.
28. Obtain a contract or commitment for abstinence.
29. Discuss alternate behaviors to substance use, e.g., exercise, sports, hobbies, etc.
31. Help patient create support systems and resources in environment to maintain sobriety.
32. Conduct role-playing exercises to help patient deal with persons, places, and things that trigger substance use.
33. Guide patient in practicing his new skills in the real world.
34. Retrain as necessary and reinforce successes.
35. If appropriate, identify patient's lack of empathy for others.
36. Teach patient alternative constructive behaviors to prevent relapse.
37. Discuss and resolve issues of separation anxiety and dependence with patient. Develop termination plan.
38. Refer patient to active support group.
DSM-5 Neurocognitive Disorders Cluster

780.09 Unspecified Delirium

Treatment Objectives:

1. Adequately diagnose the disorder
2. Determine the cause of the delirium
3. Stop or reverse the symptoms of Delirium

Additional Information Delirium:

Components of delirium management include supportive therapy and pharmacologic management.

- Fluid and nutrition should be given carefully because the patient may be unwilling or physically unable to maintain a balanced intake. For the patient suspected of having alcohol toxicity or alcohol withdrawal, therapy should include multivitamins, especially thiamine.
- Reorientation techniques or memory cues such as a calendar, clocks, and family photos may be helpful. The environment should be stable, quiet, and well-lit. Interventions include frequent orientation of patients to time, place and situation; early mobilization; attention to hearing and visual deficits and aids as appropriate; preservation of sleep-wake cycles; and adequate hydration.
- Delirium that causes injury to the patient or others should be treated with medications. The most common medications used are neuroleptics. Benzodiazepines often are used for withdrawal states.
- Delirium or acute confusional state is a transient global disorder of cognition. The condition is a medical emergency associated with increased morbidity and mortality rates. Early diagnosis and resolution of symptoms are correlated with the most favorable outcomes. Therefore, it must be treated as a medical emergency.

Medication Summary

Delirium that causes injury to the patient or others should be treated with medications.

Neuroleptics

The medication of choice in the treatment of psychotic symptoms: Older neuroleptics such as haloperidol, a high-potency antipsychotic, are useful but have many adverse neurological effects. Newer neuroleptics such as risperidone, olanzapine, and quetiapine relieve symptoms while minimizing adverse effects. Initial doses may need to be higher than maintenance doses. Use lower doses in patients who are elderly. Discontinue these medications as soon as possible. Attempt a trial of tapering the medication once symptoms are in control. Neuroleptics can be associated with adverse neurological effects such as extrapyramidal symptoms, neuroleptic malignant syndrome, and tardive dyskinesia. Doses should be kept as low as possible to minimize adverse effects. Paradoxical and hypersensitivity reactions may occur. (e.g. Haloperidol (Haldol), Risperidone (Risperdal))

Short-acting sedatives

Reserved for delirium resulting from seizures or withdrawal from alcohol or sedative hypnotics: Coadministration with neuroleptics is only considered in patients who tolerate lower doses of either medication or have prominent anxiety or agitation. Benzodiazepines are preferred over neuroleptics for treatment of delirium resulting from alcohol or sedative hypnotic withdrawal. They also may be used when unknown substances may have been ingested and may be helpful in delirium from hallucinogen, cocaine, stimulant, or PCP toxicity. Use special precaution when using benzodiazepines because they may cause respiratory
depression, especially in patients who are elderly, those with pulmonary problems, or debilitated patients. E.g. Lorazepam (Ativan)

**Vitamins**
Patients with alcoholism and patients with malnutrition are prone to thiamine and vitamin B-12 deficiency, which can cause delirium. (E.g. Thiamine (Thiamilate) Cyanocobalamin (Crystamine, Cyomin, Nascobal)

Further Inpatient Care:
Carefully assess patients to determine their level of care needs. Assessment should include behavior (24 h), daily mental status, potential for injury, and underlying medical and metabolic status.

Further Outpatient Care:
It is not unusual for patients who are elderly to require 6-8 weeks or longer for full recovery. In particular, elderly patients with postacute care complications are at risk for prolonged and persistent delirium.

**Deterrence/Prevention:**
- Prevention should be the goal because delirium is associated with adverse outcomes and high health care costs.
- A multicomponent intervention study that targeted cognitive impairment, sleep deprivation, immobility, visual impairment, hearing impairment, and dehydration showed significant reduction in the number and duration of episodes of delirium in older patients who were hospitalized.
- Patients who are at high risk for delirium should be monitored closely as outpatients, during hospitalization, and throughout surgical procedures.
- Physicians should become familiar with prescribing practices for patients who are elderly, keeping dosages low and avoiding medications that cause delirium.
- Monitoring the patient's mental status as a vital sign helps to diagnose delirium early.

**Prognosis:**
- Resolution of symptoms may take longer in patients with poor premorbid cognitive function, incorrect or incomplete diagnosis of contributing factors, and structural brain diseases treated with large doses of psychoactive medications prior to the onset of acute medical illness.
- For some patients, the cognitive effects of delirium may resolve slowly or not at all.

**Treatment Plan Delirium:**
1. Clinician will educate families and patients regarding the etiology and course of disease
2. Clinician will educate the patient, family, and primary caregivers about future risk factors.
3. Families may worry that the patient has brain damage or a permanent psychiatric illness. Clinician will provide reassurance that delirium often is temporary and is the result of a medical condition.
4. Clinician may suggest that family members or friends visit the patient, usually one at a time, and provide a calm and structured environment.
5. Clinician may encourage them to furnish some familiar objects, such as photos or a favorite blanket, to help reorient the patient and make the patient feel more secure.
Probable major neurocognitive disorder due to Alzheimer’s disease  
294.11 With behavioral disturbances  
294.10 Without behavioral disturbances  
331.9 Possible major neurocognitive disorder due to Alzheimer’s disease  
331.83 Mild neurocognitive disorder due to Alzheimer’s disease  

Major or mild frontotemporal neurocognitive disorder  
Major or mild neurocognitive disorder with Lewy Bodies  

Major or mild vascular neurocognitive disorder  
290.40 With behavioral disturbances  
290.40 Without behavioral disturbances  

Major or mild neurocognitive disorder due to traumatic brain injury  
Major or mild neurocognitive disorder due to HIV infection  
Major or mild neurocognitive disorder due to prion disease  
Major or mild neurocognitive disorder due to Parkinson’s disease  
Major or mild neurocognitive disorder due to Huntington’s disease  
Major or mild neurocognitive disorder due to another medical condition  
Major or mild neurocognitive disorder due to multiple etiologies  

799.59 Unspecified Neurocognitive disorder  

Treatment Objectives:  
1. maintain quality of life  
2. maximize function in daily activities  
3. enhance cognition, mood and behavior  
4. foster a safe environment  
5. promote social engagement, as appropriate  
6. monitor patient's health and cognition  
7. education and support to patients and their families  
8. initiate pharmacologic and nonpharmacologic treatments as appropriate  
9. assess cognitive abilities using neuropsychological testing  

Treatment Plan Neurocognitive Disorder:  
Clinician will confirm or revise diagnosis using screens or neuropsychological testing  
• Assess specific Neurocognitive domains  
• Determine whether changes are age-appropriate or related to cognitive decline  
• Differentiate between causes of brain dysfunction  
• Make recommendations designed to best manage assessed weaknesses and make most of assessed strengths  
• Determine how neurological condition has affected behavior  
• Determine how patient can best compensate for deficits, how he/she reacts to them, and whether and how retraining could be profitable  
• Use repeated testing to document changes, particularly when one aspect of the patient’s functioning appears in flux  

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Clinician will monitor and improve patient’s socialization:

Psychosocial interventions used might include:
- Schedule Routine activity.
- Separate the person from what seems to be upsetting him or her.
- Assess for the presence of pain, constipation or other physical problem.
- Review medications, especially new medications
- Travel with them to where they are in time.
- Don’t disagree; respect the person’s thoughts even if incorrect.
- Discuss interventions with staff and family members

Clinician will improve patient’s response to staff members or family

Physical interaction used might include:
- Maintain eye contact, get to their height level, and allow space.
- Speak slowly and calmly in a normal tone of voice. The person may not understand the words spoken, but he or she may pick up the tone of the voice behind the words and respond to that.
- Avoid point finger-pointing, scolding or threatening.
- Redirect the person to participate in an enjoyable activity or offer comfort food he or she may recognize and like.
- If you appear to be the cause of the problem, leave the room for a while.
- Validate that the person seems to be upset over something. Reassure the person that you want to help. Avoid asking the person to do what appears to trigger an agitated or aggressive response.
- Discuss interventions with staff and family members

Clinician will monitor and manage patient’s behavioral disturbances

In making the decision to utilize antipsychotic therapy the following should be considered:
- Identify and remove triggers for Behavioral and Psychotic Symptoms of Dementia (BPSD): pain, under/over stimulation, disruption of routine, infection, change in caregiver, etc.
- Initiate non-pharmacologic alternatives as first-line therapy for control of behaviors.
- Assess severity and consequences of BPSD. Less-severe behaviors with limited consequences of harm to individual or caregiver are appropriate for non-pharmacologic therapy, not antipsychotic therapy. However, more severe or “high risk” behaviors such as frightening hallucinations, delusions or hitting may require addition of antipsychotic trial.
- Determine overall risk to self or others of BPSD, and discuss with doctor the risks and benefits with and without antipsychotics. Some behaviors may be so frequent and escalating that they result in harm to the person with dementia and caregiver that will in essence limit the life-expectancy and or quality of life of the person with a Neurocognitive. Accept that this is a short-term intervention that must be regularly re-evaluated with your healthcare professional for appropriate time of cessation.
- Discuss medication interventions with staff, family, and attending physician.
DSM-5 Personality Disorders Cluster

ANTISOCIAL PERSONALITY DISORDER
301.7 Antisocial Personality Disorder

Treatment Objectives:
1. Curtail any unlawful activities.
2. Confront need to lie and deceive others.
3. Control impulsivity, learn to plan ahead.
4. Treat depression and anxiety.
5. Recognize importance of safety for self and others.
6. Develop successful work habits.
7. Recognize importance of financial responsibility.

Treatment Plan for Antisocial Personality Disorder:
1. Assess for comorbid disorders (substance use, depression, anxiety)
2. Treat comorbid disorders
3. Use motivational interviewing to determine anchors that would push the patient to change their behaviors
4. Focus on the patient’s personal gain at achieving a prosocial goal, as opposed to focusing on empathy training.
BORDERLINE PERSONALITY DISORDER
301.83 Borderline Personality Disorder

Treatment Objectives:
1. Understand that fears of abandonment are unreal.
2. Control self-damaging impulsivity.
3. Eliminate self-mutilating behavior.
4. Control suicidal ideations, threats.
5. Stabilize sense of self.
6. Realize that all people are good and bad.
7. Control reactive depression and anxiety.
8. Learn improved reactions to stress.
9. Medicate and/or hospitalize as necessary.

Psychotropic interventions:
(i) Treatment of affective dysregulation symptoms-SSRIs
(ii) Treatment of impulsive-behavioral dyscontrol symptoms-SSRI, maybe add low dose neuroleptic
(iii) Treatment of cognitive-perceptual symptoms –low-dose neuroleptics

Treatment Plan for Borderline Personality Disorder

1. Therapy/skills training in DBT
2. Borderline characteristics with specific skill:
3. Interpersonal chaos managed with interpersonal effectiveness training
   a. Attending to relationships
   b. Balancing priorities versus demands in life and relationships
   c. Balancing “what” to “should” ratios in relationships
   d. Building mastery and self-respect
4. Labile affect managed with emotion regulation training
   a. Identifying and labeling emotion
   b. Identify obstacle to changing emotion
   c. Reducing vulnerability to “emotional mind”
   d. Increasing positive emotional events
   e. Taking opposite action
   f. Applying distress tolerance techniques
5. Impulsiveness managed with distress tolerance training
   a. Increasing silks for tolerance and surviving crises: activities, contributing, comparisons, emotions, pushing away, thoughts, sensations
b. Using self-soothing: imagery, meaning, prayer, relaxation, one thing in the moment, vacation, encouragement

6. Confusion about self/cognitive dysregulation managed with core mindfulness training
   a. Review diary cards
   b. Explain states of mind reasonable v/s emotion mind v/s wise mind
   c. “What” skills: observing, describing, participating
   d. “How” skills: non-judgmental, one-mindful, effective
PARANOID PERSONALITY DISORDER
301.0 Paranoid Personality Disorder

Treatment Objectives:
1. Test and resolve unsubstantiated suspicions of exploitation, deception, or harm by others.
2. Recognize feelings of distrust or disloyalty as unjustified.
3. Recognize as unjustified feelings that friends will betray confidences.
4. Realize that routine remarks and events are benign.
5. Learn to forgive and forget imagined slights and insults.
6. Test and resolve perceived attacks on character or reputation.
7. Control urges to retaliate in anger.

Treatment Plan Paranoid Personality Disorder

1. Build the level of trust through consistent eye contact, active listening, positive regard, and warm acceptance to help increase ability to identify and express feelings.
2. Role model a calm, tolerant demeanor during therapy to decrease patient's fear of others.
3. Assess the nature and extent of paranoia, exploring for delusional components.
4. Explore fears of personal inadequacy and vulnerability.
5. Interpret fears of own anger as the source for mistrust of others.
6. Assess historical sources of vulnerability in family of origin experiences.
7. Assess social interactions and explore distorted cognitive beliefs operative during interactions.
8. Assess and monitor necessity for use of antipsychotic medication to counteract altered thought processes.
9. Refer and arrange for an evaluation for psychotropic medications.
10. Monitor medications' compliance, effectiveness, and side effects.
11. Report to physician on effectiveness and side effects and confront patient when he or she is not taking medication as prescribed.
12. Complete or refer for a psychological evaluation to assess for possible psychotic ideations.
13. Refer to a neuropsychological evaluation to rule out any organic factors.
14. Help patient see the pattern of distrusting others as related to own fears of inadequacy.
15. Give alternative explanations for others' behavior that counter pattern of assumption of others' malicious intent.
16. Ask patient to complete a cost benefit analysis around his or her specific fears and process exercise in therapy.
17. Complete conjoint sessions with significant others to assess and reinforce verbalizations within family group.
18. Confront irrational distrust of others and provide alternate reality based information to support trust.
19. Encourage the patient to confront out his or her beliefs regarding others by verifying conclusions with others.
20. Carry out role-playing, behavioral rehearsal, and role reversal to increase empathy for others and understanding of the impact of his or her behavior on others.
SCHIZOID PERSONALITY DISORDER
301.20 Schizoid Personality Disorder

Treatment Objectives:
1. Evaluate psychiatrically for medication and monitor compliance.
2. Adopt alternate means to deal effectively with anger.
3. Learn appropriate reactions to the routine events of life.
5. Provide vocational counseling as necessary.
6. Improve interactions with others.
7. Reduce maladaptive functioning.
8. Achieve moderate behavior.
9. Increase overall quality of life.

Treatment Plan Schizoid Personality Disorder:

• Clinician will understand that silence is a non-verbal form of relating rather than as treatment resistance.
  Resistance to silence must be controlled or eliminated.
• Clinician will help patient correct their emotional experience. Patient’s emotions may be very controlled.
  They must learn to deal with stronger emotions that may seem threatening without internalizing them.
• If the clinician believes it is warranted, clinician should role-play social skills development. This can easily
  be done in the course of counseling and employed as homework assignments.
• As therapy progresses, clinician should carefully increase social interaction on the part of the client. It is
  important that this increase in interaction should be carefully discussed with the individual. Clinician must be
  sensitive to the emotional reactions of the client regarding this progress. Also, when the patient is successful in
  engaging in increased social interaction the therapist must note the progress that he/she has made. Complete
  assessment of increased social interaction must be made and both the positive and negative accomplishments
  must be noted. The negative issues must be analyzed and any residual emotional hesitancy must be eliminated.
• It is important in this process that the therapist completely involves the client in the potential for growth in
  interpersonal communication. Prior to homework assignments, the clinician and the patient must be in full
  agreement regarding the exercise.
• All social interactions should be appropriate to the growth level of the client. The patient should never be
  “pushed” beyond their emotional limits. This could cause sudden cessation of therapy and relapse.
• The clinician must defuse and eliminate the patient’s belief that they are defective, bad, unwanted, or inferior
  to others.
• The patient must be moved away from social isolation. They may feel that they are alienated, different from
  others, or not part of any group.
• The individual must enlarge their acceptance of emotions. They will typically refrain from emotions that are
  “charged,” especially in interpersonal situations. This issue must be resolved and those “charged” emotions
  must be made acceptable to the individual.
• The patient’s belief that they must suppress their own desires, needs, and feelings in order to meet the needs
  of others must be corrected. To some degree, this will be part of the social training that the clinician does.
SCHIZOTYPAL PERSONALITY DISORDER
301.22 Schizotypal Personality Disorder

DEPENDENT PERSONALITY DISORDER
301.6 Dependent personality disorder

HISTRIONIC PERSONALITY DISORDER
301.50 Histrionic Personality Disorder

NARCISSISTIC PERSONALITY DISORDER
301.81 Narcissistic Personality Disorder

AVOIDANT PERSONALITY DISORDER
301.82 Avoidant Personality Disorder
GENERAL MEDICAL CONDITION
316 Psychological Factors Affecting Other Mental Conditions
See Adjustment Disorders

PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION
316 Psychological Factors Affecting Other Mental Conditions

Other Conditions That May be a Focus of Clinical Attention

OCCUPATIONAL PROBLEM
V62.29 Other Problems Related to Employment

PARENT-CHILD RELATIONAL PROBLEM
V61.20 Parent-Child Relational Problem

PARTNER RELATIONAL PROBLEM
V61.10 Relationship Distress with Spouse or Intimate partner
Treatment Plans Based on Theoretical Orientation

CBT Treatment Plan
1. Use Socratic questioning for questioning maladaptive thoughts and beliefs. This process involves asking a series of open-ended, brief questions that guide the patient to discover his/her idiosyncratic thoughts, feelings, or behaviors associated with a particular situation.
2. Use dysfunctional thought records
   a. First three columns are used for identifying troubling situations and the accompanying emotions and dysfunctional thoughts.
3. Identify immediate beliefs and core beliefs.
4. Challenge maladaptive thoughts using psychoeducation, thought records, and event testing.
5. Use reframing.
6. Develop balanced thinking whereas all sides of a situation are taken into consideration.
7. Re-introducing pleasant events can serve to improve mood by –
   - reversing avoidance,
   - increasing physical activity
   - increasing self-confidence
   - increasing feelings of usefulness and purpose.
8. Encourage behavioral activation, including exercise.
9. Identify effective means of coping with problems of everyday living.
10. Use active coping to deal with stressors that are not “pleasant-event driven”. The goal of active coping is to decrease stress through accomplishment or overcoming avoidance (e.g. filing taxes).
11. Use relaxation techniques designed to reduce tension, stress, worry, and/or anxiety. Some patients respond to physical procedures (e.g., muscle relaxation and/or deep breathing), while others respond favorably to guided imagery.

Person-Centered Treatment Plan
1. Facilitate client’s trust and ability to be in the present moment.
3. Encourage congruence in the client’s behavior and feelings.
4. Use reflection of feelings, paraphrasing, and open questions.
5. Use unconditional positive regard: allows clients to express how they are thinking without feeling judged, and help to facilitate the change process by showing they can be accepted.
6. Use Congruence (whether or not therapists are genuine and authentic in what they say and do) to promote genuineness.
7. Use Empathy to show understanding of the patient’s emotions.
8. Use Nondirectiveness, allowing clients to be the focus of the therapy session without the therapist giving advice or implementing strategies or activities.

Psychodynamic Treatment Plan
1. Determine level of ego organization (neurotic, borderline, or psychotic).
2. Assess for the presence of splitting or impaired reality testing.
3. Determine patient’s character style (anal, oral, or phallic).
4. Assess for levels of adaptive functioning (fully adaptive, partially impaired, and fully impaired).
5. Match character style to usual dynamic/conflict (e.g. neurotic: guilt or shame)
   a. For Neurotic organization: aid in resolution of neurotic conflict, neutralization of ego defenses, easing of prohibitive superego, development of understanding into how symptoms are maintained, and development of understanding into how symptoms create interpersonal distance.
   b. For Borderline organization: aid to further ego development by maintaining object constancy and...
skill building, maintain therapeutic boundaries, confront splitting, nurture and support any semblance of higher level defensive functioning, examine antecedents and consequences to acting out, teach alternatives

c. For Psychotic level: pacify, stabilize, support. Consider medication recommendations and hospitalization as needed.

Therapy interventions used in psychodynamic psychotherapy:

1. Transference and countertransference paradigms. Repetitive patterns that are enacted in the therapeutic relationship.
2. Drive discharge. The biological and psychological processes by which an individual achieves homeostasis by reducing or sublimating innate libido and aggression.
3. Object relations, object constancy, rapprochement. As the primary caretaker (e.g., object) is internalized during infancy, the toddler attains a sense of him/herself that allows him/her to feel safe in leaving the mother and returning to her (rapprochement) without experiencing trauma or significant loss. This psychological process heralds a developmental achievement that permits the child to experience others, especially the primary caretaker, as a constant object even when the child is away from them (object constancy).
4. Process of separation–individuation. The psychological process whereby the child gradually steps away from his/her primary caretakers and establishes a sense of self as a separate person.
5. Internal working model. A transgenerational cognitive model proposed by attachment theorist John Bowlby that predicts how a child’s expectations of relationships derive from his/her caretaker’s earliest responses to him/her. Our behaviors and views of ourselves are shaped by the model of relationships we experienced in our earliest years.
6. Internal objects, good object, depressive position. Originally conceptualized by psychoanalyst Melanie Klein, the process by which an individual comes to believe in his/her capacity to repair relationships and that his/her love survives destructiveness.
7. Mirroring. The process by which one feels seen and recognized by the primary caretaker and therefore more real. If this process is disrupted in early life, the therapist is co-opted by the patient to provide a developmental experience of having his/her emotions and desires adequately mirrored.
8. Projection of a critical superego. The tendency to find fault or see “the speck in the other person’s eye” rather than owning up to the “log” in oneself. In other words, ridding one of critical feelings so as to feel better about oneself.
9. Observational ego. The capacity to step back and observe oneself. Observation, taking stock of one’s feelings and thoughts, and reflection are strengths of a healthy ego that should develop during a successful treatment, allowing the person to observe destructive tendencies and act to correct them.

Object Relations Treatment Plan:

1. Assess for underlying family transactional patterns that are present in psychological interaction.
2. Investigate familial experience to learn about the patient by using genograms or an attachment interview.
3. Determine attachment level of patient (secure, ambivalent, anxious, or disorganized)
4. Watch out for transference of relationship patterns between therapist and patient, and increase patient’s awareness of these patterns
5. Determine link between ongoing issues of dependency, trust, control, commitment, identity and self-esteem, initiate and adequacy, and associated feelings of anxiety, depression, guilt, and shame
6. Change interpersonal dynamic within therapy setting with the hope of generalizing skill to all outside relationships.