

Professional Counselor Continuing Education



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WHAT'S INSIDE

Chapter 1: Best Practices with Lesbian, Gay & Bisexual Youth and Their Families, Updated 1st Edition

[3 Contact Hours] _____ **1**

The purpose of this course is to provide human services and mental and behavioral health professionals with definitional information, historical and sociopolitical frameworks impacting the lives of LGB youth, as well as the influences of community and family contexts.

Chapter 2: Body Image and Dissatisfaction: Theories and Cultural Considerations

[3 Contact Hours] _____ **19**

The past two decades have seen a marked increase of interest in body image. This intermediate-level course provides an overview of the complexities of body image and body dissatisfaction for a broad range of populations. This course reviews theoretical foundations of how cultural beauty ideals are transmitted. Through case examples and a review of research, it addresses the internalization of beauty messages in the media, the difference between body dissatisfaction and eating disorders, the relationship between a negative body image and mental health, and the potential progression from negative body image into a clinical eating disorder.

Chapter 3: Ethics in Behavioral Health Documentation: Reasons, Risks, and Rewards

[3 Contact Hours] _____ **46**

This intermediate – level course will help novice and seasoned practitioners approach documentation in a way that is guided not solely by what is mandated, but by what is mutually beneficial to the practitioner, the agency, the funding source, and most of all, the clients.

Chapter 4: Postcombat-Related Disorders: Counseling Veterans and Military Personnel, 2nd Edition

[4 Contact Hours] _____ **70**

With increasing frequency, military personnel and veterans experience mental health problems upon return from deployment. This intermediate-level course sensitizes mental health providers to military cultural norms. The course describes postdeployment transition, reintegration, and adjustment, and identifies common mistakes that clinicians make in treating this population. Military families are discussed, including marital satisfaction and the effects of military life on the spouse and children. Assessment and treatment methods for PTSD, depression, suicide risk, substance use disorders, and traumatic brain injury are all described. The various treatment methods are explained in detail, and include case vignettes to illustrate client and therapist interactions.

Chapter 5: Self Injury in Adults and Adolescents, 2nd Edition

[3 Contact Hours] _____ **98**

This intermediate-level course provides clinicians with the most up-to-date information on self-injury so they are better able to assess for the presence of the behavior and provide the best possible treatment. The course describes the various presentations of self-injury, presents a history of the diagnosis, and details developmental considerations, risk factors, and possible biopsychosocial functions of self-injury. Attention is paid to assessing, diagnosing, and treating self-injury in a variety of settings, including mental health and school settings.



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License Expires	Contact Hours and Mandatory Subjects
Varies depending on state.	See state requirement chart on the following pages.

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COURSE TITLE	CONTACT HOURS	PRICE	COURSE CODE
Chapter 1: Best Practices with Lesbian, Gay & Bisexual Youth and Their Families, Updated 1st Edition	3	\$29.95	PCUS03BP
Chapter 2: Body Image and Dissatisfaction: Theories and Cultural Considerations	3	\$29.95	PCUS03BI
Chapter 3: Ethics in Behavioral Health Documentation: Reasons, Risks, and Rewards	3	\$29.95	PCUS03ET
Chapter 4: Postcombat-Related Disorders: Counseling Veterans and Military Personnel, 2nd Edition	4	\$34.95	PCUS04PC
Chapter 5: Self Injury in Adults and Adolescents, 2nd Edition	3	\$29.95	PCUS03SI
Best Value - Save \$44.75 - All 16 Hours	16	\$110.00	PCUS1623



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Course Name	Course Code
All 16 Hours in the book	PCUS1623
Best Practices with Lesbian, Gay & Bisexual Youth and Their Families, Updated 1st Edition	PCUS03BP
Body Image and Dissatisfaction: Theories and Cultural Considerations	PCUS03BI
Ethics in Behavioral Health Documentation: Reasons, Risks, and Rewards	PCUS03ET
Postcombat-Related Disorders: Counseling Veterans and Military Personnel, 2nd Edition	PCUS04PC
Self Injury in Adults and Adolescents, 2nd Edition	PCUS03SI

How Many Continuing Education Hours do I Need?

NOTE: CE Rules can change. Always check your state board for the most up-to-date information.

STATE	HOURS REQUIRED	HOURS ALLOWED BY HOME-STUDY	MANDATORY
Alabama - LPC	40	10	6 hours of ethics.
Alabama - ALC	10	2.5	2 hours of ethics.
Alaska	40	20	3 hours of ethics.
Arizona	30	30	3 hours in behavioral health ethics or mental health law; 3 hours in cultural competency and diversity.
Arkansas	24	24	3 hours of ethics.
California	36	36	6 hours of laws and ethics each renewal; 7 hours of HIV/AIDS (required first renewal only). As a one-time requirement, a licensee before the time of their first renewal after July 1, 2023, or an applicant for reactivation or reinstatement to an active license status on or after July 1, 2023, shall have completed a minimum of three hours of training or coursework in the provision of mental health services via telehealth, which shall include law and ethics related to telehealth.
Colorado	40	20	None.
Connecticut	15	15	3 hours of ethics (LPC only), 1 hour of cultural competency, 2 hours of mental health conditions common to veterans and family members of veterans (once every 6 years).
Delaware	40	20	None.
District of Columbia	40	40	6 hours of ethics; 4 hours of trauma counseling; 2 hours of cultural competence and appropriate clinical treatment specifically for individuals who are lesbian, gay, bisexual, transgender, gender non-conforming, queer, or questioning their sexual orientation or gender identity and expression. In addition, 10% of the total hours must be on topics designated by the Director of DOH as a public health concern.
Florida	30	30	2 hours Preventing Medical Errors in Behavioral Health (each renewal); 3 hours Ethics & Boundaries in Psychotherapy - or - 3 hours Teletherapy (each renewal); 2 hours Domestic Violence (required every third renewal); 3 hours Florida Laws and Rules (required every third renewal); Supervisors: 4 hours Qualified Supervision Training (every third renewal).
Georgia	35	35 (Maximum of 10 hours may be obtained asynchronously.)	5 hours of ethics relating to professional counseling, social work, marriage or family therapy (must be obtained through synchronous activities); 15 hours have to relate to specialty/ profession.
Idaho	40	40	6 hours of ethics.
Illinois	30	30	All clinical professional counselors are required to complete 18 hours in clinical supervision training (one-time (lifetime) requirement) 1 hour of implicit bias awareness, 1 hour in the diagnosis, treatment, and care of individuals with Alzheimer disease and other dementias, 1 hour in sexual harassment training, and 1 hour of mandated reporter training.
Indiana	40	40	At least 20 hours of Category I Continuing Education and 2 hours of Category I Ethics Continuing Education.
Iowa	40	40	3 hours in ethics.
Kansas	30	30	3 hours in ethics; 6 hours related to the diagnosis and treatment of mental disorders.
Kentucky	10	10	3 hours in domestic violence (within first 3 years of licensure); 3 hours in law, 6 hours in suicide assessment, treatment, and management (within first year of licensure and every 6 years thereafter)
Louisiana - LPC	40	10	3 hours of ethics; 6 hours of diagnosis (assessment, diagnosis, and treatment under Diagnostic and Statistical Manual of Mental Disorders 5); 3 hours of supervision for those approved by board to supervise.

STATE	HOURS REQUIRED	HOURS ALLOWED BY HOME-STUDY	MANDATORY
Maine	55	55	An applicant for renewal as a clinical professional counselor in Maine shall demonstrate a minimum of 12 hours of coursework in family or intimate partner violence; 4 hrs in ethics.
Maryland	40	10	At least 30 CEUs shall be in Category A activities and not more than 10 CEUs may be in Category B activities.
Massachusetts	30	15	None.
Minnesota			None.
Mississippi	24	24	6 hours of professional ethics or legal issues in the delivery of counseling services; 2 hours in Telemental Health Counseling if a Distance Professional Services provider; 1 hour in supervision per year; a minimum of 2 hours per renewal period.
Missouri	40	20	2 hours in suicide assessment, referral, treatment, and management training.
Montana	20	20	2 hours related to suicide prevention.
Nebraska	32	32	4 hours in ethics, 6 hours relating to diagnosis and treatment of major mental disorders (LIMHP only).
Nevada	40	20	6 hours of ethics specifically pertaining to the field of practice of marriage and family therapy, or professional counseling; 4 hours must specifically pertain to suicide prevention; 4 hours of cultural competency and diversity, equity, and inclusion; Approved supervisor needs 2 hours of training pertaining to supervision.
New Hampshire	40	20	6 hours of ethics; 3 hours in suicide prevention
New Jersey	40	40	5 hours of ethics; 3 hours of social and cultural competence.
New Mexico	40	40	12 hours of ethics; 9 hours in supervision for all licensees who are supervisors
New York	36	12	3 hours in appropriate professional boundaries.
North Carolina	40	40	3 hours or ethics; Required Jurisprudence Exam offers 5 hours in ethics; LCMHC supervisors require an additional 10 hours of training related to knowledge and competency in the field of counseling supervision.
North Dakota	30	15	3 hours of ethics; LPCCs require an additional 10 clinical hours.
Ohio	30	30	3 hour of ethics; 3 hours of supervision training for supervising professional counselors.
Oregon	40	40	6 hours in ethics, 4 in cultural competency, 3 supervision-related training (supervisors only), and 2 hours in suicide risk.
Pennsylvania	30	30	3 hours of ethics; 2 hours of state approved child abuse recognition and reporting (3 hours at initial licensure); 1 hour in suicide prevention.
Rhode Island	40	40	None.
South Carolina	40	15	6 hours of ethics; supervisor must complete 10 hours of supervision oriented continuing education during every two-year licensure period.
South Dakota	40	40	Supervisor must complete 10 hours of supervision oriented continuing education during every two-year licensure period; 6 hours of ethics.
Tennessee	20	10	3 hours of ethics.
Texas	24	24	6 hours of ethics (completion of Texas jurisprudence exam will count as 1 hour of continuing education in counselor ethics); 1 hour of human trafficking prevention; 3 hours in cultural diversity and competency; 6 hours of supervision if licensee has supervisor status.
Utah	40	10	6 hours of ethics.
Vermont	40	28	4 hours of ethics. Remaining 36 hours must be in the theory and practice of clinical mental health counseling.
Virginia	20	20	2 hours of ethics, standard of practice, or laws governing the profession in Virginia.
Washington	36	26	6 hours of professional ethics; 6 hours of training in suicide assessment, treatment and management. The training must be repeated once every six years.
West Virginia	35	20	3 hours of ethics and 2 hours must be specific to veterans and family members of veterans; 3 hours of supervision of clinical counseling if have supervisor status.
Wisconsin	30	30	4 hours of ethics and professional boundaries.
Wyoming	45	45	3 hours of ethics; 3 hours of suicide assessment or intervention.

Chapter 1: Best Practices with Lesbian, Gay & Bisexual Youth and Their Families, Updated 1st Edition

3 Contact Hours

Release Date: March 26, 2019

Expiration Date: March 26, 2024

Upon successful completion of this course, continuing education hours will be awarded as follows:

Social Workers and Psychologists: 3 Hours

Professional Counselors: 3 Hours

Faculty

Author:

Gayle Mallinger, PhD, MSW, is an associate professor in social work at Western Kentucky University. She earned her MSW and PhD in social work at the University of Pittsburgh. Her research focuses on examining the influence of intersecting contexts on individual, family, and community resilience. Specifically, she investigates the determinants of social injustice and the evaluation of interventions aimed at promoting equity. Her current work is centered on the efficacy of varied pedagogical strategies in preparing social work students to successfully practice with lesbian, gay, bisexual, and transgender client systems.

Gayle Mallinger, PhD, MSW has disclosed that she has no significant financial or other conflicts of interest pertaining to this course book.

Mitchell Rosenwald, PhD, LCSW, is an associate professor of social work at Barry University in Miami Shores, FL. He received his MSW and PhD in social work from the University of Maryland at Baltimore, his MA in sociology from Syracuse University in Syracuse, NY, and his BA in sociology and economics from Salisbury University in Salisbury, MD. Dr. Rosenwald has worked with children and families and co-facilitated youth groups for lesbian, gay, bisexual, and transgender youth. He has presented on key issues in adolescent development for this population and his publication topics include practice with the LGBT population

in child welfare settings and psychotherapy groups. He is the co-author of *Advocating for Children in Foster and Kinship Care*.

Mitchell Rosenwald has no significant financial or other conflicts of interest pertaining to this course book.

Content Editor:

Rebecca G. Harvey, PhD, has been affiliated with the Marriage and Family Therapy Program at Seton Hill University in Greensburg, PA, as an assistant professor since 2004 and as its program director since 2009. Dr. Harvey received her MSW in 1996 and her PhD in marriage and family therapy in 2007, both from Syracuse University in Syracuse, NY. In addition to her academic appointments, Dr. Harvey has had more than 15 years of clinical experience, including as a family therapist, support group facilitator, crisis counselor, and health education coordinator. She maintains private family therapy practices in Beverly, MA, Syracuse, NY, and Greensburg, PA. Dr. Harvey has written extensively and presented throughout the United States, Canada, and Mexico on topics related to sexual identity, sexual health, and gay and lesbian youth.

Rebecca G. Harvey has no significant financial or other conflicts of interest pertaining to this course.

Behavioral Health Planner: Lys Hunt, MSW, LICSW

The planner who worked on this continuing education activity has disclosed that they have no significant financial or other conflicts of interest pertaining to this course.

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to diagnostic and treatment options of a specific patient's medical condition.

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INTRODUCTION

Learning objectives

After completing this course, the learner will be able to:

- Discuss lesbian, gay, and bisexual (LGB) youth development.
- Explain contemporary challenges facing LGB youth and their families.

Course overview

While lesbian, gay, and bisexual (LGB) youth have always existed, it is only within the past few decades that their visibility as a population, and a fuller exploration into their development, have been the focus of psychological and social inquiry. Gathering prevalence information is fraught with difficulty; however, many behavioral health and healthcare professionals in the United States, knowingly or unknowingly, have or are likely to encounter LGB youth and their families in their practice. These professionals are in a unique position to help these youth and their families through the various transitions and other issues that they may encounter. Indeed, research suggests that the more these families accept their children, the better off the children will be in their health and well-being (Ryan & Diaz, 2011).

This basic-level course begins its exploration of this youth population with a definition of terms, a model of identity development, and a focus on diversity considerations. The course then discusses four major areas that affect LGB youth in their development as adolescents. Because issues facing any adolescent are commonly also family issues, particular focus is paid to interventions from a family systems perspective,

- Differentiate the family therapy models used with LGB youth and their families.
- Identify additional interventions for LGB youth and their families.

including an in-depth exploration of three models of family therapy (structural, solution-focused, and narrative) that can be applied to work with LGB youth and their families.

The purpose of this course is to provide current information on issues and dynamics that affect LGB youth and their families, as well as best practices for working with this population. The target audience for this course is behavioral health and healthcare professionals, including psychiatric-mental health nurses, social workers, mental health counselors, marriage and family therapists, and psychologists; however, other professionals who interact with LGB youth will find this course useful.

After successfully completing this course, the learner will have an increased knowledge and understanding of the LGB youth population, the issues that LGB youth face, and specific models of family and other interventions that may be used in working with these youth and their families. It is hoped that this course inspires practitioners to pursue advanced knowledge and skills that will strengthen their interventions with this population.

LGB YOUTH DEVELOPMENT

Understanding youth sexual orientation

Although lesbian, gay, and bisexual (LGB) youth have always existed in the population, in the past few decades there has been a significant increase in the visibility of LGB adolescents. Counting the number of LGB youth in the United States is a particular challenge because responses to survey questions on sexual orientation tend to underreport LGB identity and the populations surveyed tend not to be nationally representative; moreover, youth may indeed not come out with LGB identification in adolescence. However, it is helpful to have some “ballpark” statistics to know that the chance of a professional working with an LGB youth is not only quite possible but also very probable. According to the American Academy of Pediatrics (AAP), up to 10% of the population may be lesbian, gay, or bisexual (AAP, 2014). It is very likely that there are many more youth who will question their identification and ultimately “come out” who are also not counted in surveys. Given this reality, it is vital that families provide stability and support for these youth as they develop their sexual orientation. Indeed, it is essential that practitioners help families identify supportive measures that optimize outcomes, as well as reject behaviors that can result in poor health and mental health outcomes for the youth (Ryan & Diaz, 2011).

Origins of sexual orientation

A common question is why someone is lesbian or gay. Of course, asking this question illuminates a larger question as to why someone is interested in the origins of a homosexual or bisexual orientation – after all, individuals tend not to ask about why someone is heterosexual. Nonetheless, the latest research suggests that a number of factors may be responsible for determining sexual orientation. The American Academy of Pediatrics believes sexual orientation is fixed and is created by a combination of factors, including genetic predisposition (AAP, 2014). Summing up the research, the American Psychological Association (APA; 2008) states:

There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no

findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles; most people experience little or no sense of choice about their sexual orientation (APA, 2008, p. 2).

In summary, it is important to recognize that there are probably many reasons for a person's sexual orientation, and research in this area continues. It is also important to emphasize that an LGB sexual orientation is *not* pathological but, instead, is reflective of human variance. It is vital for practitioners to know that focusing on why youth (and adults) are LGB might be interesting, but distracts from the larger goal of assisting them with normative development.

Definitions

It is important to begin with a clear understanding of definitions, which have caused confusion among professionals. *Sexual orientation* is the romantic/emotional and sexual attraction and affiliation that an individual experiences toward another. Heterosexual orientation (attraction to the opposite sex) has historically been perceived to be the only “normal” sexual orientation; however, as norms have changed and the American Psychological Association removed “homosexuality” from its *Diagnostic and Statistical Manual of Mental Disorders, Second Revision (DSM-II)*, list of psychological disorders in 1973 (and other mental health and medical associations followed suit), homosexual and bisexual sexual orientations have increasingly been seen as legitimate and genuine alternatives.

As the terms associated with sexual orientation are reviewed, it is important for clinicians to keep in mind that as youth begin, and continue, their process of self-realization with respect to sexual orientation, the youth's self-identification may develop in ways that are more flexible or fluid, and less rigid, than some of these terms indicate. Therefore, *sexual minority* is an umbrella term that can apply to this population of youth who are in the process of exploring and defining their sexual orientation that is outside of heterosexuality. Clinicians should be aware of this fluid self-identification process and be mindful of not being too rigid when helping youth and families work with the following labels.

It is also important for clinicians to be mindful and think beyond the word “sexual” (which is part of the common terminology of *sexual orientation* and *sexual minority*) when working with this population. This means that a youth’s attraction and behavior toward another person has emotional and romantic components as well, which are very important dynamics to assess and address in the clinical setting.

Lesbian is a term some females use to describe their sexual orientation and attraction to other females, while *gay* is a term used by many males and some women to describe their same-sex sexual orientation and attraction. *Bisexual* is a term used by some individuals to describe their sexual orientation and attraction to both sexes. Bisexuality for some may be a step in the process on the way to recognizing her or his sexual orientation, or it may be the final recognition of identity itself for a person whose sexual orientation extends to individuals of both sexes.

Heterosexism is a term that refers to the social belief that the world is and should be heterosexual. Heterosexism in the United States is presented in various forms, from the current federal restriction on the definition of “marriage” as between a woman and a man (in the Defense of Marriage Act) to popular love songs and Valentine’s Day greeting cards offering only heterosexual options. Heterosexism is the pervasive yet sometimes subtle social view or force that reinforces heterosexuality as the only “normal” and therefore “acceptable” sexual orientation; this force becomes very important to LGB youth, as this course will later discuss.

Homophobia is prejudice and/or discrimination toward individuals based on their perceived or actual sexual orientation. Such homophobia is grounded ultimately in fear of this social subgroup and it reinforces heterosexism at the societal level. A number of issues that LGB youth experience relate to coming of age in a world where homophobia is still fairly pervasive and threatens their well-being and sense of safety. Internalized homophobia is an intrapsychic barrier and a task to be surmounted by youth who are coming to terms with their uncertainty or shame about their LGB identity.

The *closet* is the dynamic in which homophobia or internalized homophobia prevents an individual from recognizing her or his nonheterosexual orientation. *Coming out* is the process by which an individual acknowledges to himself or herself, and to the people in their lives, that they are not heterosexual. It is important to note that they may also identify as *questioning* or *queer*, or choose not to identify. Assuming any one of the “labels” that have been discussed in this section is an extremely complex process. It is during this important process that behavioral health professionals can often be helpful, although the youth’s journey and self-identification likely began long before discussing it with anyone.

While this course focuses on youth with LGB sexual orientations and their families, it is important to note that the concept of *gender identity* is, at times, confused with sexual orientation. Gender identity is separate from sexual orientation and refers to an individual’s internal sense of femaleness or maleness (which encompasses any gendered thought and/or behavior). Individuals who feel that their sense of gender “matches” their biological sex can be referred to as *cisgender*. Conversely, individuals who feel some incongruence with the sex with which they were born and with their inner sense of maleness or femaleness may identify with the opposite gender. This is

referred to under the umbrella term of *transgender*, commonly abbreviated as “T” (Mallon, in press). Individuals who are transgender express their gender identity in a variety of ways, including occasionally dressing as a member of the opposite gender, living as a member of the opposite gender, and sometimes physically changing their anatomy through an operation or operations. Gender identity issues are largely misunderstood by society, and this lack of understanding has led some people to alienate and feel hateful toward youth who are transgender. Transgender individuals can also face prejudice and/or discrimination called *transphobia*.

The development of gender identity and sexual orientation may at times overlap. A youth may articulate gender identity concerns (“I should have been a girl”), which during the development process can continue into a transgender identity but may also often transition into an LGB sexual orientation. It is important for clinicians to remember that although these concepts are related and overlapping, they are distinct. Not all individuals who are transgender are LGB, and not all LGB people are transgender. One’s inner sense of maleness or femaleness is quite different from the object of one’s romantic or sexual attraction. Although these two groups often share an experience of being stigmatized because their life experiences are challenging to traditional notions of gender, sex, and sexuality (and this may create affinity), these two groups are in fact so different that some LGB individuals exhibit prejudice toward those who are transgender. The reason that individuals who are LGB and those who are transgender are considered together is more for increased visibility in society and the advancement of civil rights than because of any other affiliation.

LGB youth and individuals in general will identify as lesbian, gay, or bisexual; however, others may identify as questioning or queer (Q). Thus, when this population is referred to with a Q in the label, it pertains to *questioning* – in which case the youth is wondering about his or her sexual orientation but has not come to a conclusion, or *queer* – in which case the youth is using, through reclaiming, a previously homophobic term. Still other youth wish not to identify with any of these labels because they perceive sexual orientation as being fluid. One of the most important and difficult issues for sexual minority youth is that they must develop a healthy identity in the midst of great stigma. Therefore, the difference between how they label themselves versus how others label them is an integral part of this process of healthy development. The uses of Q can be meaningful because youth eventually get to claim or reject labels as they see fit. One of the most fundamental and powerful things a professional can do for youth is to create a space where they are allowed to explore identity without forcing any labels.

At times the clinician might also encounter the acronym “LGBTQQIS.” Aside from the aforementioned definitions, the I refers to *intersex* (youth who are born with genitalia of both genders and are typically raised as females), and the S refers to *straight* (heterosexual allies – those heterosexual individuals who advocate for greater acceptance for this population). From a cultural perspective, some males, particularly in African American and Hispanic communities, might state they are on the “down low” and, while having same-sex behavior with males, do not identify as gay or bisexual. Finally, *Two Spirit* is a term specific to the Native American community in which some individuals believe they are born with and thus embody both genders. Table 1 presents, for reference, some of the core definitions that have been described.

Table 1: Definitions	
Bisexual ("B")	A term used by some individuals to describe their sexual orientation and attraction to both sexes.
Cisgender	A term used to describe individuals who feel some congruence with the gender with which they were born (assigned gender) and their inner sense of maleness or femaleness.
Coming Out	The process by which individuals acknowledge to themselves and to the people in their lives that they are lesbian, gay, or bisexual. They may also identify as questioning or queer, or choose not to identify.

Table 1: Definitions	
Gay ("G")	A term used by many males to describe their sexual orientation and attraction to other males. Some females also utilize this word.
Gender Identity	An individual's internal sense of femaleness or maleness.
Heterosexism	The pervasive yet sometimes subtle social view or force that reinforces heterosexuality as the only "normal" and therefore "acceptable" sexual orientation.
Heterosexual	Individuals whose sexual orientation is attraction to the opposite sex.
Homophobia	Prejudice and/or discrimination toward individuals based on their perceived or actual sexual orientation.
Internalized Homophobia	An intrapsychic barrier and a task to be surmounted by youth who are coming to terms with their uncertainty or shame over their LGB identity.
Intersex ("I")	Youth who are born with genitalia of both genders and are typically raised as females.
Lesbian ("L")	A term some females use to describe their sexual orientation and attraction to other females.
Queer ("Q")	A term some individuals use to identify a nonheterosexual identity. This reclaims a previously homophobic term.
Questioning ("Q")	A term used by an individual who wonders about her or his sexual orientation but has not come to a conclusion.
Sexual Orientation	The romantic/emotional and sexual attraction and affiliation that an individual experiences toward another.
The Closet	The dynamic in which homophobia or internalized homophobia prevents an individual from recognizing her or his nonheterosexual orientation.
Transgender ("T")	A term used to describe individuals who feel incongruence with the gender with which they were born (assigned gender) and their inner sense of maleness or femaleness. The person innately identifies with the opposite gender.
Transphobia	Prejudice and/or discrimination directed toward transgender individuals.

LGB youth identity development

Adolescence – specifically early adolescence, on which this course will focus – is the developmental period between the ages of 12 and 18 (Newman & Newman, 2015). In this period, youth "[confront] a new psychosocial conflict, in which pressures to ally oneself with specific groups and to learn to be comfortable functioning as a member of a group are major preoccupations. This conflict is called *group identity versus alienation*" (Newman & Newman, 2015, p. 365). While this normative task applies to all youth, it is complicated by the reality that LGB youth face an additional developmental task that is unique to their population; this task addresses the need to accept a nonheterosexual sexual orientation in a social context that, although showing signs of easing, is still replete with heterosexism and homophobia. Although a central limitation of any model is that there cannot be a "one size fits all" application, the following model does present some core considerations that can assist practitioners in understanding and empathizing with LGB youth.

Models of LGB identity development

A classic model of identity development among LGB youth is Troiden's model (Troiden, 1989). The first stage is *sensitization*, in which children might have an experience or experiences that provide beginning awareness that they may be different, but they likely lack the understanding to describe or articulate this to themselves or to others. The second stage is *identity confusion*, in which a youth is increasingly aware that he or she is not heterosexual. During this stage the youth begins to become aware of and directly face pervasive stigma, heterosexism, and his or her own internalized homophobia. Because of this, it can be very difficult for the youth to acknowledge an LGB sexual orientation. It might be safer to avoid, conceal, or even reimagine past same-sex behaviors. The third stage is *identity assumption*. In this stage, youth begin to feel more comfortable in taking on a nontraditional sexual orientation.

Often they have created a space in which to begin safely exploring and questioning whether they could in fact begin to identify as LGB. The final stage is *commitment*. In this stage, internalized homophobia has decreased as the youth continues to feel more comfortable integrating a lesbian, gay, or bisexual identity with his or her self-concept. Here, the individual is able to come out to self and others to the extent he or she chooses (Troiden, 1989).

Table 2 presents the model of homosexual identity development that can be applied to LGB youth and has possible application to bisexual identity development.

Table 2: Stages of Homosexual Identity Development
<ol style="list-style-type: none"> 1. Sensitization. 2. Identity Confusion. 3. Identity Assumption. 4. Commitment.
<p><i>Note.</i> From Troiden, R. R. (1989). The formation of homosexual identities. <i>Journal of Homosexuality</i>, 17(1), 43-74.</p>

Consistent with more recent thinking on any stage model, identity development among LGB youth does not necessarily always proceed linearly through subsequent stages without returning to an earlier stage. Moreover, a caution regarding stage theory models is that they focus clinicians, families, and even youth themselves on individual factors and de-emphasize the contextual elements that have vital implications for the development of healthy sexual identities for LGB youth. For example, a youth might be approaching the final stage of commitment and yet, after being bullied at school for being out as a gay teen, the youth might believe that, for safety purposes, he might return to the closet of the identity confusion stage.

Yet another youth might have such great social support and personal resiliency that she practically skips the identity confusion stage and commits to being lesbian. For others still, a commitment might be to a “queer” identity or no identity at all because some youth question the need and utility of categories of sexual orientation in the first place.

Since the introduction of Troiden’s model of homosexual identity development (Troiden, 1989), further scholarship has provided additional insight. After reviewing a number of earlier theoretical models, in 2006 Margaret Rosario and colleagues concluded that:

“[I]dentity formation consists of becoming aware of one’s unfolding sexual orientation, beginning to question whether one may be LGB, and exploring that emerging LGB identity by becoming involved in gay-related social and sexual activities” (Rosario, Schrimshaw, Hunter, & Braun, 2006, pp. 46-47).

In their research, Rosario and her colleagues also found that two types of development occur: youth can maintain their sexual orientation over time from an earlier age, or they can more gradually change to another sexual orientation. For example, in their study, youth who identified as gay/lesbian and bisexual earlier in life were more likely to identify as only gay or lesbian when they were older, while those who exclusively identified as bisexual when younger were more likely to continue to identify as bisexual as they became older.

Role of cultural diversity in identity development

Aside from this general discussion of identity formation and development, LGB youth are not an otherwise uniform group. Cultural diversity is present within the whole of the human experience and its presence within the LGB youth population is no exception. The culturally diverse variables of gender, gender identity, race, and class are some additional factors affecting identity development that need to be considered. Ability, national origin, and religion are other such variables. It is well known that gender plays a highly significant part in the development of children and adolescents; females are expected to embody more feelings (be affect-oriented), whereas males are socialized to be more task-oriented. With LGB youth, the influence of gender on sexual orientation can play out such that it might be easier for girls to “come out” than boys because, for example, it is more acceptable in the United States to see women rather than men walking hand-in-hand and showing affection. In Rosario and colleagues’ 2006 study, female youth were more likely than male youth to identify as gay/lesbian.

Race plays a very important role with regard to sexual orientation. Heterosexism is still pervasive in African- American and Latino communities. Youth of color may struggle to manage the stigma associated with holding two “minority” statuses –

sexual orientation and race (Kuper, Coleman, & Mustanski, 2014). This is made more complicated by those who identify as “down low” (described earlier as a label that refers to an individual’s same-sex attraction and behavior without identification of being gay or bisexual; Kuper et al., 2014). Racism in the LGB community continues to exist (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). The civil rights movement for LGB individuals has largely been a Caucasian endeavor. This does not mean that people of color have been completely ignored, but it is only in recent years that LGB organizations have been making better efforts to include discussions of race.

Finally, class is relevant, particularly in the context of access to supports. Kosciw, Greytak, and Diaz (2009) found that LGB youth who were poverty-stricken were less likely to have supportive school environments and more likely to encounter homophobia at school. Identity development is linked to social supports, and some of these social supports come at a cost. Because some LGB or questioning youth are concealing their identities from their families, they may be more self-reliant on their own funds to access social supports. For example, although smartphones and computers with Internet connections are commonplace, some individuals have limited or no access to such technologies due to their associated costs. Much social support for LGB youth is generated through Internet connections; therefore, not having full access to these potential supports might hinder identity development.

To reduce the barriers of poverty and increase the numbers of youth who receive the benefits of social supports, many resources for LGB youth are purposely free of charge. However, even free supports have associated costs. Those youth with more means are more likely to have the finances to arrange transportation and pay other costs associated with attending LGB youth community meetings typically found in more urban regions. Those with fewer funds might again face difficulty obtaining this support and, even with means, this difficulty may be further compounded if these individuals live in rural areas (Leedy & Connolly, 2008).

Identity development among LGB youth is a complex process. At its core, it is about an individual’s safe exploration, confusion and questioning, and commitment to an LGB sexual orientation. It is further complicated by the diversity of the youth involved based on gender, race, age, class, and other variables. The best practice for a practitioner is to have some familiarity with these developmental issues and processes, knowledge of the youth’s environmental context unique to his or her region (e.g., different school districts’ responses to LGB students), and associated supportive resources for LGB youth in the region. As always, the practitioner needs to begin with the client’s identification of goals he or she would like to achieve.

CONTEMPORARY CHALLENGES

Coming out

Impact on youth

As described earlier, *coming out* refers to the process by which an individual consciously discloses to herself or himself, and to others, the identification that he or she is lesbian, bisexual, or gay. (Coming out can also refer to transgender acceptance.) Research shows that youth are coming out at younger ages, usually in the early-to mid- teen years. This is younger than in earlier cohorts and the trend shows that the age of coming out continues to get younger over time (Drasin et al., 2008). This occurs for a variety of reasons. The exponential growth in the use of the Internet and social networking has created instantaneous groups in which youth can build community. In-person communities, whether Gay/Straight Alliances (GSAs) in school and/or youth support groups affiliated with social service or mental health agencies are also on the rise. The increased presence of contemporary adult role models who are public about their identity and/or relationships, including NFL football

player Michael Sam, U.S. Senator Tammy Baldwin, actors Neil Patrick Harris and Jodie Foster, and other celebrities, provide more positive images of adults who can be successful, adjusted, and open about being LGB. In addition, state regulations related to marriage equality have widened the national dialogue concerning discrimination based on sexual orientation in the media, schools, and communities.

Nevertheless, certain factors also contribute to keeping youth *in the closet or closeted* – that is, forced to hide or even making it difficult to admit to themselves an LGB orientation. For example, the role of religion is complex and can present a very strong viewpoint that nonheterosexual orientation is immoral. However, in recent years, many religions and denominations have developed organizational subentities that are affirming of LGB individuals. Additionally, the role of family members can also be complex, and the degree to which a youth feels comfortable to come out is based in part on the family’s acceptance of the LGB

sexual orientation. Sometimes youth will actually come out to relatives who are not their parents, saving the perceived most-difficult disclosure for last.

Family response

The response of the family, particularly the parents, is typically so central to a youth's identity development that it can be a common issue when LGB or questioning youth and their families have family therapy, especially upon the youth's coming out. Ideally, parents (or adult caregivers) showcase their unconditional love for their children and instantly embrace their child, regardless of any sexual orientation. Although this does occur sometimes and should be celebrated, it is common for even supportive parents and family members to experience a grieving process. Ironically, a youth's coming out to parents commonly serves as a forced catalyst to the family's own coming out process (their public acknowledgment that they have an LGB family member) and the sometimes sudden onset of grief in particular (Parents, Families and Friends of Lesbians and Gays [PFLAG], 2014). Of course, when a family comes out, they also do so in the context of heterosexism and homophobia as they currently exist in the larger society. Parents will often need to grieve that their children will not grow up and marry a person of the gender that the parents thought they would; their children may not have children (although plenty of LGB adults have their own children) or may have children in non-traditional ways; and the realization that they (the parents) will need to either hide their child's LGB identity or come out to their own friends, other relatives, and so forth when one day asked why their child is not married (to the opposite gender). The challenges heterosexism and homophobia present regarding these tasks should be acknowledged and addressed as part of the family's or parents' own coming out process (Saltzburg, 2009).

It should be noted that the above is applicable when a youth explicitly comes out. There are other situations in which, for many reasons, families might "suspect" for years (even into adulthood) that their children or siblings are LGB, including that they never date someone of the other gender and/or they have a close "companion" of the same sex. In these cases, the youth is at least partially closeted and, therefore, the family's perception (which may not be confirmed) is that the youth is LGB. To show support, families can help normalize same-sex relationships by asking if their loved one has "someone special" in her or his life (instead of an assumed gender-specific role). Additionally, families can create an atmosphere of support by clarifying their affirming view of LGB people in general, discussing LGB people and lives in everyday conversation, including well-known personalities such as Ellen DeGeneres, and/or by viewing age-appropriate LGB characters and stories in

Violence and bullying

Impact on youth

Tragically, individuals are still targeted for violence because they are gay, lesbian, or bisexual (as well as transgender). According to Federal Bureau of Investigation (FBI) statistics, 20.2% of reported hate crimes in 2013 were based on sexual orientation (FBI, 2014). While this percentage does not break down the age range of those who were victimized, it does depict a social reality in which LGB youth know that violence can occur and they need to be somewhat vigilant for their safety. In 2009, President Obama signed the Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act, which expands federal definitions of hate crimes to include those related to sexual orientation (U.S. Department of Justice, n.d.).

Violence also occurs in school in the form of bullying. According to the Human Rights Campaign, youth who are LGB (as well as transgender youth) are twice as likely to report being bullied in the forms of verbal harassment, physical assault, and online harassment (cyberbullying) as non-LGBT students (Human Rights Campaign [HRC], n.d.). Bullying takes place both in person and as cyberbullying through social media like Facebook and Myspace (HRC, 2011). This genuine fear of bullying and other

the media (e.g., television programs such as *Modern Family* and *Glee*), and affirming support of marriage equality or other issues of interest to the LGB community.

Parents may learn of their own child's LGB identification at the same time they learn their child is involved in a romantic relationship. Although sometimes the parents are instantly accepting of their child and their child's girlfriend or boyfriend, often this information can be overwhelming. Whenever possible, parents and other relatives need to avoid the "exceptionalization" argument in which parents make an "exception" for their child being LGB. In other words, parents might accept their child being LGB because the child is "not like" other LGB individuals. Parents might cite their love for the child and/or the child's adherence to gender conformity, which allows them to accept their child being LGB while still maintaining a homophobic stance toward other LGB individuals. When this attitude is pervasive, it can negatively affect the youth and her or his relationship as the parents accept their child but not the child's boyfriend or girlfriend. In actuality, this indicates that the parents have not completely accepted their child's LGB sexual orientation because, if they did, such acceptance would encompass all of the child's life, including choice of relationship and the romantic partner as well.

Many parents and other relatives gradually become more comfortable with having an LGB family member and can go through a self-reflective process that reminds them that the unconditional love they have for the youth will see their family through this "adjustment." In these cases, family therapy as well as adjunct therapies can be extremely helpful. However, for other families, their grief process becomes stuck on anger, emotional abuse, physical abuse, and perhaps abandonment (where the youth is forced to leave the family home). Although such negative responses to stress may be temporary in some families, for others they serve as permanent wedges and cause a lifetime of estrangement. Unlike most other forms of prejudice where, for example, parents provide support for their children who are experiencing challenges associated with racism, LGB youth cannot always assume that their parents will be sources of support. Indeed, this support can vary and change so much over time that the safe anchor that parents typically provide for their children cannot be automatically assumed. What is clear is that parental rejection of a child who comes out increases that youth's risks, whereas supportive parent-child relations better protect LGB youth from the challenges they face (Ryan & Diaz, 2011). Family therapy is therefore an increasingly important intervention for youth because even small improvements in family relations can be pivotal for their self-esteem and development.

violence can result in LGB youth avoiding school or having difficulties concentrating on their schoolwork because they are understandably concerned for their safety and avoiding harassment. In some schools, a common prevention/intervention for bullying is having "safe spaces" in school in which a student can report bullying behavior. In essence, the school administration should appropriately intervene without bias to address this form of bullying; however, the reality is that schools range widely in how aware of and concerned they are about the bullying of LGB students. This presents an additional challenge for students enduring bullying because they are identified as LGB. Fortunately, if "out" youth can forge ahead despite bullying at school, they can experience better long-term well-being (Russell, Toomey, Ryan, & Diaz, 2014).

Finally, violence can at times occur in the home, where parents might physically abuse and/or neglect their children upon finding out they are LGB. Youth may either be forced to leave their homes or they choose to run away from a violent household. It is estimated that 15% to 30% of homeless youth are LGB (as well as questioning and transgender) and face major challenges of surviving on the streets, including survival

sex, substance misuse, homophobia, suicide risk, and sexual exploitation (Rosario, Schrimshaw, & Hunter, 2012; Sherouse, 2015; Winter, Elze, Salzburg, & Rosenwald, in press). Federal programs are beginning to respond to the need to help this population (Winter et al., 2015).

Family response

The ideal family response is one of complete support. Parents and other relatives should create an atmosphere in which their children feel safe to report that they have been a victim of a hate crime or have been bullied at school. Youth who are not out to their parents may actively hide the fact that they are being bullied precisely because to disclose this would highlight that they are being targeted for their sexual orientation, which would risk outing them before they are ready. Most parents who are aware of their child's LGB identity are very concerned about their

Mental health

Impact on youth

This problem was clearly brought to the national forefront in 2010 when, within a one-month period, five LGB youth in separate incidents all committed suicide as a result of being bullied. As a minority group, LGB youth experience prejudice and discrimination that not only affect their development into adulthood, but also can, for some, negatively affect their mental health (CDC, 2014b). The resilience of LGB youth varies tremendously based on the amount and degree of experienced stigma, sense of self-esteem, and social supports. Some youth progress well through early adolescence as they successfully negotiate the "group identity versus alienation" developmental task. Others experience varying degrees of alienation that may result in depression or even suicide, reflecting the affected youths' perception that ending life would be the best way to end their pain. It is important to note that LGB youth have a higher attempted suicide rate than heterosexual youth (CDC, 2014b). It is therefore essential to be attuned to the emotional and perhaps psychological impact that the coming out process and homophobia can have on youth. LGB youth also have a higher substance use rate than their heterosexual peers (Mustanski & Liu, 2013).

Family response

Families are a major protective factor for LGB youth. When parents respond effectively and supportively, it decreases the other risks their child faces because of being LGB (Ryan & Diaz, 2011). Ideally, families should be the stable entity that provides the support for LGB youth to explore their sexual orientation in combination with their overall development. When parents are rejecting, it often springs from their hope that this will actually help their child to fit in and be happier (Ryan & Diaz, 2011). Clinicians can therefore engage parents about their hopes to help their children, and underscore the importance of their acceptance and affirmation of their children. Moreover, clinicians can guide parents away from behaviors that, while meant to help, actually increase the risk of negative outcomes for their children.

Questions that parents can ask themselves in preparation for talking with their children appear in Table 3. These questions are important for parents, caregivers, and other relatives to be aware of; their genuine concern is vital and will certainly provide much-needed guidance and stability for youth.

Although this varies by culture, parents may be open to suggesting to their child that counseling, including individual

children's safety after they come out. They can take the lead in maintaining open lines of communication and periodically checking to see how safe their children feel in the school and the community. Additionally, parents can maintain strong ties with the school staff so that if and when bullying occurs in school, they can more easily advocate on behalf of their children.

For those parents who love their children but are struggling in their own coming out process as parents of an LGB child, the family system can be disrupted, and it is important that any conflicts be resolved in a constructive, peaceful manner. Parents or other relatives who are upset with the youth should be very aware of how their position affects not only the child but also other family members. Families can be greatly aided during this difficult time by counseling and community support, which can help provide a stable anchor for the families.

and family counseling, might be helpful. The youth should have a choice about whether or not to go to counseling. Other supports include Gay/Straight Alliances at schools, online blogging, and LGBTQ community youth groups that provide other support in lieu of, or in combination with, counseling. Parents can also be mindful that focusing exclusively on the child's mental health can be myopic and might serve to neglect the real factor that they, themselves, may be "part of the problem" and that the family as a whole may need treatment.

Table 3: Questions for Parents to ask Themselves

- *Are they aware of any emotional challenges that their child might be facing? How well can they talk to their child about these challenges?*
- *What are their hopes for their child?*
- *In what ways are they or have they tried to be helpful to their child?*
- *What gets in their way of being more effective when talking with their child? Do they know how to seek professional assistance?*
- *Are they aware that they, as a family system, might need assistance?*
- *Is their child showing symptoms of depression, anxiety, substance dependence, or an eating disorder?*
- *Are they able to talk to their child about safe sex, contraceptives, and sexually transmitted diseases?*

One final statement is crucial regarding those professionals who persist in believing and advocating that a gay, lesbian, or bisexual sexual orientation can and should be changed. Neither is true; these archaic attitudes reflect a continued homophobia and are particularly dangerous when held by mental health practitioners because of the influence they have on LGB and questioning youth and their families. Specifically, such practitioners endorse the benefits of *reparative therapy*, which espouses the view that nonheterosexual orientation is both immoral and can be changed. Such an approach to treatment is antithetical, of course, to current understanding of sexual orientation as human variance rather than a psychological disorder. As discussed earlier, the American Psychological Association removed "homosexuality" from its list of "disorders" in 1973; in 1997 the same organization stated that reparative therapy was not an appropriate practice intervention because it can cause harm (APA Council of Representatives, 1997). Other major mental health organizations have followed suit.

increased among young men who have sex with men (MSM), particularly among black/African American gay youth (Whitmore et al., 2012). Despite major education efforts, factors that account for this increase include a gap in education on disease transmission, lack of knowledge of HIV or STI status, substance use, and an overall lack of concern that they are at risk for infection (CDC, 2014a). Along with HIV, youth contracting other STIs is a further area of concern when youth are sexually active.

Hepatitis, syphilis, and gonorrhea are among the STIs that need immediate attention. As with HIV, individuals may not know they have an STI when they are sexually active.

Family response

For some families, one of the largest concerns upon learning that their child is LGB (particularly as a gay male) is that he or she will contract HIV. While this is a stereotype because certainly not all gay or bisexual youth have HIV, it is most important for parents to begin to create a supportive atmosphere in which youth can feel comfortable dialoguing about safe sex. For some, the youth may take the lead in this conversation, but for others it will likely be up to the parent or some other trusted relative or family friend to initiate this conversation. While potentially embarrassing, it is critically important to have this conversation. When possible, it is important for families to have a frank, yet supportive, discussion with their child, sooner rather than later, about “safe sex.” This includes discussion of a range of options including abstinence, nonsexual intimacy, and sexual activity with the use of condoms or other contraceptives. Parents should

contact their child's pediatrician or local health department for the “facts” on safe sex.

Additionally, the attentive parent or caregiver will pay particular attention to ensuring that their child's pediatrician is “LGB-friendly,” meaning that he or she is sensitive to and respectful of LGB youth. If families live in more urban areas, chances are there will be an LGB community center or a publication with some references to LGB-friendly physicians. These community centers or physicians can be contacted about referrals to similarly sensitive pediatricians if there are none immediately identified. In more rural areas, a search on the Internet, followed by a telephone or in-person screening, can also help ensure that an LGB-friendly physician is found.

Although this course focuses on the needs of LGB youth, it is important to note in this section that those transgender youth who are interested in physically transitioning from male to female (MTF) or female to male (FTM) are only legally able to do so as adults. A similar search for a respectful and knowledgeable pediatrician or physician is paramount for addressing these youths' medical needs.

Child welfare

Impact on youth

As mentioned, one of the negative consequences of a youth coming out is the lack of acceptance by the family. At the extreme, this nonacceptance manifests with verbal and physical abuse, including ordering the child to leave the home, resulting in the child's homelessness. In such cases it is hoped that the proper authorities, including child welfare social workers (and in extreme cases, the police), become involved in these youths' lives to ensure their safety, well-being, and access to a permanent, stable place to reside.

When youth enter the child welfare system, they may receive care in a variety of settings, including foster care or group homes. It is important that the care providers have received proper diversity training on sexual orientation (as well as on gender identity). Fortunately, the major private nonprofit organizations and public entities (e.g., the National Foster Parent Association, the Child Welfare League of America), and increasingly the federal government, have excellent supports and resources for helping LGB youth in care. One such resource is *Twenty Things Supervisors Can Do to Support Workers to Competently Practice with LGBTQ Children, Youth, and Families* (National Resource Center for Permanency and Family Connections, 2014).

However, despite these good intentions, LGB youth in care are often at the mercy of the culture of individual child welfare constituencies with respect to supporting them. Foster parents have been found to have a range of attitudes, from acceptance to rejection (Clements & Rosenwald, 2007). Further, a national study of child welfare agencies found similarly mixed results. This is particularly alarming considering that when children of different genders or race enter care, it is assumed that child welfare agencies do not discriminate; yet, with respect to sexual orientation and gender identity, such prejudice and discrimination are alive and well (Rosenwald, 2009). As this

issue receives more and more attention, LGB-friendly foster homes, group homes, and emergency shelters are slowly becoming more realistic options for LGB youth. Given that initial experiences of child maltreatment may have already traumatized LGB youth, placement planning needs to include considerations for sexual orientation and gender identity so that these children do not experience additional homophobia and other discrimination in supposedly safe environments.

Family response

The notion of “family response” in this context needs to be expanded to include the foster parents, group home staff, and the larger community's support for LGB youth. As mentioned, agency and state mandates vary as to what they require for youth. It is incumbent on childcare professionals (foster parents, group home staff, etc.) to be comfortable working with and being respectful of LGB youth. The National Foster Parent Association and the Child Welfare League of America have excellent materials for working with these newly constructed families.

Not all LGB youth who reside in foster care stay there. For some, it is a temporary situation and the youth returns home, under supervision, as long as the parents can ensure their safety and agree (whether voluntarily or under court mandate) to address the factors that resulted in the past maltreatment. Various professionals will commonly be involved in monitoring the family's functioning, and will provide family therapy (discussed in the next section) to help identify the family dynamics that led to the abuse and ensure that these dynamics are changed so the maltreatment is not repeated. Other youth, unfortunately, become homeless and need community services. In these cases the community needs to think about the need for creating homeless shelters and transitional living services, for both LGB youth and LGB young adults, to help provide structure and increased optimism for their lives and well-being.

FAMILY THERAPY

Practitioners working with LGB youth and their families are invited into the families' lives, and even their homes, to assist them with, at times, very intimate and sometimes very painful information during tumultuous periods in their individual and

Practitioner readiness

Prior to the following presentation of the three family therapy models discussed in this course, four considerations must be addressed. First, the concept of the *identified patient* from family therapy is useful when working with any family, regardless of the model to be used. The identified patient is the family member who is assumed, typically by the relative arranging

family development. Although it might seem daunting to help an entire family, the skilled family practitioner is well equipped to provide assistance.

the family therapy, to be the reason for all of the problems and distress that the family is experiencing. The family systems view, however, holds that no one person is responsible for the existence of a problem. Rather, the family must be viewed in its entirety as a system wherein members each play a role in the maintenance of a problem as well as its solution.

Second, it is important for practitioners to be mindful that they (the practitioners) are providing assistance to the families; they are not solving problems for them. It is up to families themselves to define what they want to work on and then to do this work. This honors *self-determination*, and all of the models of family therapy rely on this perspective.

Third, practitioners have a range of models to select from in their work with families. Practitioners choose models they are familiar with and are competent to practice, and which have underlying assumptions that best match their own worldview. Practitioners often consider the *fit of a model* with each family's unique presenting issues.

The fourth consideration, *countertransference*, is particularly important for practitioners working with LGB youth and their families. Regardless of the model of practice used, families will typically look to the therapist as the "expert" and imagine that the therapist possesses great authority and influence over the family members' lives. Therefore, it is incumbent upon the therapist to self-reflect on her or his own views of working with lesbian, gay, and bisexual youth. Such self-reflection is useful to combat countertransference – those feelings that are brought up within the therapeutic encounter which trigger subconscious feelings in the therapist. Therapists, like all members of society, live in a world where heterosexism and homophobia are common, and they need to be both aware of and work to change such deeply instilled attitudes and beliefs. To be most

Structural family therapy

Theory

Structural family therapy is currently the most influential model of family therapy in the United States and abroad (Nichols, 2014). Originated by Salvador Minuchin and developed by Minuchin and his colleagues in their work with families in Wisconsin and later in Philadelphia, structural family therapy "[recognizes] the overall organization that regulates [family] ... interactions" (Nichols, 2014, p. 110). (For additional readings on this model of therapy, see the Resources section of this course.) The goal of structural family therapy is for the family and the therapist to reorganize the family's structure in order to improve the experiences of all family members (Minuchin, 1974). Table 4 shows the central concepts and intervention skills associated with structural family therapy.

Table 4: Concepts and Intervention Skills of Structural Family Therapy
<p>Concepts</p> <ul style="list-style-type: none">• Family structure.• Subsystems.• Boundaries:<ul style="list-style-type: none">◦ Rigid (Disengagement).◦ Clear (Normal).◦ Diffuse (Enmeshment). <p>Intervention Skills</p> <ul style="list-style-type: none">• Joining and accommodating.• Enactment.• Structural mapping.• Highlighting and modifying interactions.• Boundary making.• Unbalancing.• Challenging unproductive assumptions. <p><small>Note. From Nichols, M.P. (2014). <i>The essentials of family therapy</i> (6th ed.). Boston: Pearson; and Minuchin, S. (1974). <i>Families and family therapy</i>. Cambridge, MA: Harvard University Press.</small></p>

This model focuses on three central concepts: 1) family structure, 2) subsystems, and 3) boundaries (Minuchin, 1974; Nichols, 2014). Family structure relates to the overall expected patterns of family interaction as well as the relationship patterns in its subsystems. Subsystems contain smaller units of family members such as the parental system, the parent/child system, the

helpful in conducting family therapy, and to make sure they are not doing harm, therapists should initiate this process and perhaps attend diversity training or their own counseling to ensure that they have extinguished their own heterosexism and homophobia to the extent possible.

A final consideration relates to current understandings of trauma because some of the youth with whom practitioners work – and some of these youth's family members as well – might have diagnoses that include PTSD, acute stress disorder, or even dissociative identity disorder (DID). In this "Age of the Brain," groundbreaking research is uncovering the extent to which psychological trauma – from abuse, neglect, and similar experiences – impacts individuals' brain development and functioning (Van der Kolk, 2014). Neurological research currently focuses on trauma's impact on brain components such as the amygdala (which regulates emotion) and the hippocampus (which stores memories), as well as a host of neurotransmitters (including the "stress hormone" cortisol and the "bonding" hormone oxytocin). There is also promise that positive interactions and activities such as therapy can mitigate the negative effects of trauma on the brain (Van der Kolk, 2014). Therefore, practitioners are encouraged to seek additional continuing education in the dynamic field of trauma-informed care because it enhances their work with all clients, including work with LGB youth and their families.

female system (mother and daughters), and the sibling system. Boundaries refer to the type of relationships that exist between and within subsystems; boundaries can range from "rigid" to "clear" to "diffuse" (Minuchin, 1974). Neither boundary extreme is that helpful in family functioning because rigid boundaries reflect "disengagement," in which nurture is limited, while diffuse boundaries reflect "enmeshment," in which independence is limited. In the middle of these extremes is the clear boundary, which promotes a healthy combination of nurture and independence.

The following brief family description demonstrates these concepts. The family consists of a mother, father, and two children – a 15-year-old daughter and a 14-year-old son. The parents have decided to seek family therapy because the son has been suspended from school for fighting and "they need help." In family therapy it is revealed that the son was actually fighting in self-defense because he was bullied for being gay.

This family's structure includes three subsystems: the "couple" subsystem (the wife and husband); the "parents/children" subsystem (which includes the various subsystems of "father/son," "father/daughter," "mother/son," and "mother/daughter"); and the "sibling" subsystem (the sister and brother). The couple's boundary is rigid, meaning the couple are emotionally distant with one another and therefore tend to be disengaged. In the parent/child subsystem, the boundary between the mother and her children is also rigid (she is more emotionally distant with her children), while the father's boundary with his children is more enmeshed (he is overly emotionally involved with his children). The siblings have a clearer boundary with one another; they care for one another appropriately as well as honor each other's need to be independent.

General information on the hypothetical Davis/Leonard Family is presented in the vignette below. As structural family therapy, solution-focused family therapy, and narrative family therapy are discussed, the various skills and interventions appropriate to each of these models will be applied to this family that is in the midst of the coming out process.

The Davises are a middle-class African American family who reside in Denver, Colorado. Danielle Leonard is a 15-year-old girl who has recently come out to her family as a lesbian. Danielle is the daughter of Mrs. Davis and her first husband, Mr. Leonard, who has sporadic contact with his daughter.

Danielle is a sophomore in high school and an A student. Mrs. Davis, Danielle's mother, is 46 years old. She works as an accountant for a law firm in the city. Mrs. Davis is married to Mr. Davis, 42, a construction foreman who works in the neighboring county. Mrs. Davis has no other children; Mr. Davis has two children from a previous relationship who live three hours away.

The Davises have been married for 10 years. The family has been fairly close-knit. One of the major activities they do as a family is to attend church weekly. For Mrs. Davis, church attendance is very important because her father is a retired Baptist minister. Mrs. Davis's father lives next door and stays with Danielle when the Davises are away for any extended period of time.

This portrait of a "typical" American family was ruptured when Danielle told her mother that she is attracted to other teenage girls, and in fact has been dating Ashley for the past three months. Mrs. Davis was completely stunned by this announcement and told Danielle that she was not happy about her choice and some things would need to change in the house.

Highly upset, Mrs. Davis told her husband and her best friend about Danielle's revelation. Both were surprised as well about Danielle's announcement.

Danielle said she would not stay in a house with an unsupportive mother and would seek out her "real" father and go live with him if the Davises did not get their act together and accept her relationship with Ashley. Mrs. Davis's friend suggested that the family might benefit from family counseling and referred her to a therapist she had used herself for a different matter.

After two days of composing herself, Mrs. Davis gave the therapist a call and hired her to help the family "sort out this mess."

The following shows how a practitioner would apply the structural family therapy model in practice with the Davis/Leonard family.

For the practitioner working with the Davis family, the first phase was to join and accommodate with the family. The therapist took time to talk not just with Mrs. Davis but also with Mr. Davis and Danielle. (Danielle's biological father was not part of the sessions.) Mrs. Davis was happy that the practitioner came to the home and expected her to side with her and her husband, both of whom were quite unhappy with Danielle's "choice." The therapist did indeed offer empathy and support to the couple and yet also empathized with Danielle, who stated that there was nothing wrong with being lesbian and that her parents were the ones with the problem, namely, being homophobic. Once the therapist established some rapport with the family members, she helped the family members articulate more specifically what they would like to have happen in their family therapy. Danielle was able to say that she would like her mom and stepfather to be less judgmental, and the therapist suggested that perhaps the parents would like to better understand how Danielle had come to understand herself as a lesbian.

Enactment was the next step to occur. In the second session, the therapist asked Mrs. Davis why she was so angry over Danielle's announcement. Mrs. Davis responded that she did not want Mr. Davis to be upset. Mr. Davis thanked his wife for looking out for him. Danielle shared how "stupid" her mother was for putting her husband's happiness over her (Danielle's) welfare. This natural enactment provided assessment information to the therapist that Mrs. Davis seemed to defend her husband over her daughter's mental health and that Mrs. Davis seems to interrupt Danielle. Moving on to structural mapping, the therapist remembered that Danielle's coming out as lesbian was not the "sole" problem in the family; in fact, the therapist formulated a hypothesis that the

Davis couple subsystem was actually somewhat disengaged in that Mrs. Davis appeared to be afraid to talk to her husband about Danielle's coming out (or other matters) because Mrs. Davis feared that Mr. Davis would leave her.

The consequence of this was that Mrs. Davis had an enmeshed relationship with Danielle and wanted to control Danielle's life because Mrs. Davis was actually afraid of confronting her husband. This information was gained through a variety of sessions with each family member privately as well as with different combinations of the family subsystems (e.g., Danielle and her mother, Mr. and Mrs. Davis, Danielle and Mr. Davis, and Danielle alone) and the family as a whole.

Turning to Step 4, highlighting and modifying interactions, the practitioner suggested (drawing on knowledge of LGB development as well as structural family theory) that if the family wanted to understand Danielle's experience they had to accept that she had the right to live her own life. Furthermore, the therapist told the family that as a lesbian teen Danielle would need their help and guidance to manage the prejudice and discrimination she would likely face. If they hoped to be this support and to have continued influence on her life, they had to respect her life experience. The Davises were surprised by the therapist's directness. Additionally, the practitioner reminded Danielle that she had known about her sexual identity a lot longer than her mom and stepfather had. While she had become used to the idea, the information was new to her parents. The therapist told Danielle that she needed to figure out how to respect her mother and stepfather while she was continuing to explore her identity and new romantic relationship. The practitioner used a combination of "intensity" and "empathy" to do this.

As the therapist and the family entered Step 5, boundary making, the therapist suggested that two subsystems in the family – the couple subsystem and the parents/child subsystem – could benefit from clearer boundaries. Danielle and her stepfather tended not to speak much (having a rigid boundary), while Danielle and her mother were fairly enmeshed. Additionally, the couple's boundary with each other was somewhat rigid. The therapist suggested to Mrs. Davis that she might want to concentrate on talking with her husband more and being less concerned about the "problem" of Danielle's coming out. Indeed, the therapist hypothesized that Mrs. Davis communicating with her husband more and trying to control her daughter less could be healthier for the family. Using empathy, the therapist could communicate this in a way that Mrs. Davis could hear.

Moving to Step 6, the therapist shifted to unbalancing, in which Mrs. Davis and Danielle shared some of the pain that predated Danielle's coming out; Mrs. Davis had wanted to control Danielle because Mrs. Davis felt guilty about divorcing Danielle's father. Danielle was unaware of this but knew she didn't like being controlled and interrupted by her mother. Separately, the therapist worked with Danielle's and her stepfather's relationship, as well as the couple's relationship with each other. The goal of this work was to create clearer boundaries. The culmination of this stage was that Danielle's coming out served as a catalyst for an intervention, the outcome of which was that Danielle felt empowered to become more independent and assertive in her continuing coming out process and new romantic relationship. She did so in a manner that was more respectful to her mother and stepfather. Mrs. Davis, in turn, apologized to her daughter for trying to control her for years; Mr. Davis stated he recognized ways in which Mrs. Davis was controlling of Danielle. Further, he regretted that he had benefited from Mrs. Davis controlling Danielle. He may have even encouraged it since it got him out of having tense discussions.

Rather, in the future, he could just stay out of it and let Danielle and Mrs. Davis handle any conflicts that arose. The couple was inspired to begin healthier communication with one another.

As the family began to experience clearer boundaries, increased communication, and independence, Mr. and Mrs. Davis were asked by the therapist to look at some of their assumptions about the meaning of Danielle's lesbian identity. Mrs. Davis realized that she was proud of her daughter no matter what, and while it would still take some adjustment, she wanted to support her daughter. Both Danielle and

Mrs. Davis listened more to Mr. Davis's honest concern with loving his stepdaughter and his wife and yet still needing to reconcile this with his religion. The therapist suggested that the family seek spiritual support through consultation with a minister who was affiliated with a congregation that welcomed participation by LGB individuals. Although this path was not quick or easy, the three family members became more respectful of each other with increased communication, Danielle's increased independence, and more mutual respect.

Intervention skills

The structural family therapy model can be used in sessions with all family members present and in separate sessions with individuals and subsystems. There are seven key steps that encompass the assessment and therapeutic interventions of this model (Nichols, 2014).

Step 1: Joining and accommodating

The first step is for assessment to occur and this is achieved by the family practitioner "joining and accommodating." This means that because often not all family members will initially welcome the practitioner, or even the idea of family therapy, it is incumbent upon the therapist to build rapport with each member. This is achieved by genuinely soliciting each family member's view of the problem, which will very likely conflict with the views of other family members. To aid in the joining and accommodating process, the therapist will often talk with each family member separately as well as with all family members together.

The therapist solicits each parent's view of the problem, which they both identify as their son's fighting. The son says his view of the problem is that everybody is focusing too much on his fighting and making a big deal out of the fighting and that they should just forget it because he isn't going to do it again, because he will just ignore the people who were bothering him. The daughter says that being home "stresses her out" because of all the arguing and she didn't fight so she doesn't know why she needs to even be there.

Step 2: Enactment

The second step is "enactment." In this step, the practitioner wants to see the family's patterns of interaction live and in the moment; the practitioner sets this in motion by asking questions of each family member and seeing the "natural" interplay that occurs. This allows the therapist to observe how family members respond to one another and reveals information about the boundaries and family structure.

The therapist observes that when the son is asked why he fought in school, the father interrupts his son and states that his son had a lapse of judgment.

Step 3: Structural mapping

As the practitioner gains insight into the family structure, it is time to proceed to the third step, "structural mapping." In structural mapping, the practitioner makes tentative hypotheses about the subsystems and types of boundaries in the family, and views the problem as one that resides in this interwoven system rather than in any particular family member who needs to exclusively undergo all the change.

When the parents argue with each other about why their son is fighting, they blame one another, a response that reveals their own disappointments with themselves and each other. In the structural mapping stage the practitioner may suggest to the family that the parents' fairly rigid boundary with each other has influenced their son's sense that he could not come out to them in the past and, as a result of not having this support, he had a quicker response to fight at school.

Step 4: Highlighting and modifying interactions

Following the practitioner's discovery of these patterns, she or he then identifies them and suggests how to change the

interaction. This refers to the fourth step: "highlighting and modifying interactions." Practitioners use intensity, which is a blunt intervention that challenges family members to reflect on their own roles in the problem. As an alternative intervention, practitioners may use empathy through listening and recognition to help family members become more reflective about their roles in the underlying problem (Nichols, 2014).

The therapist shares her observation that the more the mother yells at her son, the more the son ignores her and the more distant they become – mirroring the parental subsystem's interactions. The son's fighting, as well as his subsequent self-disclosure in therapy that he is gay, has forced the parents to interact and communicate with each other, which differs from their typical disengagement from each other.

Step 5: Boundary making

As a family's insight increases, the practitioner is ready to take the lead on the fifth step, "boundary making." Boundaries should be "clear" within a family (Minuchin, 1974). With the goal of creating clearer boundaries within the family structure as a whole, the practitioner could point out that disengaged families with rigid boundaries tend to have avoided conflict in the past (Nichols, 2014). The following examples reflect the essence of boundary making.

The therapist works with the father (who models enmeshed boundaries with his children) and both children, to help the father provide space for his children to voice their independence. The therapist also works with the mother and children together, as well as with the couple separately, on encouraging each subsystem to open up to each other, discuss their differences, take responsibility for their part in the current family dynamic, and have more positive interactions in trying to create healthy boundaries and more open communication in the family.

Step 6: Unbalancing

With "unbalancing," the sixth step, the practitioner focuses on changing the relationship within a subsystem. Because dynamics within a subsystem influence boundaries in the overall family structure, it is the intention of this step to ensure that the subsystem, and its boundaries, are as clear as possible. This is achieved by the practitioner temporarily "siding" with each subsystem member in series. The intention of this intervention is to shift the dynamics so that insight is possible in the final step.

The therapist sides with the wife when the husband is chastising her for contributing to their son's secrecy. When the husband yells at the wife, the therapist interrupts the father and tells him he needs to take responsibility for his part in contributing to the family's problem.

Step 7: Challenging unproductive assumptions

The final step, "challenging unproductive assumptions," draws on the earlier efforts at boundary making and unbalancing by providing opportunities for reflection and insight to reframe the problem. Practitioners can use educational interventions that support positive characteristics and downplay negative characteristics. These and other exchanges have the potential to help families form clearer boundaries and promote healthier family functioning.

The therapist empowers the children 1) to speak to their mother about their wishing she was more positively involved in their lives, rather than only becoming involved when there is “a problem” (this reduces the rigid boundary), and 2) to speak to their father about wishing he would not emotionally

“smother” them (this reduces the diffuse boundary) and that he would spend more time in positive communication with his wife, rather than always arguing and then relying on his relationships with his children for a sense of connection and camaraderie.

Solution-focused family therapy

Theory

Solution-focused therapy was founded by Steve de Shazer and his colleagues at the Milwaukee, Wisconsin, based Brief Family Therapy Center. Beginning in 1979, they worked to derive a model of time-limited, brief therapy; many publications have been written on the model’s application, including de Shazer’s 1985 book *Keys to Solution in Brief Therapy* (de Shazer, 1985; see Resources section for additional reading on this theory). The goal of this therapy model is to promote the client’s already existing abilities to solve his or her own problem with the therapist’s guidance (de Shazer, 1988). The concepts and skills used in solution-focused family therapy are presented in Table 5.

Table 5: Concepts and Intervention Skills of Solution-Focused Family Therapy

Concepts

- Focus on present.
- Exceptions.
- Solution-talk.
- Client as expert.
- Resiliency and resourcefulness.

Intervention Skills

- Describing the problem.
- Setting goals and using “the miracle question.”
- Exploring exceptions.
- Using scaling questions.

Note. Adapted from Nichols, M.P. (2014). *The essentials of family therapy*. (6th ed.). Boston, MA: Pearson; and de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York, NY: W.W. Norton.

The solution-focused model relies on five concepts. Its *focus on the present* helps to ensure that the client seeks solutions that can resolve the problem in the present rather than dwelling on the causes of the problem in the past. *Exceptions* are those instances in the past (or even the present) the client identifies as when the problem was reduced or absent; identifying such exceptions provides the client some optimism with respect to goal completion. While some description of the problem is required, the solution-focused practitioner will structure the session on the present and focus the families on what is called *solution-talk*. Solution-talk is based on the premise that families have the solutions to their problems within them, and that sometimes it just takes a practitioner to help “mine” these solutions. Such an assumption reflects a belief in the *client as expert* rather than the practitioner as expert. Indeed, solutions generated by a practitioner could very likely not be long-lasting because they are given “to” a family rather than found from within the family by the family themselves. Finally, families are both resourceful and resilient. *Resourcefulness* means that families are capable of thinking of and pursuing resources (otherwise known as “strengths”) that can help them survive and even flourish; *resilience* refers to the family’s continued ability to cope and endure despite challenging times.

The following vignette shows how a practitioner would apply the solution-focused family therapy model in practice with the Davis/Leonard family described earlier.

Using the solution-focused model, the therapist met with the Davis family and began with a problem description, asking the family to describe the problem. Danielle stated that her mother and stepfather needed to “get a grip” on her being lesbian and stop panicking. Danielle was hurt that they were not being supportive. Mrs. Davis believed the problem was that Danielle had only casually thought about this

decision and did not think about the repercussions it would have on the family as “people would talk.” Mr. Davis had a very hard time reconciling Danielle’s coming out with his religious views. In essence, Danielle seemed upset with Mrs. and Mr. Davis, and the couple was shocked and dismayed by Danielle’s revelation. The therapist summarized that the family seemed to be having a really difficult time with Danielle’s coming out; Danielle was having problems with Mr. and Mrs. Davis’s reaction and they were having difficulty accepting her coming out.

Moving to goal setting, the practitioner asked, regarding the session, “What needs to occur so that our counseling session will be successful?” Indeed, the therapist’s earlier assessment of the problem was accurate because Danielle stated she wanted acceptance from the adults and the couple stated they wanted to be the same family as they were before. An important point in goal setting is that the goals need to be realistic. In response to Mr. Davis’s idea that Danielle could change her sexual orientation, the practitioner gently explained the view of mental health and medical associations that sexual orientation cannot be changed and that it is not pathological. The couple stated that they wanted Danielle to accept their views. Therefore, the first goal was for the family to be more accepting of each other’s views. (Note: The therapist did not want to be complicit with honoring homophobia but, true to solution-focused therapy, the solutions needed to originate with the family. The therapist saw that it was a process in which views could be accepted for what they were and they could possibly change.) Mrs. Davis stated that she wanted everyone to get along like before Danielle’s coming out, because this was a very distressing situation for her. The others agreed, so the second goal was for the family to get along like before Danielle’s coming out. The therapist suggested rephrasing this goal as “to get along like they did before they experienced this current stress” (to take the onus off Danielle and reframe it as an experience that the family was sharing).

Exploring exceptions was a very useful technique for the family because it helped them recall other challenging times in the past and how they “survived” them. The practitioner asked three questions: “When have you not experienced this problem?”; “Are there times when you don’t have this problem?”; and “What do you notice is different when the problem is not there?” Of course, Mr. Davis replied that everything was fine when Danielle had not come out and the family got along well. The therapist reminded the family that again it was not realistic for Danielle to change her sexual orientation. However, the therapist then explored variations of these questions by asking, “What times in the past had the family experienced stress and yet survived well as a family?” The family recalled that Mr. Davis had been in a terrible accident at work and Danielle and Mrs. Davis had shown him tremendous support. The therapist suggested that while the situations were different, what was most important to remember was that the family provided each other with support during a time of unexpected stress and that the family could draw on this experience and apply it to the current “stress” that the couple was experiencing in response to Danielle’s announcement.

In a subsequent session, all three family members were asked to rate progress in achieving the two stated goals, namely: 1) to accept each other’s views more, and 2) to get along like they did before. The scaling technique was used to measure the family’s progress on their goals.

When asked how accepted she felt by her mother and stepfather, Danielle rated their progress toward this goal as a 2 on a scale of 1 to 10. Mr. Davis and Mrs. Davis believed that Danielle did not accept their views much either, and they rated her progress as a 2 as well. The family also believed that collectively they rated as a 2 for the second goal. The practitioner stated that this was a good sign because a 2 is higher than a 1; based on the scale, the family was doing better than their conversation would suggest. This surprised all three members but gave them a bit of hope. The practitioner then asked what it would take for them to get to a 3 on both goals and expressed confidence that they could achieve this based on the fact that they had survived another stressful situation in the past with Mr. Davis's accident. The family agreed that they would continue the family sessions, communicate with each other more, and have ground rules to not yell at each other. This was incremental improvement, but the family was on their way to achieving their goals.

Intervention skills

Four sets of skills are part of the solution-focused practitioner's approach to working with families: problem description, goal setting (including the "miracle question" described below), exploring exceptions, and scaling questions.

Problem description refers to the initial assessment in which the practitioner asks the family to describe how they see the problem. While the family may be accustomed to a problem-oriented focus, the practitioner learns of their past efforts in addressing the problem; this reminds the family that they have the capacity to resolve their problems.

The practitioner then asks what has and has not worked in the past to solve the problem, thus introducing the idea that the family has the capacity to resolve their problems (Nichols, 2014).

Drawing on the earlier example of the family whose son was fighting in self-defense over being bullied for being gay, the therapist asks for a brief history from the different family members' perspectives and then explores how they have previously tried to solve challenges the family faced.

Goal setting is an extremely important technique in solution-focused family therapy because it enables both the client and the therapist to know when the problem is solved and to measure progress from session to session (de Shazer, 1988). Good questions for the therapist to ask include: "Specifically, how will you be doing this?" and "What specifically will tell you that you've solved your problem (or reached your goal)?" (Nichols, 2014, p. 231). Such goal setting is optimistic in nature because it presumes the family's ability to solve their problem.

Narrative family therapy

Theory

Narrative therapy is the newest of the three models presented. The concepts of narrative therapy were originated by Michael White and David Epston; together they co-authored *Narrative Means to Therapeutic Ends* (White & Epston, 1990). Over the last 30 years narrative therapy has come to be a mainstream model for working with families with various presenting issues. The concepts and intervention skills of narrative family therapy appear in Table 6.

The goal of narrative family therapy is to help families "transform ... identities from flawed to preferred, not by getting family members to confront their conflicts but by separating persons from problems and then uniting the family to fight a common enemy" (Nichols, 2014, p. 247).

While there are many elements associated with narrative family therapy, the three central concepts are deconstruction, unique outcomes, and reconstruction. These concepts can be used to assist family members with reconceptualizing the problems that are present in their families.

The first concept, *deconstruction*, refers to helping families understand how they live their lives based on the stories they

A very common goal-setting strategy is asking the *miracle question*, which is a question to elicit a family's vision of when the problem is solved. The therapist can ask: "Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?" (de Shazer, 1988, p. 5). Such a question forces families to focus on the absence of the problem and how achievement of their goals could help them attain a future without the problem. The goals do need to be realistic.

The therapist asks the miracle question of the family, and the parents report that they would spend more time with their son and daughter to ensure that their children felt loved, and would advocate with the principal for their children's safety at school. It is important to note that the goals need to be very realistic; therefore, wanting someone to change a sexual orientation (or wanting someone to be alive when he or she is not, etc.) are not examples of realistic goals.

Exploring exceptions is a technique in which the focus is on the family identifying a time when something went well versus what has gone wrong. This promotes family resourcefulness and reinforces the idea of the family as the expert on their particular circumstance. Examples of questions that explore exceptions include: "When in the recent past might the problem have happened but didn't (or was less intense or more manageable)?" and "What was different about those times when the problem didn't happen?" (Nichols, 2014, p. 355).

The therapist asks the family to describe an earlier time when they overcame a challenge. The family shares that several years ago the daughter had been hospitalized for a month due to an illness and the family had been able to

Scaling is a technique in which the family members are asked to use a scale to identify their progress toward a goal (e.g., a scale of 1 to 10, with 1 representing the "least progress" and 10 representing the "most progress"). This technique provides a practical way for families to measure their own progress on goals both within and between sessions, and can provide a strong sense of optimism and encouragement for families. It is noteworthy that small change on a scale (e.g., a one-point difference) is recognized, and a realistic question, such as "What will it take for you to move from a 4 to a 5?" helps clients focus on realistically continuing their short-term goals.

When asked by the therapist about their progress on this scale, the family states that they are a 2 on the scale of accomplishing their goal of spending more time together, and they brainstorm and select ideas to increase that score to a 4 over the next week.

have told themselves. Instead of focusing on family pathology, deconstruction looks at the roots of the problem as being outside of the family and the family as simply narrating their story based on a social construction. Specifically, deconstruction exposes the problem-saturated stories that can infiltrate a family and make life difficult for them, often without their knowledge of the stories' origin. Deconstructing these problem-saturated stories provides an opportunity for families to fully understand how their lives have been narrated by a particular message that they have unwittingly internalized and acted upon. The process of deconstructing sets the stage for families to gain a new perspective.

Table 6: Concepts and Intervention Skills of Narrative Family Therapy

Concepts

- Deconstruction.
- Unique outcomes.
- Reconstruction.

Intervention Skills

- Mapping the influence of the problem on the family.
- Externalizing conversations.
- Deconstructing destructive cultural assumptions.
- Relative influence questions.
- Reading between the lines of the problem story.
- Reauthoring.
- Reinforcing the new story.

Note. From Nichols, M.P. (2014). *The essentials of family therapy* (6th ed.). Boston, MA: Pearson; and White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: W.W. Norton.

The concept of unique outcomes provides a bridge that links deconstruction and reconstruction. Unique outcomes are those instances in which an individual or a family finds exceptions to their problem-saturated story. They are based on the belief that families have the potential to resist, and have previously resisted, these harmful stories by serving as “building blocks” for preferred stories, or the stories that the families want for their lives (White & Epston, 1990; Nichols, 2014). This insight can help motivate families to enter reconstruction, which occurs when families create new stories (i.e., narratives) that empower them rather than disempower them. Reconstruction provides new ways for families to move forward by freeing themselves of the problem.

Intervention skills

The central skills used by a narrative family therapist include

- Mapping the influence of the problem on the family.
- Externalizing conversations.
- Deconstructing cultural assumptions.
- Asking “relative influence” questions.
- Reading between the lines of the problem story.
- Reauthoring.
- Reinforcing the new story.

Mapping the influence of the problem on the family is the first step of assessment, in which the practitioner explores the family’s understanding of the problem’s negative influence on them. However, the flexibility of this model is such that the skills do not appear sequentially, but rather co-occur during various phases of the therapy.

In conjunction with the first step is a related step of having *externalizing conversations*. Here the practitioner asks questions to help the family isolate the problem from the family.

Returning to the son who is fighting at school and has kept his sexual orientation a secret from his parents, the therapist asks, “Were there times in the past where ‘Secrecy’ tried to get the better of you, but you didn’t let it?”

Because problems are sometimes so intrinsic to a family’s thinking, the forced separation of the problem (by making the externalized problem the focus versus the family member) allows a family to put the role of the problem in perspective.

During mapping, the therapist asks about the family’s anger with the son’s secrecy. The therapist asks the family how “Anger with Secrecy” has affected the family, perhaps illuminating that “Anger with Secrecy” compels them to disconnect and be distant from one another or, conversely, that “Anger with Secrecy” has prompted them to engage in arguments.

During mapping and externalizing conversations, it is sometimes important for the practitioner to engage in *deconstructing cultural assumptions*, which means challenging stereotypes of gender, appearance, sexual orientation, and other stereotypes

that are reflective of dominant yet harmful cultural narratives (Nichols, 2008). Here the therapist asks how the family members were taught and received messages about different groups of people in society. This can promote self-reflection on attitudes and stereotypes for which self-reflection did not exist before.

The practitioner helps the family recognize that cultural assumptions about what it means to be gay had influenced the family’s views, and messages about sexual orientation had contributed to their anger about the son’s secrecy. Indeed, such a question might spur insight that the parents themselves had internalized these cultural assumptions, namely that the parents should be angry about having a son who identifies as gay and therefore should keep this knowledge secret.

Asking *relative influence questions* assesses how deeply the problem has disrupted the family’s life. Asking these questions promotes the externalizing conversations and “is initiated at the outset of the first interview, so that persons are immediately engaged in the activity of separating their lives and relationships from the problem” (Epston & White, 1990, p. 42). This provides the family with a useful gauge to see the problem’s influence.

The therapist asks the parents: “How often does ‘Anger with Secrecy’ appear in your interaction with your son?”

As families are sharing the impact of the problem on their lives, a therapist who is *reading between the lines of the problem story* helps the family explore those times when the problem has not been present (similar to exceptions in the solution-focused model) (Nichols, 2014). This investigation provides an opportunity for the practitioner to assist them in looking for the unique outcomes, namely, those times when the problem did not occur.

In the example, the therapist would explore with the son a time when “Anger with Secrecy” was not present, as well as ask the parents about times when they had not been angry about their son not directly sharing his sexual orientation with them.

The following vignette shows how a practitioner would apply the narrative family therapy model in practice.

The narrative therapy family practitioner began working with the Davis family by mapping the influence of the problem on the family. For Danielle, the problem was the homophobia displayed by her mother and stepfather; for her mother and stepfather, the problem was Danielle’s “homosexuality,” although this was more of a problem for Mr. Davis than for Mrs. Davis. Moving toward externalizing conversation about how the family perceived Danielle’s coming out, the therapist assessed the family and helped them identify that Danielle and Mr. and Mrs. Davis, respectively, were perceiving Danielle’s coming out from two very different perspectives. Though it was challenging to the family members, the practitioner explored the problems as the family presented them; however, being aware that the problem was not same-sex attraction in itself but, rather, the reaction to it, the practitioner suggested that the family explore the consequences of homophobia and homosexuality. The therapist also deconstructed the destructive cultural assumption of homosexuality by educating the couple that same-sex attraction and love is representative of human variance and is not pathology-based, as they may have been socialized to believe through their religion and society as a whole.

The therapist helped the family move toward a common understanding of the problem by continuing to look at its impact. What were the consequences of homophobia from Danielle’s perspective? She felt alienated from Mrs. and Mr. Davis. What were the consequences of “homosexuality” from the couple’s perspective? Both terms, homosexuality and homophobia, might have been very sensitive words for the various family members.

If so, perhaps the common “problem” was how the family members were disappointed in one another and how this disappointment (note the separation from person) was affecting their family. They agreed that the common “problem” was labeled “disappointment related to coming out” (DRCO), and the coming out process could be explored to the extent DRCO had affected the family. All family members shared that this DRCO affected them a great deal. Asking relative influence questions served to further provide information on the impact of DRCO on the family members’ lives, including DRCO’s interaction with the family members’ faith.

Shifting to reconstruction, the practitioner read between the lines of the problem story and sought unique outcomes such as times the couple did not feel in conflict with their religious beliefs when loving and supporting their daughter. The practitioner asked the couple if there was a time when they were not DRCO and Mrs. Davis said there was one time, when she had hugged her daughter and told her she loved her anyway, even though she was still in shock. The practitioner recognized this as significant. Mr. Davis said there was never such a time for him. Then the practitioner creatively expanded the unique outcomes to see if there was a time when the family was not disappointed with each other, and they shared a number of positive moments when they had been proud of each other. Going with this new story, the practitioner acknowledged that if they had pride in each other before, they could have pride in each other again, and encouraged them to have hope for their survival as a family unit.

This belief by the therapist provided inspiration for the family to continue to think about how to “reauthor” their story in family therapy by continuing to explore how, as a family, they could be proud of each other amidst the news of Danielle’s coming out. This remained a challenging process but the therapist reinforced the new story by writing a letter to the family explaining that they were on a journey that, while challenging, filled everyone with optimism because they were doing the hard work to ensure that they could be proud of each other as a family again. The practitioner also recommended that the family could visit a Parents, Friends

and Families of Lesbians and Gays (PFLAG) meeting (a support group for families of LGBT youth) to find support from other families who were also reconstructing their stories and engaging in the healing process.

When reconstructing the new story, two other skills are used, reauthoring and reinforcing the new story. Reauthoring refers to “the process of persons’ entering their stories, taking them over and making them their own” (White & Epston, 1990, p. 13). Via the unique outcomes (building blocks to new narratives) that the families have identified, and awareness of the social influence of the problem on their behavior, families create new stories or narratives.

The therapist helps the family create a new story in which they replace “Anger with Secrecy” with “Compassion” when they think of their son/brother (and when the child thinks of himself). This reauthoring shifts the focus by empowering the family so that they can address and provide support on overcoming the family’s contribution to the reasons that left the son feeling a need to keep his sexual orientation secret.

Of course, building a new narrative is not easy because families have been socialized, at times for years and decades, into the problem-saturated story. Therefore, it is important for the practitioner to lead the family in reinforcing the new story. The practitioner can assist by actually writing a letter to the family, telling them of their progress in shifting stories that will help them heal. Other examples include providing the family with certificates which announce their new stories, and sharing the new story with others who will support the family in their new view as witnesses to or allies in the new story (Nichols, 2014).

These additional social supports can help the family in adhering to their new story of being compassionate with one another and deciding, with the son/brother, that they want to provide support to him and be a source of compassion and stability for one another while they make this new journey together. The therapist could write the family a letter recognizing the new story that they have decided to live by. The therapist could also encourage the family to share this news with a few trusted extended family members and friends to help reinforce their new story.

OTHER MODALITIES WITH LGB YOUTH AND THEIR FAMILIES

While the focus of this course is on using specific therapeutic models in working with LGB youth and their families, other interventions are helpful at times in working with this population. The knowledgeable practitioner will increase her

Crisis intervention

A spate of teen suicides in the U.S. LGB community in 2010 brought important attention to the needs of youth who are in crisis. At times, healthcare professionals may encounter an LGB youth who is suicidal – the intervention would be no different from that for those who are not LGB: ensure safety, establish rapport, identify positive options, make referrals, and follow up. Interventions can range from ensuring that parents are monitoring their child and have access to appropriate hotlines,

Individual therapy

Individual therapy or counseling is another common intervention with this population. The practitioner might identify one or more family members who would benefit from private counseling. These needs might include further assistance with self-acceptance related to coming out, further assistance with accepting a family member who is LGB, and potential conflict between an individual’s culture or religion and sexual orientation. If this is the case, the family members can consider this additional option. Models of individual therapy that can be used in working with LGB youth or their individual family

or his competence by having general knowledge about these interventions because questions about them might arise in the course of family therapy.

such as the Trevor Project (see Resources), to, in the most extreme cases, arranging for involuntary hospitalization of the youth. While suicidal ideation requires urgent attention, other crises include child maltreatment where the child is at imminent risk for physical harm, neglect, or being forced to leave the family home. In these cases, healthcare professionals should call the regional child abuse hotline and, in the most urgent of situations, contact the police.

members include solution-focused therapy and narrative therapy (discussed earlier), as well as cognitive-behavioral therapy, psychodynamic therapy, and motivational interviewing.

It is important to reiterate that reparative or conversion therapy, in which an LGB individual is encouraged to “renounce” his or her LGB status, is not recommended by any major medical or mental health associations because it operates from the assumption that LGB status is immoral and because counseling based on this assumption can be harmful (AAP, 2013).

Group work

Coming out and facing the variety of issues related to being LGBT can be daunting, and many individuals (both youth and parents) do not wish to face them alone. While many seek some form of informal social support, some individuals benefit from participation in formal group work.

Group work can be led by formal facilitators or be self-led. Groups for this population include working with youth as well as the nationally known PFLAG. The purposes of group work

include support, socialization, and therapy. A popular model of group work for this population is “mutual aid,” in which the group provides mutual support, respectful challenging, and rehearsal to assist group members in attaining their goals (Rosenwald, in press). Additionally, in this Internet age, online groups have become increasingly popular and greatly assist families in more rural areas where real-time support and therapy groups do not exist.

Information and referral

As the topic of LGBT youth becomes more commonplace in the public arena, more resources are being created. The healthcare professional who works with LGBT youth and their families should have a general awareness of local, state, and national resources that can provide assistance to this population. A comprehensive guide to these resources appears in the Resources section, which covers a wide range of information including youth advocacy, family support, legal advice, and religious and spiritual considerations. Knowing this information and conveying it to LGBT youth and their families can provide assistance both during and after the practitioner has ended the professional relationship with the family.

At times, a practitioner might be directly involved in the referral process or might provide the information to the youth or family so that they may self-refer. “Outing” the youth or family is a major ethical violation, and specific permission in the form of assent from the youth and consent from the parents is required if disclosing the child’s sexual orientation is directly or indirectly part of the referral. When making the referral directly, it is important to respect confidentiality and foster trust in families for mental health supports. For example, if a school counselor is connecting the family with a therapist who specializes in work with LGBT youth, she can specifically ask the family to sign a release allowing her to talk with the therapist. In addition, the

school counselor can tell the family specifically what she will say, as in “I think it will be helpful to tell the therapist about how coming out has been affecting everyone. That way the therapist can be most helpful.” If a youth wants to be out but his or her parents do not, the school counselor can work with the family to find wording they are comfortable with. If an agreement cannot be reached, the school counselor can simply provide referral information to the family and let them communicate directly with the therapist.

Often it is helpful for youth and families to be referred to supports that are geared specifically to LGBT youth and their families. This can be very helpful but also challenging because for some people it will be the first time they will attend something that has the potential to “out” them. Examples of such supports are a community or school LGBT youth support group or a PFLAG meeting. When referring clients to these resources, it is a good idea to talk with the family about how it will be for them to attend a meeting with other LGBT youth or family members. What would be hard about it? How would they handle this? It is also important to note that for some youth whose families are not supportive, they may need to be referred to supports that do not require parental permission and will protect their confidentiality.

Conclusion

This course provided an overview of lesbian, gay, and bisexual youth development and contemporary issues that affect youth. Additionally, the course provided three models of family therapy (structural family therapy, solution-focused therapy, and narrative therapy) and applied the three therapeutic models to helping the family portrayed in the corresponding vignette. Finally, the course offered brief discussion about additional interventions to assist LGBT youth and their families, including crisis intervention, individual therapy, group work, and information and referral.

While the models presented here provided the basics of intervention, those interested in implementing these interventions are strongly encouraged to take additional course

work on the family therapy models presented as well as to seek additional information on the other interventions described.

Further, behavioral health and healthcare professionals are encouraged to be “change agents” in their personal and professional lives with respect to this population. This means that these professionals must constantly be aware of heterosexism and homophobia that occur in society and seek to reduce them, whether by conversing with a colleague or writing a letter to one’s legislator. Indeed, this can apply to any form of prejudice and discrimination that is encountered. The increased attention to the issues facing LGBT youth is an encouraging sign, but much work remains to ensure that LGBT youth – and their families – are as safe, supportive, and healthy as possible.

Resources

- **American Academy of Pediatrics**
Medical organization that provides information, including relating to LGBT youth.
Website: <http://www.aap.org>
- **Dulwich Centre**
International center for narrative therapy and community work.
Website: <http://dulwichcentre.com.au>
- **Family Acceptance Project**
Organization focused on interventions with LGBT youth and their families.
Website: <http://familyproject.sfsu.edu/home>
- **Human Rights Campaign**
Resource for education and lobbying for the LGBT population.
Website: <http://www.hrc.org>
- **It Gets Better Project**
Organization that provides mentorship and support to LGBT youth.
Website: <http://www.itgetsbetter.org>
- **Minuchin Center for the Family**
Organization devoted to training and consultation on structural family therapy.
Website: <http://minuchincenter.org>
- **National LGBTQ Task Force**
Organization devoted to LGBTQ civil rights and policy.
Website: <http://thetaskforce.org>
- **Parents, Families and Friends of Lesbians and Gays (PFLAG)**
Resource for support individuals for the LGBTQ population.
Website: <http://pflag.org>

- **Solution-Focused Brief Therapy Association.**
Organization devoted to solution-focused brief therapy.
Website: <http://www.sfbta.org>
- **The Gay, Lesbian & Straight Education Network (GLSEN)**
Organization that provides support for LGBTQ youth in schools.
Website: <http://www.glsen.org>

- **The Trevor Project**
Online resource and hotline that helps youth who are contemplating suicide and provides answers to general questions about youth sexual orientation and gender identity.
Telephone: 866-4.U.TREVOR [866.488.7386]
Website: <http://www.thetrevorproject.org>

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BEST PRACTICES WITH LESBIAN, GAY & BISEXUAL YOUTH AND THEIR FAMILIES, UPDATED 1ST EDITION

Final Examination Questions

Select the best answer for each question and complete your test online at **EliteLearning.com/Book**

- What percentage of the youth population is estimated to identify as gay or lesbian?
 - Less than 5%.
 - 10%.
 - 25%.
 - 30%.
- Homophobia refers to the:
 - Prejudice and/or discrimination toward individuals based on their perceived or actual sexual orientation.
 - Social structure that privileges heterosexual identities and discounts same-sex interactions.
 - Process by which an individual becomes comfortable with his or her sexual orientation.
 - Dynamic that occurs when a person questions her or his gender identity.
- Which of the following terms describes the process of an individual admitting to himself or herself and to other people that he or she is lesbian, gay, or bisexual?
 - Resiliency.
 - Coming out.
 - Boundary making.
 - Heterosexism.
- An additional developmental challenge for LGB youth is:
 - The shift to adults as their primary social influence.
 - Determining the origin of their sexual orientation and seeking to extinguish it.
 - Assessing family structure to determine the implications of identity development in a narrative family context.
 - Accepting a primarily nonheterosexual sexual orientation in a social context that is still characterized by heterosexism and homophobia.
- One stage of Troiden's model on homosexual identity development is identity:
 - Clarity.
 - Despair.
 - Assumption.
 - Formation.
- Diversity includes attention to variance in the LGB population by race, gender, and:
 - Intelligence.
 - Boundaries.
 - Class.
 - Height.

7. Which of the following is a true statement about the coming out process?
 - a. This process only affects the youth in question.
 - b. This process affects bisexual youth more than lesbian and gay youth.
 - c. This process can prompt families to enter a grieving process.
 - d. This process occurs at older ages than ever before.
8. "The Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act addresses which of the following issues affecting LGB individuals?"
 - a. Heterosexism.
 - b. Violence.
 - c. Relationships.
 - d. Coming out.
9. Which of the following is a true statement about LGB youth and suicide attempts?
 - a. LGB youth attempt suicide at a rate similar to that of their heterosexual peers.
 - b. LGB youth have a higher suicide attempt rate than their heterosexual peers.
 - c. LGB youth have a lower suicide attempt rate than their heterosexual peers.
 - d. The relationship between suicide attempt rates and an LGB identity in youth is unclear.
10. Reparative therapy is an intervention model that is considered:
 - a. Helpful with upper-class families.
 - b. Particularly useful for lesbian youth.
 - c. In need of more research to determine its utility.
 - d. Damaging to a client's health and well-being.
11. When working with LGB youth in foster care, practitioners should:
 - a. Expand the notion of "family" to include foster parents, group home staff, the child's community, and others involved in the child's care.
 - b. Assume that the youth will never return home due to safety concerns.
 - c. Feel confident that heterosexism and homophobia faced at home do not occur in child welfare settings.
 - d. Reduce their involvement so as not to conflict with the foster care worker.
12. Subsystems are a central concept associated with:
 - a. Narrative family therapy.
 - b. Structural family therapy.
 - c. Solution-focused family therapy.
 - d. Mutual aid therapy.
13. When a boundary within the family system is rigid, the family is characterized by:
 - a. Enmeshment.
 - b. Clarity.
 - c. Cloudedness.
 - d. Disengagement.
14. Asking the "miracle question" is a technique used in:
 - a. Mutual aid therapy.
 - b. Narrative family therapy.
 - c. Solution-focused family therapy.
 - d. Structural family therapy.
15. The use of "scaling" is an important technique associated with:
 - a. Structural family therapy.
 - b. Narrative family therapy.
 - c. Solution-focused family therapy.
 - d. Mutual aid therapy.
16. "Deconstruction" is a central concept of:
 - a. Narrative family therapy.
 - b. Structural family therapy.
 - c. Cognitive-behavioral therapy.
 - d. Reparative therapy.
17. Narrative family therapy techniques include:
 - a. Externalizing conversations.
 - b. Joining and accommodating.
 - c. Exception seeking.
 - d. Enactment.
18. A central component of crisis intervention is:
 - a. Providing self-disclosure.
 - b. Reviewing mutual aid.
 - c. Identifying enmeshment.
 - d. Ensuring safety.
19. The purpose of group work with the LGB population includes socialization, therapy, and:
 - a. Engagement.
 - b. Enmeshment.
 - c. Support.
 - d. Structure.
20. Information and referral are:
 - a. Important services commonly offered by the practitioner.
 - b. Unnecessary because clients are experts in their lives.
 - c. Quite challenging because few resources exist.
 - d. The task of the parent(s) in helping their children.

Chapter2 : Body Image and Dissatisfaction: Theories and Cultural Considerations

3 Contact Hours

Release Date: November 26, 2018

Expiration Date: December 31, 2023

Upon successful completion of this course, continuing education hours will be awarded as follows:

- **Social Workers and Psychologists: 3 Hours**
- **Counselors and Marriage and Family Therapists: 3 Hours**

Faculty

Author:

Sara E. Pula, PhD, NCC, LCPC, ACS, is a locally recognized expert in the field of body image and body dissatisfaction, particularly regarding females in adolescence and early adulthood. She has worked in the field for more than 20 years, creating a group counseling curriculum, guest lecturing, and presenting at professional conferences on a national and local level. She is the author of "Understanding the Relationship between Culture and Body Image: How Do Asian American and Hispanic American Women Construct a Body Image?" In addition to serving as the director of clinical training at Trinity Washington University in Washington, DC, Dr. Pula teaches counseling content courses and supervises clinical training. Dr. Pula trains students on eating disorder and body image assessments and facilitates campus-wide body image and eating disorder screenings. She sits on the Anne Arundel County Social Services Advisory Board, chairs the Emerging Leaders Committee for the Maryland Counseling Association, and sits on the National Capital Area Consortium on Traumatic Death and Restoration Committee. Dr. Pula received her master's degree in School Counseling from the George Washington University in 2002 and her doctoral degree in Counseling Education and Supervision from the George Washington University in 2014. She is a Licensed Clinical Professional Counselor in the state of Maryland and an Approved Clinical Supervisor.

Sara E. Pula has no significant financial or other conflicts of interest pertaining to this course.

How to receive credit

- Read the entire course online or in print.
- Depending on your state requirements you will be asked to complete:
 - A mandatory test (a passing score of 75 percent is required). Test questions link content to learning

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Lauren McLean has no significant financial or other conflicts of interest pertaining to this course.

Behavioral Health Planner: Beth B. Russell, PhD, LCSW

The planner who worked on this continuing education activity have disclosed that they have no significant financial or other conflicts of interest pertaining to this course book.

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to diagnostic and treatment options of a specific patient's medical condition.

INTRODUCTION

Learning objectives

After completing this course, the learner will be able to:

- Describe terms, prevalence, and cultural factors related to body image and body dissatisfaction.
- Explain the theories that address body image and body dissatisfaction.
- Identify the effects of negative body image on an individual's well-being, including mental health.
- Describe standard assessment scales for measuring body image and body dissatisfaction and treatment methods.

Course overview

The past two decades have seen a marked increase of interest in body image. This intermediate-level course provides an overview of the complexities of body image and body dissatisfaction for a broad range of populations. This course reviews theoretical foundations of how cultural beauty ideals are transmitted. Through case examples and a review of research, it addresses

the internalization of beauty messages in the media, the difference between body dissatisfaction and eating disorders, the relationship between a negative body image and mental health, and the potential progression from negative body image into a clinical eating disorder.

INTRODUCTION

Throughout the past two decades, an increased interest in body image and its related topics has erupted. This is in part due to girls and women feeling “normative discontent” with their physical appearance, an increase in global negative evaluations of bodies, and the study of culture and acculturation. Additionally, research has expanded to populations not previously studied, including males; ethnically diverse populations; lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals; and individuals with appearance-altering medical disorders (disfiguring congenital conditions, dermatological issues, disfiguring cancers, dental issues, immune system disorders, etc.; Frederick & Essayli, 2016; Huxley Clarke, & Halliwell, 2014; Liu, Peh, & Mahendran, 2017; Shen et al., 2015). Other contributing factors to this rise in interest include how negative body image and body dissatisfaction influence men and women's health, such as the potential for clinical eating disorders, disordered eating, lower levels of self-esteem, and increased rates of depression. The focus on prevalence by ethnicity and identifying variation within, among, and across cultures exacerbates the many facets of these challenging issues. Culture has a great deal to do with how beauty is conceptualized, how ideal beauty is defined, and whether ideal beauty is valued or devalued. Cultural beauty ideals should therefore be continually evaluated and reevaluated by society, by individuals within each culture, and by body image researchers. In addition, acculturation has been widely researched among ethnic minority women, and acculturative stress has been correlated with a drive for thinness in Hispanic women (Olvera, Matthews- Ewald, McCarley, Scherer, & Posada, 2016). The wide range of populations and body image issues just indicated illustrates the complexities of understanding body image in the United States today.

Despite the noted growth of interest in understanding body image, gaps in knowledge still exist in the academic literature and clinical training of master's level human service and

behavioral health practitioners. Clinicians are not routinely trained in body image issues. They are trained only to recognize eating disorder issues rather than body image issues, although training and knowledge in eating disorders are limited as well. These gaps of understanding and knowledge include the following: poor understanding of body dissatisfaction in women from diverse ethnic backgrounds; confusion over the relationship between acculturation and body image for ethnic populations; body dissatisfaction symptomatology based largely on the experiences of only Caucasian women; and the fact that information reported on body dissatisfaction in women from diverse ethnic backgrounds is mostly limited to such global assessments as satisfied versus dissatisfied with overall body image, rather than more specific, culturally defined aspects of body image.

The purpose of this intermediate-level course is to provide human service, behavioral, and mental health professionals with an overview of the complexities of body image and, in particular, body dissatisfaction, for a broad range of populations. This course reviews theoretical foundations of how the cultural beauty ideals that influence an individual's body image are transmitted. It addresses the internalization of beauty messages, such as the thin ideal and its perpetuation through the media; the difference between body dissatisfaction and an eating disorder; the relationship between a negative body image and mental health issues such as anxiety and depression; and the potential progression from negative body image into a clinical eating disorder. Lastly, the course addresses how to assess various body image issues, such as an individual's rating of separate body parts, and treatment options for those with a negative body image or body dissatisfaction. This course is for social workers, psychologists, mental health counselors, and marriage and family therapists who want a better understanding of body image and body dissatisfaction, its manifestation in clinical practice, and possible intervention strategies.

BODY IMAGE AND BODY DISSATISFACTION

Definitions

Before discussing the many facets of body-related concerns, it is important to define the terms *body image* and *body dissatisfaction* that will be used throughout the course. *Body image* is a global term that represents how a person feels internally and subjectively perceives his or her own outer physical appearance. It is an individual's perception of his or her physical form that may be positive or negative. Body image is often closely related to an individual's level of self-esteem, behaviors, and attitudes. The term *body image* is often used interchangeably with such terms as *body image disturbance*, *body dissatisfaction*, and *body esteem*.

Body dissatisfaction is defined as the negative subjective evaluation (dysfunctional feelings and beliefs) about an individual's body and includes cognitive, behavioral, and affective features. Body dissatisfaction usually includes an individual's dysfunctional feelings and beliefs of self-appraisal. It is one of the most important global measures of distress and is often attributed to social factors such as the media, peer interactions, and comparing an individual's body to a perceived ideal body image. A closely related, yet distinct, body image construct is that of shape/weight overvaluation. This is defined as a person's concern with his or her shape and/or weight and how that factors into his or her feelings of self-worth (Mitchison et al., 2017).

PREVALENCE RATES AND CULTURAL FACTORS

Adolescent girls

By the time a young girl reaches adolescence, ages 10 through 19 as defined by the World Health Organization (2018) and ages 12 to 19 in the United States, she is at risk for body image concerns, concerns with weight, and disordered eating. Disordered eating is used to control weight and includes such behaviors as dieting (through the use of diet pills or participating in eating trends), fasting, and purging (through the use of laxatives or vomiting). In preadolescent girls (ages 9 to 11), up to 50% report dissatisfaction with their weight or shape, and 10% report participating in dieting (Rodgers, Paxton, & McLean, 2014). In 12-year-old girls, 14% report binge eating, 25% to 55% report dieting, and 48% report unhealthy weight-control behaviors (e.g., fasting, using food substitutes; Westerberg-Jacobson, Ghaderi, & Edlund, 2012). In adolescent girls nationwide, 21.8% reported engaging in disordered eating behaviors, 45.8% in dieting, 50.2% in unhealthy weight-control behaviors, and 6.8% in extreme weight-control behaviors (Bucchianeri et al., 2016; Loth, MacLehose, Bucchianeri, Crow, & Neumark-Sztainer, 2014). Some studies have even shown female children as young as 6 years old reporting body dissatisfaction (Grogan, 2016). Thus, it is important for clinicians to understand the underlying factors of why so many adolescent girls do not have a healthy body image, as well as the correlations among body image concerns and other health-related risks.

Body dissatisfaction and negative body image are risk factors for clinical eating disorders, low levels of self-esteem, symptoms of depression, negative affect, and disordered eating (National Eating Disorders Association [NEDA], 2018). Similarly, clinical eating disorders (nervosa [AN], bulimia nervosa [BN], and binge eating disorder [BED]) can lead to general, yet serious, health concerns. These include amenorrhea (loss of menstrual cycle), osteoporosis, muscle loss and weakness, hair loss, dehydration, electrolyte imbalances, type 2 diabetes, kidney disease, tooth decay, pancreatitis, high blood pressure, high cholesterol, heart disease, and gallbladder disease (NEDA, 2018). Further, as individuals with body dissatisfaction and weight concerns progress from adolescence into early adulthood, dieting and disordered eating not only persist but often increase (Grogan, 2016). In a longitudinal study, girls aged 11 to 18 who indicated high weight importance continued to participate (75.1%) in dieting and disordered eating behaviors 10 years later, at ages 21 to 28. Those who indicated high weight importance and low body satisfaction but did not participate in dieting or disordered eating in adolescence reported initiating these behaviors (46.7%) during study follow-up at ages 21 to 28. These data indicate the insidious and lasting nature of body dissatisfaction and weight concerns from adolescence well into adulthood (Loth et al., 2014).

Women

Traditionally, body image has been seen as a young person's issue, affecting young girls, adolescent girls, and college-aged women. Recently, body image and body dissatisfaction studies have been expanded to include middle-aged and older women (including postmenopausal women), women with uterine fibroids, pregnancy and postpartum body image issues, body image issues associated with intimate partner violence, and those with issues associated with substance abuse recovery.

Studies on body image in middle-aged and older women revealed that body image disorder and/or eating disorders are common in the older female population (ages 55 and up). Further, older women tended to report BEDs and subclinical eating disturbances (e.g., disordered eating) more than clinical levels of anorexia or bulimia (Mangweth-Matzek, Hoak, & Pope, 2014). In a study of 1,849 women in the community aged 50 and older, 13.3% reported eating disorder symptoms, and 3.5% reported binge eating (Gagne et al., 2012). Similarly, in an online study of 5,868 women, body dissatisfaction was found to exist in various age groups of women, with 72% of women in the

In a study of body dissatisfaction associations with disordered eating among ethnically diverse adolescents, Asian American girls reported the highest body dissatisfaction (29.6%), then Hispanic American girls (28.4%), and finally, African American girls (23.6%). In terms of engaging in dieting behavior, ethnicity followed the same pattern, with Asian girls reporting 58.6%, Hispanic girls reporting 46.9%, and African American girls reporting 38.9% (Bucchianeri et al., 2016). For a further breakdown of these numbers in greater depth, see Table 1.

Of these diverse populations, high body dissatisfaction was more likely to predict dieting (69.4%), unhealthy weight-control behaviors (71.6%), and binge eating (7%) in Asian American girls. High body dissatisfaction was more likely to predict extreme weight-control behaviors in African American girls (8.8%). Unhealthy weight-control behaviors included fasting, eating very little food, using a food substitute (e.g., Slimfast), or skipping meals. Extreme weight-control behaviors included taking diet pills, making oneself vomit, using laxatives, and using diuretics (Bucchianeri et al., 2016).

Table 1: Body Dissatisfaction and Disordered Eating Among Ethnically Diverse Female Adolescents

Asian American Adolescent Females:

- 63.7% engage in unhealthy weight-control behaviors
- 6.4% engage in extreme weight-control behaviors
- 6.9% engage in binge eating
- 18.5% report depressive symptoms
- 16.3% report low self-esteem

Hispanic American Adolescent Females:

- 48% engage in unhealthy weight-control behaviors
- 6.7% engage in extreme weight-control behaviors
- 4.0% engage in binge eating
- 18.2% report depressive symptoms
- 17.3% report low self-esteem

African American Adolescent Females:

- 46% engage in unhealthy weight-control behaviors
- 7.5% engage in extreme weight-control behaviors
- 4.8% engage in binge eating
- 17.5% report depressive symptoms
- 8.6% report low self-esteem

Note. Adapted from Bucchianeri, M. M., Fernandes, N., Loth, K., Hannan, P. J., Eisenberg, M. E., & Neumark-Sztainer, D. (2016). Body dissatisfaction: Do associations with disordered eating and psychological well-being differ across race/ethnicity in adolescent girls and boys? *Cultural Diversity and Ethnic Minority Psychology*, 1, 137-146. <http://dx.doi.org/10.1037/cdp0000036>

age group of 75 and above reporting dissatisfaction with their bodies. Although these numbers are a bit lower than those for other age groups (see Table 2 for additional statistics by age group), nearly 3 out of 4 women in this age group reported feeling discontent.

Table 2: Body Dissatisfaction of Adult Women by Age

35 to 44	93%
45 to 54	89%
55 to 64	89%
65 to 74	88%
75+	72%

Note. From Runfola, C. D., Von Holle, A., Trace, S. E., Brownley, K. A., Hofmeier, S. M., Gagne, D. A., & Bulik, C. M. (2013). Body dissatisfaction in women across the lifespan: Results of the UNC-SELF and Gender and Body Image (GABI) studies. *European Eating Disorders Review*, 21, 52-59.

Perimenopausal women reported higher rates of eating disorders, higher rates of feeling fat, and higher scores on the Body Shape Questionnaire than premenopausal women (Mangweth-Matzek et al., 2014). Researchers concluded that menopausal women exiting reproductive life are at increased risk for eating disorders similar to the risk of adolescent girls entering reproductive life at puberty. This increased risk is due to women feeling the importance of their appearance, experiencing “fat talk” (conversation that reinforces the thin ideal as a female standard of beauty), experiencing “old talk” (conversation that reinforces the young ideal as a standard of female beauty), and

Boys

In adolescent boys, body image concerns consist of weight perception, lean muscularity, masculinity, athleticism, and body strength. For adolescent boys, there is a reverse directionality of body distortion compared with adolescent girls. Adolescent boys tend to perceive themselves as too small, strive to increase their size, and work toward the muscular ideal, whereas adolescent girls tend to perceive themselves as too large, strive to decrease their size, and work toward the thin ideal. In normal-weight males (as defined by being proportional for height and weight), 19% to 25% perceive themselves as too small (i.e., underweight; Chapman & Woodman, 2016; Dakanalis & Riva, 2013). Risks of body dissatisfaction in adolescent boys include reverse anorexia (fear of being too small), steroid use, excessive exercise, depression, and eating disorder symptomatology (Dakanalis & Riva, 2013; Tod, Edwards, & Hall, 2013).

In adolescent boys nationwide, 11.2% reported engaging in disordered eating behaviors, 31.1% in dieting, 38.1% in unhealthy weight-control behaviors, and 3.9% in extreme weight-control behaviors (Loth et al., 2014). Similar to the persistence of body dissatisfaction and disordered eating in adolescent girls, adolescent boys (11 to 18 years of age) who indicated high weight concern and weight importance continued to engage in disordered eating in early adulthood (21 to 28 years of age). It is important to note that these studies are not as numerous in comparison with research on adolescent girls, so the numbers may in fact be higher than reported. Clinicians working with adolescent boys may want to take into consideration that adolescent boys and girls should be screened for disordered eating patterns and body dissatisfaction.

In a study of body dissatisfaction associations with disordered eating among ethnically diverse adolescents, boys showed similar results as ethnically diverse girls, with Asian American boys reporting the highest body dissatisfaction (29.6), then Hispanic American boys (24.6), then African American boys (23.4). For a further breakdown of specific factors by race, see Table 3.

Men

Until the past few decades, body image concerns for men have not been addressed in much of the clinical literature or behavioral health training programs. And yet, body dissatisfaction and disordered thinking are common issues that arise in a large percentage of men who seek treatment for issues related to mental health. Body ideals for men in the United States consist of an overall mesomorphic (i.e., lean and muscular) ideal (Edwards, Tod, Molnar, & Markland, 2016). This includes being lean, focusing on muscularity, and having an overall body in the shape of a “V” – broad shoulders contouring down to a thin waist and having abdominal muscles that represent a “six-pack” (Murnen, 2012). Other body ideals also include having a full head of hair, yet a hairless chest, and a well-groomed body. The functionality of the male body is also an important underlying factor in understanding body image, with an emphasis on action and being strong, dominant, and competitive. Stereotypical male attitudes include liking athletics and the importance of winning (Deaner, Balish, & Lombardo, 2016; Murnen, 2012). Popular media routinely feature men

feeling fat due to hormonal issues and slowed metabolism. The research also stated, inconclusively, that these incidences were more likely recurring eating disorders from past experiences, rather than late onset of a new eating disorder (Mangweth-Matzek et al., 2014). Lower body satisfaction predicts more fat talk, higher rates of depression, and greater perceived societal pressure to be thin (Sharpe, Naumann, Treasure, & Schmidt, 2013). Thus, menopausal women should be screened carefully for such risk factors, including fat talk and depression, and be provided support and/or counseling when appropriate.

Of these diverse populations, high body dissatisfaction was more likely to predict dieting (39.1%), unhealthy weight-control behaviors (48.7%), and binge eating (2.7%) in Asian boys. High body dissatisfaction was more likely to predict binge eating in African American boys (3.5%) and mixed-race/other boys (3.3%; Bucchianeri et al., 2016).

Table 3: Body Dissatisfaction and Disordered Eating Among Ethnically Diverse Male Adolescents
Asian American Adolescent Boys: <ul style="list-style-type: none">• Of Asian American boys, 48% engaged in unhealthy weight-control behaviors, with• 5.0% engaging in extreme weight-control behaviors,• 3.2% engaging in binge eating,• 16.5% reporting depressive symptoms, and• 16.6% reporting low self-esteem.
Hispanic American Adolescent Boys: <ul style="list-style-type: none">• Of Hispanic American boys, 40% reported engaging in unhealthy weight-control behaviors, with• 2.8% engaging in extreme weight-control behaviors,• 2.1% engaging in binge eating,• 16% reporting depressive symptoms, and• 18.3% reporting low self-esteem.
African American Adolescent Boys: <ul style="list-style-type: none">• Of African American boys, 38.1% reported engaging in unhealthy weight-control behaviors, with• 5.6% engaging in extreme weight-control behaviors,• 2.9% engaging in binge eating,• 15.5% reporting depressive symptoms, and• 18.8% reporting low self-esteem.
Note. Adapted from Bucchianeri, M. M., Fernandes, N., Loth, K., Hannan, P. J., Eisenberg, M. E., & Neumark-Sztainer, D. (2016). Body dissatisfaction: Do associations with disordered eating and psychological well-being differ across race/ethnicity in adolescent girls and boys? <i>Cultural Diversity and Ethnic Minority Psychology</i> , 1, 137-146. http://dx.doi.org/10.1037/cdp0000036 .

who are considered attractive due to their lean and muscular physique. However, this ideal contrasts significantly with the average heterosexual or gay male in the United States, leaving many dissatisfied with their bodies and appearance. Men who are slender or very heavy in particular tend to experience body dissatisfaction. Forty-one percent of heterosexual men consider themselves to be too heavy and are self-conscious about their weight. This number rises to 83% in heterosexual men who are considered obese. Thirty percent of heterosexual men are dissatisfied with their muscle size and tone, and 22% are dissatisfied with their physical appearance (Frederick & Essayli, 2016). Similar to girls and women, men who are dissatisfied with their appearance are more prone to experience such mental health issues as depressive symptoms, low self-esteem, eating disorders, and negative affect (Wilson, Latner, & Hayashi, 2013). This is illustrated in the following case study.

Case study 1

Andrew, a White male, 45 years of age, struggled with thinking he was ugly and fat as a young child. This is not so uncommon these days, even for boys, but when his body image issues spiraled into an eating disorder, nobody ever thought to ask him about issues with food. In the 1980s and 1990s, eating disorders were considered a problem of young, White, teenage girls among the psychiatrists and therapists treating Andrew for his “depression.” Nobody considered his “overeating” as an actual eating disorder because there was little discussion of boys or men with the diagnosis of an eating disorder. What his doctors, therapists, coaches, family, and friends saw was a boy, and eventually a man, who liked to eat a lot. The consensus was that he just needed to work on dieting and getting more exercise. More so, if he would just stick to a prescribed program and lose weight, he would be more confident and feel better about himself. His disorder waxed and waned for almost two decades as a result of the near total lack of awareness of signs and symptoms of eating disorders and body image disturbance in males.

As a chubby teen, Andrew was told over and over again that he was too fat to be acceptable to his peers, too slow for his coaches, too embarrassing for his family, and just too big by any number of people. To Andrew, food was the epicenter of love, joy, and happiness in his lonely world. He felt like everyone wanted to take that away, leaving him all the more vigilant and anxious. As Andrew grew older, he realized that dieting seemed to be the thing that made everyone proudest of him. Because attention was what he wanted most, he didn’t care if his crash diets left him weak, irritable, loopy, and tired. He didn’t care that living like that was unsustainable, that he’d become an emotional wreck, or that he’d inevitably be driven to binge eat and recycle his self-loathing as a result. He needed the high praise that came from having a slender body. He didn’t necessarily have to be perfect, with washboard abs and rock-hard biceps. That was never the issue. But he couldn’t have an overhanging belly. He couldn’t have a little bump over the top of the button and zipper of his pants. He couldn’t have male breasts, which he had developed by the time he was in middle school. So Andrew dieted and got the praise he wanted, and people picked on him less at school. Every now and again, a cute girl found him cute too. And all his male role models

finally found him acceptable, whether it was his swimming or baseball coach, a doctor, or his father. Losing weight may not be the easiest way to get attention, but it was the best and most effective method he had at his disposal, and it reinforced his unhealthy relationship with food.

Andrew believes the messages he has been sent that being a man means having willpower, and every time Andrew failed on a diet, he felt it proved how inferior his manhood was. Although in no way effeminate, Andrew often thought he had more feminine physical features than masculine ones because he was more soft and squishy than muscular and solid. He often wanted to be able to talk about these issues with somebody who really understood, but he never felt comfortable doing so. He therefore tried to fix himself, to shed his body of all his “gross and awful” fat, to lose his torturous male breasts, love handles, and Buddha-like potbelly.

Andrew remained unhappy and had thoughts of suicide. He was prone to fits of rage and tearing apart his room, punching walls and doors, and even putting his fist through windows. He pressed knives against his wrists and screamed at himself to just “go ahead and make a cut.” He didn’t want to socialize, couldn’t keep a job, and dropped out of college. There were many signs of depression that had nothing to do with his binge eating. Eventually, it was his lethargy, pervasive sadness, loss of interest in life, loss of sex drive, and fits of rage that led Andrew to get some help. (Case study from Walen [2016]. Used with permission.)

Clinician’s Note

This case study shows how boys and men, until recently, had been excluded from the eating disorders conversation. Further, it shows how binge eating was not an identified disorder and what a disservice this was for many people. If individuals did not fit into certain categories – female, suffering from anorexia or bulimia – they were likely to be misdiagnosed and mistreated. The case study shows the cyclical nature of a binge eating disorder, as well as the connection with depression, the stigma of not fitting into gender stereotypes, and the negative decline of someone with an undiagnosed eating disorder and body image issue.

LESBIAN WOMEN

The body image experiences of gay men and lesbian women vary considerably from each other, as well as from those of heterosexual men and women. In assessing the body image experiences of gay men and women, one must consider the role of gay and lesbian culture in shaping these experiences. For example, lesbian women face the oppressive ideals of the dominant heteronormative culture as well as the ideals of the lesbian community, which differentiates between someone who is “femme-identified” (representing the dominant heteronormative female image) and a more androgynous or “butch” image (representing the dominant heteronormative male image). Some argue that being a sexual minority woman may serve as a protective factor and lead to higher body esteem in that lesbian women have reported less body dissatisfaction than heterosexual women (Alvy, 2013). When lesbian and bisexual women did report body dissatisfaction, it was not related to thinness as a beauty ideal but to physical fitness and health (Huxley et al., 2014). Chmielewski and Yost (2013) studied bisexual women’s experiences with body image, and their findings suggest that bisexual women do experience objectification (seeing human beings as an object) and self-objectification (seeing oneself as an object), that they are highly sexualized because of their sexual orientation (and therefore are sexually objectified), and that they face a dichotomy between rejecting and accepting the beauty ideal that can lead to guilt over not being able to fully reject beauty norms.

Bisexual women face objectification not just because they are women but because of their sexual orientation as well, and they may not be able to find support in either the lesbian, gay, bisexual, transgender, queer (LGBTQ) community or the straight/heterosexual community.

In their 2014 study of homosexual and heterosexual women’s body image, Markey and Markey found that heterosexual women tended to wish for thinner bodies more than did lesbian women. Further, women of either sexual orientation who had partners who were thin thought of themselves as heavier than women whose partners were bigger (i.e., high body mass indexes [BMIs]). These results indicate that women, regardless of sexual orientation, base their current and ideal bodies not only on their own weight statuses but also those of their romantic partners. The study further confirmed that lesbian women may prefer larger bodies due to a focus on athleticism and the functionality of the body, rather than the thin ideals expected in heterosexual culture (Markey & Markey, 2014). In a different study by Markey and Markey (2013), the authors discussed that there is a pervasive attitude that lesbian women are immune from weight-related concerns; however, the authors found that weight is a concern for lesbian women, particularly if a woman’s partner is thinner than she is. Thus, these findings expand the notion of what constitutes an ideal body type and add to the complexities of what constitutes the creation of one’s body image.

In a study of the relationship among the sociocultural pressures to be thin and lesbian and bisexual women, Huxley and colleagues (2014) indicated that most of their participants were indeed negatively affected by thin-ideal expectations and body dissatisfaction. The resultant themes of this study were as follows: “normative” body dissatisfaction, mainstream pressures, critiquing mainstream pressures, and pressure within lesbian, gay, and bisexual (LGB) communities. Reported dissatisfaction focused on size and with at least one aspect of their bodies. Researchers attributed this to being a natural process for women (wanting to be thinner) and noted that losing weight was a boost to self-confidence. All of the participants felt pressure

Case study 2

Julie is a 47-year-old woman of very petite stature (4'11" and 88 pounds). She didn't know she was gay (she prefers the term "queer") when she was growing up. Julie knew gay adults but did not know any young gay people. The gay women she knew did not share her fashion style, which affected her inability to identify as gay/queer. It wasn't until Julie saw and met young queer women who shared her sense of style that she was able to see herself as queer and find herself attracted to women. Julie believes that how queer women were represented in the media or her larger culture affected her ability to come out. It wasn't until a sexy and cool girl in high school flirted with her that she had any hint that she could be queer. (Julie went to an arts school, so this was not as unusual as it might have been in other schools in the 1980s). It wasn't until Julie realized that she could like both girls and boys that the idea ripened in her mind.

Julie was always small, the shortest in all of her classes at school; however, this didn't bother her. She remembers wanting to look more grown up when she was 13 because she looked younger than she was. She liked her physical appearance in general but wanted a little more curviness. Julie didn't work too hard to change her physical appearance because she was pretty happy with how she looked. She would have liked to have been a little taller and a little fatter (wanting more shapely legs), but she didn't do anything to try to make that happen. Julie never altered her diet or even thought of doing that. She wore some makeup and grew her hair long because she liked it. Julie enjoyed being creative with her clothing or at least fitting in fashionably, but she found this difficult because her family didn't have enough money to buy a lot of clothes, and her mother,

from the media to be thin and discussed comparing themselves to these images. More than half of the participants expressed anger at these depictions and consciously sought to avoid the media. Despite this, some still acknowledged dissatisfaction with their bodies, demonstrating a discrepancy and revealing that they were still not exempt from the thin-ideal expectations. Some participants even described pressure from within the LGB community to be thin and that they felt the need to lose weight after coming out in order to attract nonheterosexual women. These complexities are further explained in the following case study.

who was the person in charge of clothing acquisition, did not care about fashion or even if her children dressed particularly neatly. Julie struggled with this the most – how to be herself in a family that did not value fashion or beauty the same way she did.

Julie mostly wanted to be seen as at least “in-the-know,” fashionably-speaking, at school because she loved dressing nicely and also did not want to be teased. Julie experienced a lot of anxiety about her clothing when it came to school but really none about her body. In the community she dressed daily for (school), dressing in clean, neat, and reasonably fashionable clothing was important. There wasn't a great deal of pressure or teasing – there weren't even cliques that she recalls being aware of – but because it was so difficult to fulfill the basic social requirements of daily dressing, Julie felt a lot of anxiety.

Clinician's Note

Julie represents the enormous influence the media holds over individuals' identity, both in terms of how they see themselves and whether or not they can express themselves freely in society. This is a form of oppression that is often unrecognized by health and mental health clinicians. Julie also highlights how a person's socioeconomic status – and ability or inability to afford a certain fashion style – can influence self-esteem and body image. Lastly, it shows how a parent's attitude (i.e., approval, disapproval, or nonchalance) toward an important issue for the child can affect his or her body image.

GAY MEN

Similar to heterosexual men and boys, the ideal body for gay males is lean, muscular, and V-shaped (broad shoulders, flat abdomen, narrow waist; Moskowitz, Turrubiates, Lozano, & Hajek, 2013). For gay men, sexual orientation is a significant predictor of such body image variables as dissatisfaction with physical appearance, dissatisfaction with weight, dissatisfaction with attractiveness (self-rated), dissatisfaction with muscle mass, low comfort in a swimsuit, and participating in self-ideal discrepancy processes (Frederick & Essayli, 2016). Although gay men have been found to report a higher level of body dissatisfaction than heterosexual men (Jankowski, Diedrichs, & Halliwell, 2014; Michaels, Parent, & Moradi, 2013), the interpretation of this information is complex. Critics of body image research with gay men highlight that these studies have such design flaws as recruiting from clinical samples, which means the population was already very narrow and could not be representative of the overall population of gay men, and using populations that include both gay and bisexual men. Gay and bisexual cultures vary and should not be combined to represent each other. Thus, these design flaws may have inflated the reported incidence of body dissatisfaction among gay men (Davids, Watson, Nilsson, & Marszalek, 2015).

Behavioral and mental health clinicians must be careful not to assume that all gay men are focused on physical appearance or that there is one body ideal in the gay male community. For example, some gay men reject the stereotypical muscular

male ideal in favor of a larger body type, identifying as “bears” (Davids et al., 2015; Moskowitz et al., 2013). The bear community is a subculture within the gay and bisexual male community that rejects the idealized male beauty typically embraced by gay men. Bears tend to be heavier, shorter, and hairier; pursue male partners who are also heavier and hairier; and reject potential partners who are too thin. Bears believe that men should weigh more and should have more hair and embrace genetically predetermined, aging bodies. Within the bear community are further subcultures: cubs (younger hairy men), grizzly bears (White, hairy, heavier men), big teddy bears (heavier than grizzly bears), otters (hairy but thin), black bears (hairy men of color), and panda bears (hairy Asian men), to name a few.

In working with gay men, mental health clinicians must take into account their unique social experiences. These can include sexual objectification by other gay men, internalized heterosexism, and childhood harassment for gender nonconformity. Internalized heterosexism is when individuals have negative thoughts and feelings about their own homosexuality, usually from living in a judgmental, unaccepting, heteronormative society. Gay men who experienced harassment in childhood for not conforming to societal gender expectations can be motivated to seek the masculine ideal in order to avoid further stigmatization in adulthood, thus causing more body image concerns (Buchanan, Bluestein, Nappa, Woods, & Depatie, 2013). Experiences of

sexual objectification have been found to result in greater body shame, restrained eating, and body dissatisfaction (Dakanalis & Riva, 2013). Further, clinicians should not confuse a person's participation in LGBT activities, such as participating in a gay pride parade, as a connection to the gay community, which is seen as a protective factor against such concerns as internalized heterosexism. Research shows that this is merely involvement

Case study 3

Michael is a gay male in his mid-50s who currently lives in California. He has had body image issues his entire life. He still isn't sure if this is because he was born a gay man or is a result of his perfectionistic nature. He believes sexuality is attributed from birth (nature, not nurture). He has been plagued all of his young life by self-doubt surrounding body image and believes that straight men have a lot of the same pressures gay men have regarding societal expectations.

Michael's first memory of body shaming, which then resulted in body image issues, was from the age of 13. He was very close to his mother, as many gay men are, and she body shamed him in a way that he has never forgotten. One day, at the age of 13, he was mowing the lawn in the back of their house. He took off his shirt because a lot of other men and boys did this when doing yard work. Even then, he felt aware that his body was not what it should be. Michael intuitively knew that he didn't look like other boys at the time. He came into the house for a drink of water and found his mother looking at him disapprovingly. When he asked her what the problem was, she said, "I have the only son on the block with cellulite." Michael was mortified to hear this and felt like he "died a thousand deaths." This comment started Michael's obsessive campaign to lose weight and has stayed with him all these years.

Michael feels that if he had been born female, his obsession to lose weight probably would have turned into bulimia and/or anorexia nervosa. He very rapidly lost 30 pounds and grew approximately a foot and a half taller – to his current height of 6'1". This growth, combined with the weight loss, made him look so emaciated that kids at school asked him if he had cancer. Even so, he still wouldn't eat anything that wasn't on his "allowed foods" list, and he ran miles a day.

As Michael entered high school and puberty set in, he realized that being a male who is super skinny is not a good thing. He was soon picked on. He started eating food again at a more normal rate – that of a teenaged male – and continued running and lifting weights regularly. His goal was perfection – no fat, large muscles, washboard stomach, big biceps, and broad shoulders. He would stop at nothing but was still very skinny. Girls started noticing his looks and making their interests known. Michael avoided that subject completely.

When Michael went to college, he lived in an all-male dorm. He made good friends that have lasted throughout adulthood, but his sexuality was still hidden, and college caused a huge crisis for him. Michael "hit the wall" and was still unable to express his sexuality. He fell into a depression and dropped out of school. He returned as a commuter student and completed his degree. He never let up on his workout regimen, and it was not a good time in his life.

After completing college, Michael moved to New York City, where he obtained a job with a major record company. As he started making new friends, he realized that all of his new male friends were gay and asked himself, "What's that about?" His new gay friends helped him come out of the closet and find his way as a young gay man. Michael describes this time as a social whirl of going to the gym as a pack. "We'd work out abs, pecs, biceps, etc. We all felt an enormous need to be as perfect as possible." The social whirl continued on evenings and weekends at the NYC nightclubs and gay bars. "Our goals for each outing

in the gay community, rather than a true sense of belonging and psychological connection to the gay community. Moreso's research has shown that a person's psychological sense of community is correlated with reduced feelings of sexual objectification and reduced body dissatisfaction (Davids et al., 2015).

were to have a fantastic time, meet men, and get laid. In order to get the attention of the gay men we desired, we had to be 'hot.' This meant no fat at all, washboard stomachs, large biceps, fantastic bubble butts, pumped legs, and more. We never missed our workouts. Further, we were all thin because we couldn't afford food after blowing our paychecks in the clubs." [A "bubble butt" is a firm, perky butt. Some gay men wear support underwear that has a big opening in the butt area so that the support material fits around and lifts the buttocks and the opening pushes them out.]

Michael had his heart broken many times, and through it all, he engaged in extreme workouts, dieted religiously, and even went to tanning booths before a date with a new man. At one point, working out gave him acne on his back, so he went to a dermatologist. The dermatologist refused to treat him, claiming it was "garden variety" acne and that he couldn't help Michael "look perfect." The dermatologist referred him to a psychiatrist to help him deal with his need to be perfect. At this point in his life, however, Michael felt that if he wasn't perfect, he wouldn't be able to compete with all of the other gay men who were perfect, and he would therefore die alone.

Eventually, Michael moved back to Washington, DC. He made new gay male friends but with that came the "gay social whirl in DC." This involved more working out in packs religiously, more gay clubs, more gay bars, and more men. He started to get bored with the whole thing, and with the help of a gay therapist, he started working on how to have a gay life without all of the "shallow stuff." Michael's therapist helped him see that there wasn't just one type of gay man and that there were so many more out there. But without the "scene," Michael hit another deep depression because he didn't know who to be if not a perfect gay man on the social scene. Michael had an on-and-off-again romantic relationship with an older man for 17 years. Over time, Michael realized his partner was a commitment-phobic man who had issues from his own tough journey as a gay man. Eventually, this man dumped Michael because he stated he was "attracted to men in their late 20s, early 30s .. and that's not you." He felt time had done him in and that he wasn't a perfect 30-year-old anymore.

Michael then moved to California, where he met the man who became his husband. His husband is tall and handsome and has a normal build for a man of his age. He doesn't go to gyms, and neither does Michael. Michael's husband accepts him with the normal body of a man in his 50s. Michael still finds himself unable to relax 100% into this love and acceptance, but he still thinks to himself, "If I just don't eat this or that or maybe if I start working out again, I can get back to my former self." He feels that the young gay man he used to be is still in there, looking at every lump of fat, the sagging body, and the wrinkles. Michael feels a bit of sadness when he reflects on his past and his development as a young man, understanding that he was never really fat and was quite beautiful, tall, and lean. He wishes he could go back to his younger self and say, "You are so beautiful just the way you are! Don't let anyone tell you otherwise . . . even your own mother! Let your light shine and just be happy! It's all going to be fine in the end."

Clinician's Note

In his 20s, Michael was 6'1", weighed 180 pounds, and wore size 29 jeans. At the age of 55, he is 6', weighs 192 pounds, and wears size 34 jeans. When reading his case study, it is easy to see how insidious body image issues can be in the gay community. The focus on his appearance was so intense that he spent tremendous mental and physical energy trying to reach the body type idealized by his friends and community. This can be attributed to a youth- and appearance-obsessed society, expectations from the gay community, and critical words from his mother during a crucial time in his adolescent development. He clearly participated in social comparison processes, had disordered eating that bordered on a clinical eating disorder, and suffered depression from his experiences as a gay man.

WOMEN OF COLOR

In the past two decades, a large shift has occurred in the research literature on body image, body dissatisfaction, and eating-related psychopathology to focusing on prevalence by ethnicity and identifying variation within, between, and across cultures (Cash & Smolak, 2012; Robbeson, Kruger, & Wright, 2015; Wildes, Emery, & Simons, 2001). This shift initially focused on cultural influences and differences in women in the United States (Cotter, Kelly, Mitchell, & Mazzeo, 2015) but has broadened to women in numerous foreign countries (Mchiza et al., 2015). Women from ethnic minority groups, such as African Americans, Asian Americans, and Hispanic/Latina Americans, had been presumed to be at reduced risk for eating disorders

African American women

Historically, research pertaining to African American women and body image has proposed that African American women experience lower levels of body image dissatisfaction than White women, favor larger body sizes, and are not as likely as White women to internalize sociocultural standards of beauty (Grogan, 2016). Contrary to such research, Kelch-Oliver and Ancis (2011) found that African American women are susceptible to the influence of multiple factors that result in internal struggle and frustration. These factors include external messages regarding beauty; attempts to adhere to standards of beauty prescribed by Black men; and conflicting messages from family, peers, and the media. Further, Black women are affected by the beauty standards dictated by the men in their lives. Kelch-Oliver and Ancis (2011) emphasized that it is important for therapists and researchers to understand the complexities facing Black women. They recommend shifting the focus away from weight-specific issues to other cultural standards such as skin color, hair texture, facial features, and body shape/size. Capodilupo (2015) showed that when Black women internalized a Western idealized media image of Black women (i.e., long, straight hair and light skin tone), their body esteem and appearance satisfaction suffered. Further, a multidimensional body image was revealed, showing that facial attractiveness is experienced differently than physical attractiveness and that skin color satisfaction/dissatisfaction differs from body satisfaction/dissatisfaction.

In terms of specific body image issues, hair is an important body image domain for African American women. Women report feeling more confident when they believe their hair looks good, making time and financial sacrifices to obtain the right look, favoring the versatility of wearing numerous hairstyles, being able to express their personality based on hairstyle, and dealing with the microaggressions of those who do not understand African American hair (Awad et al., 2015). Many African American women feel a subtle form of oppression, called a *microaggression*, when White men or women discuss their

and body dissatisfaction as a result of endorsing larger, more attainable body ideals than White women (Grogan, 2016). However, recent research has shown that ethnic minority women are less protected against the thin ideal prevalent in the United States (Olvera et al., 2016) and that Latina and White women show similar levels of body dissatisfaction (Grogan, 2016). Further, it is known that there are ethnic-group differences when assessing perceived ideal body size for an individual's own ethnic group (Olvera et al., 2016), with Latina women being more likely to endorse slimmer ethnic body ideals than other minority groups.

hair. Historically, African American women have been forced to move away from their natural hairstyles to represent/emulate the hairstyles of the dominant, White culture. Wearing the hair naturally can be seen as a political statement against the institutional systems of oppression within the United States or as a way to express pride in their culture. There are numerous microaggressions that pertain to body image and portraying the female body as an object. Many of these microaggressions are rooted in racial/cultural stereotypes.

Another important body image domain for African American women is skin tone. This is mostly in terms of how others view their skin tone – favorably or unfavorably. African American women report that a light skin tone is still the favored tone (Awad et al., 2015). In terms of body type, overall, a curvy body is favored over the White thin ideal. However, some African American women strive to be thinner to advance their chances of achievement in the business world in which the White thin ideal is still the standard (Awad et al., 2015). Previous research has shown that African American women accept diverse body types and body weights; endorse larger specific body parts, such as hips, buttocks, and thighs (Thompson, Sargent, & Kemper, 1996); and focus more on personality traits to define beauty than physical aspects (Grogan, 2016). Not all African American women have body image problems and disordered eating; in fact, African American women with a strong racial identity often experience lower levels of body dissatisfaction because their racial identity serves as a buffer from body image issues (Watson, Ancis, White, & Nazari, 2013). This study did indicate, however, that the more that African American women adopted a Eurocentric body image ideal, the more they experienced the same negative consequences of body image issues as other racially diverse women. The following case study illustrates the complexities of body image and dissatisfaction for African American women.

Case study 4

Juliana is a 13-year-old African American adolescent who lives with her parents and three siblings. Juliana is a vibrant and friendly adolescent who values art and reading. Juliana was often described by her teachers and peers as quiet and polite. Prior to beginning middle school, Juliana was excited to start classes and make new friends. As the school year began, Juliana made a few new friends and was doing well academically. However, Juliana often worried about her appearance as she noticed her peers often focused on their looks. Sometimes,

Juliana was bothered by the fact that her parents did not have the money to buy her "cute" clothes like some of her peers. Sometimes, Juliana felt uncomfortable when her family and peers would make comments about her appearance. Juliana was more full-figured than her siblings and some of her peers. Juliana sometimes heard her family and peers make comments about certain parts of her body. However, Juliana never shared her discomfort with these comments.

As the end of seventh grade approached, Juliana decided to start eating healthier foods and cutting down on calories. Prior to the beginning of eighth grade, Juliana began losing weight and eating less. As Juliana continued losing weight, she received compliments from her peers, which reinforced her desire to eat healthier and restrict calories. Juliana's mother, a nurse, noticed that her daughter was drastically losing weight and expressed the concern to her husband. Juliana overheard her parents discussing her drastic weight loss, and she wondered if her "healthful eating" had somehow gone wrong.

As eighth grade began, Juliana started exercising more frequently and skipping meals. Juliana would cook meals for her family and decline to partake in the meals. Juliana became preoccupied with beauty magazines and TV shows about modeling. Her school counselor observed that Juliana had drastically lost weight and checked in with her one day. During the meeting, the school counselor noticed that Juliana appeared to be sad and uninterested in the conversation. She expressed her concerns to Juliana's parents, who then consulted with a pediatrician. The family was then referred to an eating disorders specialist. Weighing 84 pounds, being 5'7" tall, and being so emaciated that she had lanugo (hair growth – a hallmark sign of anorexia) on the back of her arms, Juliana was admitted to inpatient treatment at a local hospital. She was at risk for cardiac arrhythmia and had to be fed through a feeding tube.

After 2 weeks of inpatient treatment, Juliana transitioned to outpatient treatment. Juliana worked with a counselor, a nutritionist, and a psychiatrist during her recovery process. Juliana experienced frequent relapses until she entered college, and as a young adult, she is actively involved in the recovery process. To this day, there are moments when Juliana is dissatisfied with her body and worries whether her life would be better if she were as thin as she was prior to recovery. Juliana's responsibilities have increased, and she worries whether she will meet the expectations. Juliana attends graduate school and is working part-time. Juliana practices self-care and works with a

Hispanic/Latina American women

In traditional Hispanic/Latino cultures, large, plump, round-shaped bodies are valued because they represent wealth and health for both men and women. This is particularly true for elders, such as parents and grandparents, who may have come from families of lesser means (Romo, Mireles-Rios, & Hurtado, 2016). Latino cultures are also thought to be more accepting of a wider range of body types and, instead of valuing a thin ideal, are thought to value a thick ideal that endorses a curvy body with a small waist, large breasts and hips, and round buttocks (Cash, 2012). In a recent study of undergraduate, female Hispanic Americans, participants reported the following cultural beauty/body ideals: large, curvy hips; straight, long hair; shapely breasts; curvy buttocks; fit legs; tan skin tone; full thighs; and a healthy weight (Pula, 2014).

Research indicates a strong association between body dissatisfaction and mental health concerns in Latina girls and women. Some studies have shown Hispanic girls to be more

Case study 5

Lily is a 19-year-old Hispanic American college student at a liberal arts college on the East Coast where the population is predominantly Caucasian. Lily is 5'3" tall, weighs 120 to 125 pounds, and has a BMI of 21.8 (normal range). She was born in the United States and grew up in Lancaster, Pennsylvania. Her mother is of Dominican and French heritage and was also born in the United States. Her father is of Dominican descent, and Lily is uncertain of where he lives. Lily's parents divorced when she was quite young, and he is not a part of her life. Lily has a younger sister.

Lily believes Hispanic American women are more interested in a healthy weight and having balance than being "very thin" and are more accepting of their natural body types than Caucasian women. They are concerned about "belly fat" and "chicones"

counselor on issues related to her self-esteem, relationships, and body image, yet she worries that she will not be as successful in her endeavors and fears failure. Juliana feels exhausted by her responsibilities, especially counseling.

Clinician's Note

In this case study, it is important to take note of the progression of what seem to be fairly typical teenage-girl activities into a full-blown eating disorder. Juliana begins by participating in the social comparison processes her seventh-grade peers are engaged in (comparing themselves to each other and to images portrayed in the media), and she next proceeds to internalize the "uncomfortable" comments she hears from family and peers (reflecting the tripartite model described later in greater detail) about her overall appearance and certain body parts. With this, she begins to alter her behavior – restricting her food intake and eliminating certain foods from her diet, what she calls eating healthier foods and cutting calories but is really disordered eating. She begins to lose weight, and this is positively reinforced by the compliments she receives from peers. By the start of eighth grade, her disordered eating has progressed into an eating disorder, in which she increases her amount of exercising while severely restricting her calorie intake (skipping family meals). She drastically loses weight, to the point that she begins to grow lanugo – fine, white hair that individuals develop when they are so emaciated that they lose body heat. In an effort to keep warm, the body develops lanugo, just as a newborn does. At this point she is diagnosed as anorexic and is at risk of dying due to cardiac arrhythmia. This case study shows how a body image issue can progress to a full-blown eating disorder. It also demonstrates how powerful internalized, negative, self-critical messages can be. More than 10 years later, Julia is still battling poor body image, negative thinking, and low self-esteem and is exhausted from having to care for herself physically and emotionally.

dissatisfied with their bodies than White girls and that college-aged ethnic minority women may be more at risk for body dissatisfaction when exposed to the mainstream White standard of beauty, given that the mainstream ideal may be particularly unattainable for minority women whose physical characteristics are divergent from this ideal (Romo et al., 2016).

Another factor influencing the body image of Hispanic women is that of dual identity and the idea that Hispanic women bridge multiple cultures, races, traditions, and communities and are often confronted with two sets of cultural values. Further, Hispanic individuals often identify as bicultural rather than as belonging solely in the mainstream or solely in an ethnic identity, thus creating a complex set of cultural values to negotiate through (Grogan, 2016). Addressing the intersectionality of cultural expectations, cultural norms, and issues of cultural values is an essential aspect of ensuring efficient and comprehensive, as well as culturally appropriate, treatment.

(love handles), but her experience of beauty ideals in her culture has been of a more accepting attitude. Growing up, Lily recalls being among groups of church women who talked and complained about their body concerns while congregating and cooking. She feels their complaining reflected an attitude of acceptance and openness about their bodies, more so than being critical of them. Lily admits to having felt a lot of pressure about appearance, particularly from growing up with a Caucasian influence in her community and from mainstream American media messages. Lily felt frustrated and that she was doing something wrong when she did not achieve such societal beauty ideals and expectations as looking like a model on television. She explains that these expectations are not even attainable and made her feel like she needed to change

because she didn't "fit in very well." Lily feels that the typical "thick" ideal for Hispanic American women is changing, "going down in size," particularly for younger Hispanic Americans. She believes this is a result of exposure to American media.

In middle school and high school, Lily was very self-critical and was dissatisfied with her height, breast size, and nose. At that time, negative thoughts and feelings of discomfort with her body restricted her behavior in several ways. For example, in middle school, she did not go to pool parties or the beach because she did not want to wear a bikini. Wearing a one-piece suit was not a solution because then she would have just felt that she did not fit in because everyone else was wearing a bikini; she would have just compared herself to everyone else. To compensate, she would either not go to such events or wear a cover-up if she did go. In high school, Lily had more time for activities such as cross-country running and enjoyed how empowering this experience was for her. These experiences were instrumental in forming her body image and stayed with her through her transition to college.

However, as a freshman in college, Lily feels slightly negative about her body. She does not currently have the time to work out like she used to (running every day) and has therefore gained some weight. Being an athlete has played into her sense of body image; she judges herself against the standards of her athlete body. Lily defines body image as:

... Not just physically how you look. It has a lot to do with your self-esteem, how you feel. [You're always] sizing yourself up compared to other people. I think that how you feel maybe in regards to other people or how you feel despite other people, I think, is what your body image is.

Lily currently feels fine with her body. She claims that she has "gotten used to it" and is not really "that uncomfortable with my body." She is satisfied with her skin/complexion, smile, bust size, and height but dissatisfied with her nose, thighs, and legs, all of which she would like to be thinner. She is also dissatisfied with her hair, which she wishes were not frizzy and curly. Lastly, Lily is very self-conscious about her dark body hair, particularly in private areas, and this also restricts her from wanting to wear a bathing suit. She has considered laser hair removal so that she no longer has to deal with this issue.

Lily has felt pressure from the American media to achieve the ideal body and believes that looking good is not just about fitting in and looking nice but has larger implications, such as in natural selection, sexual attraction, and finding a mate. In terms of Spanish-language media, Lily believes that Spanish news programs are both less restrictive and more restrictive than American media in that they offer more variety in the shapes and sizes of the women they depict, but women are commonly dressed in more provocative outfits of a more sexual nature.

Lily uses her style of clothing as a way to differentiate herself from her Hispanic American culture, preferring to dress in a

Asian American women

Traditionally, the Central Asian countries of Korea, Japan, and China have viewed plumpness as a sign of prosperity, health, and beauty. Physical features common to these populations include an epicanthic eye fold (fold of skin of upper eyelid partially covering the inner corner of the eye); a broad, flat nose; and yellowish skin pigmentation. Theorists have surmised that the idealization of Western beauty standards has led to the desire for a double eyelid, or eye fold, and a sculpted nose. In metropolitan areas of Korea, plastic surgery to create an eye fold is common, and glues and tapes are used in Japan to create an eyelid crease (Kawamura & Rice, 2009). The American Society of Plastic Surgeons reported that the plastic surgery procedures most requested by Asian American women are eyelid surgery, nose reshaping, and breast augmentation (Frederick, Kelly, Latner, Sandhu, & Tsong, 2016). Furthermore, an investigation in 1991 reported that Asian American women who had undergone plastic surgery for their eyes and noses hoped that this would

preppy, classy style rather than the stereotypical bold, colorful patterns Hispanic women dress in. She also works hard to control her curly, thick hair, which is very hard to brush. In an attempt to clean it and control it, Lily washes her hair, uses a leave-in conditioner, towel-dries it, and "I might, um, try to brush it out a little bit." Getting a comb through her hair can be quite difficult, and sometimes she uses an anti-frizz oil product. She has also tried such techniques to straighten her hair as using a straightening iron (this takes 30 to 40 minutes) or doing a keratin treatment every 4 to 8 months. Lastly, Lily feels that a person's socioeconomic status, versus culture, has an influence on appearance and body image. She has noticed that money creates more ability for one to conform to media and societal expectations, highlighting how resources affect body image.

Clinician's Note

This case study of Lily, a Hispanic American woman of Dominican ethnicity, clearly shows the influence culture has on the formulation of body image. Lily described spending time with Hispanic women from her church who reinforced an attitude of acceptance and openness toward their bodies. This serves as a protective factor for Lily. However, she also references the strong influence the American media has had on her body image and being a marginalized minority at home and on her college campus. These are risk factors and have put her in the position of feeling "less than" and wanting to adhere to the American beauty ideals rather than those of her culture. She is experiencing being "American but not American" (Pula, 2014).

Further, Lily states that she is currently "fine" with her body, has "gotten used to it," and is not really "that uncomfortable with" her body. Although these statements may seem to represent self-acceptance and growth, they are not particularly strong, self-affirming statements and raise doubt about how Lily really feels about her body image. A clinician working with her should pay close attention to these negative statements and work on countering them. A clinician should also use a strength-based model in working with her and praise her for being so aware of the numerous pressures around her, often with contradictory messages. Lily is also acutely aware of the access money and wealth provide to people in attaining beauty and social status. Although she is rationally aware of the intersectionality of body image for many women – the combination of culture, mainstream media expectations, and the financial ability to attain such images – she needs more support for and work on accepting her body as it is. Being on a college campus, away from family and the strong support of her Hispanic community, puts her at risk for low self-esteem, continued struggles with body image and body dissatisfaction, and the possibility for depression and disordered eating.

enhance their beauty and elevate their social status (Frederick et al., 2016; Kaw, 1993).

Another important beauty ideal for Asian Americans is skin tone. For centuries, white skin has been idealized in Japanese, Chinese, and Korean cultures as a sign of upper-social-class status, femininity, and purity, and it continues to be valued today. Dark skin, on the other hand, has been viewed as a product of being a lower-class field laborer and is therefore not valued traditionally. However, tanned skin is valued in the United States, as a sign of health, vitality, and a life of leisure. For Asian Americans, the issue of skin tone may further contribute to an internal struggle between upholding traditional values and trying to assimilate to Western cultural values, possibly exacerbating internalized racism and a devaluing of one's own physical appearance (Frederick et al., 2016).

In terms of body satisfaction, Asian American women have reported dissatisfaction with their height, eyes, overall face, breasts/chest, and arms (Mellor et al., 2013). More specifically, Asian American women focus on face satisfaction (Frederick, Bohrnstedt, Hatfield, & Berscheid, 2014), which includes eye shape, nose shape, and the balance of the overall face. Frederick and colleagues (2016) found that Asian American women reported less satisfaction with eye appearance, facial appearance, nose appearance, and face shape than Caucasian women. In addition, Asian American women reported dissatisfaction with their eyebrows and eyelashes (Pula, 2014). They reported feeling that their eyebrows are very different from all other cultures in that they

Case study 6

Karen is a 20-year-old Chinese American chemistry major. She is 5'5" tall and weighs 110 pounds; her BMI is 18.3, which is considered underweight. Karen was born in the United States, and her family has been in the United States for approximately two generations. Both of her parents were born in the United States, but her mother is of Chinese descent, and her father is of Irish and Italian descent. Karen has one sister and grew up in Massachusetts. Karen has been estranged from her father since she was 13 years old.

Karen feels that body image is more about how a person thinks he or she looks than a person's actual looks. "Body image is how you feel about the way that you look and the way you perceive your body, rather than how it actually is. Because you can be the skinniest, healthiest person around, but have a negative body image because you don't perceive yourself as having a good body." Karen believes that beauty/body ideals in the United States vary by ethnicity. For White women, it is important to have "bigger boobs but look very proportionate and very slim," and the ideal for African American women is to have "bigger proportions in general," such as a "big butt" and "big assets." For Asian Americans, the ideal is to be "much thinner" and to be in shape. Having large breasts or buttocks does not matter for Asian American women.

Karen is satisfied with her basic body shape, slender build, nose (it is okay because it allows her to wear glasses), and skin tone, but she is dissatisfied with her face, stomach (wishes she had more abs), breasts (wishes they were bigger), and hair (hard to control). In terms of her face, she feels her jaw is too pronounced, she wishes her eyes were wider, she doesn't like her eyelids or eyebrows, and she doesn't like her eyelashes because they point downward.

Karen explains that eyebrows are very important in the Asian culture due to how they are different from other cultures:

Eyebrows are a huge thing in Asian culture. Asian eyebrows are so different because they point down, and the hair is usually a little bit thicker. My mom and my aunt always plucked theirs super-super thin because otherwise they grow

Case study 7

Catherine is a 19-year-old Korean American college student at a university on the East Coast. She was born in the United States, is 5'6" tall, weighs 140 pounds, and has a BMI of 22.6 (normal range). Catherine's parents were both born in Korea; her father moved to the United States when he was 14, and her mother moved to the United States when she was 26. Catherine has a younger sister and brother, grew up in a very White neighborhood, did not have many Korean friends, and considers her family to be very Americanized.

Catherine believes body image is the way society perceives how men and women physically look. The "perfect" body image is usually influenced by celebrities in the media through television, movies, and the Internet. She believes that fashion and appearance contribute to the body image stereotypes that are cultivated in American society. Catherine is satisfied with her hair, skin tone, height, and lips (full) but dissatisfied with her

are very bushy and unruly, grow in one direction (downward), are rectangular, and require a lot of maintenance. Similarly, they were dissatisfied with their eyelashes, which grow downward, get in the way of glasses, and do not curl on their own or with the assistance of an eyelash curler. Participants reported feeling that their unique eyebrows and eyelashes further separate them from mainstream cultures (Pula, 2014). These findings are prime examples of how body issues are transferred from one culture to another. The following three case studies are adapted from Pula (2014, pp. 2-58). The clinician's notes appear at the end of the three case studies.

down a little bit and it makes it look really bushy. That's something I get annoyed about sometimes, like they don't naturally swing back. They hang down almost, even though they're not long, but they almost point down. And they're usually like rectangles; they don't have a natural shape. If you don't pluck them, they're like two rectangles, and they don't have an arched shape.

Karen also feels self-conscious about her skin tone because it is pale enough to be considered White by some but still has some color that is not dark enough or yellow enough to be easily recognized as Chinese. She believes Asian American women are "White but not White," and this relates to more than just skin tone but also not fitting in with American culture. She says:

Asians are always like "we're not like White people." I actually heard this not so much from my family but from the mother of a very close friend. She was always like, "oh, you know, we're not like White people." I guess it's more of a superiority thing, almost, like we know how to discipline our children. We conform to a different standard, like a higher standard. The standards we make for ourselves aren't like the typical White culture; they're higher. You want to be of perfect intelligence, you want to be respectful of parents, and you conform to different ideals.

Karen also has a somewhat negative impression of White people, describing them as aggressive and using social climbing as a way to be successful in their careers. This is considered a form of cheating in Asian culture and is discouraged. Karen explained that Asian Americans do not engage in this kind of behavior and will only rely on their individual intelligence to progress in their careers.

Karen's beauty routines consist of showering at night, only wearing makeup half the time (more so for nice occasions like a dance or having her picture taken), always having painted nails (which she does herself), washing her hair three to four times a week (only conditioning twice a week), and waxing her facial hair every now and then.

stomach, eyebrows (wishes they were fuller), upper arms, thighs, and calves.

As an Asian American woman, there is pressure to participate in facial plastic surgery, mostly to obtain a double eyelid and a different type of nose. Because Korean women engage in a lot of plastic surgery and it is very accessible in Korea, this is where Catherine would go if she were to get plastic surgery. Korean women prefer a thinner, skinnier, slenderer nose rather than the typical button nose. They want a thinner, longer nose, to elongate their face to look more like a White woman. Catherine believes these two areas of the face are focused on because they are the two areas that separate Asian women the most from White women and that they obtain these surgeries to conform to the White ideal. Another procedure Korean American women engage in is Botox injections, particularly when they are older. Catherine explained that the Korean American ideal is closer to the White woman's ideal because

in the United States, “that’s what we’re surrounded by every single day, rather than a Korean woman who’s the ideal physical beauty. I think that because we’re around these White actresses

Case study 8

Michelle is a 21-year-old college student at a university on the East Coast. She is 5’ tall, weighs 135 pounds, and has a BMI of 24.4 (normal range). Michelle was born in Vietnam, as were her parents, and has lived in the United States for 15 years. Michelle has a younger brother who was also born in Vietnam. Michelle grew up in Tennessee. Her parents own and run a nail salon.

Michelle defines body image as how someone views himself or herself physically – how a person criticizes his or her own body. Fashion and appearance are also part of body image. Michelle is satisfied with her self-esteem (does not feel she needs to be the prettiest girl; feels “okay” walking around without makeup) but is dissatisfied with her weight (biggest concern), thighs (too big), height (too short), breasts (too large), overall body (not proportional), eyes (wishes they were bigger), nose (wishes it were smaller), and arms (wishes they were smaller and more toned).

As a Vietnamese/Vietnamese American woman, the most important beauty ideal is “whether you’re skinny or not.” The second priority is how Caucasian, or American, a Vietnamese American woman looks. The more American/Caucasian, the prettier she is considered to be. This holds in both the United States and in Vietnam. Vietnamese women are “trying to be as Americanized as they can be,” including how they do their makeup, their style of dress, and the music they listen to. In addition, being thin in Vietnam represents whether or not a person is considered lazy. Michelle stated that she feels less pressure to be skinny in the United States than in Vietnam, but this really depends on the type of Asian parents one has. For example, Michelle’s parents emphasize being healthy, so they do not focus on weight, but some of her friends’ parents put great pressure on them to diet and lose weight. Vietnamese American beauty ideals also include larger breast and buttock size; long, thin legs; thin arms; long, thin fingers; thin, elongated toes; long, thick hair; big eyes; thinner, slimmer nose; high cheekbones; full lips; and a long face. This is different from other Asian cultures, which value a round, circular face. Vietnamese Americans value an oval, long face. Further, although they want a curvy body, it should be a long, fit, curvy body. In terms of height, Vietnamese American women are usually short and want to be taller.

Michelle also explains the importance of food traditions within Asian culture and how these traditions make maintaining thinness more difficult. Michelle described her mother welcoming her home from college by cooking a lot of traditional Vietnamese food. Although Michelle has asked her mother to cut down on certain ingredients, such as sugar and salt, it does not result in any change. Michelle acknowledges that her mother encourages her to eat now when she is young and can afford to do so: “she’d say, you know, you’re at an age where you can eat and you have an appetite, and that’s more important than, you know, worrying about your weight now, ‘cause it shows that you’re healthy.”

The ideal skin tone for Asian Americans is one that is white – not pale, but fair-skinned – indicating innocence, purity, and high social status. A light skin tone is connected to socioeconomic status and being from a well-off family, whereas dark skin indicates being outside and perhaps working in the fields and with crops; “it shows that you work harder.” Michelle reported that this issue of skin tone does not pertain to Vietnamese American women, who strive to be tan just like Caucasian women. Michelle explained that “being in America, your definition of what beauty is, changes.”

and just White icons, and just, like, White women all around, I think that’s probably what my mind, especially, is geared toward.”

Michelle explained in a very passionate response that looking good is “extremely, extremely important. More so, I think, than women are willing to admit.” Women are so bombarded “by all these great images and what society and what men want women to look like” that there is no way to get away from it. Michelle is identifying the process of objectification. “I don’t think that it does not affect anyone; I think it does affect a lot of women,” Michelle says. She further explained that women are either willing or not willing to admit how important appearance is in American society and that beauty ideals are so indoctrinated that women may not even be aware of them.

The American media “has this very narrow thinking, perhaps, of what beauty is . . . and so they try to fit everyone in there.” This showing of diversity is not a genuine celebration of all cultures, but a strategy “to show that if you can relate to, if you’re of the same race of this girl in the media, then you can relate more to it, so you buy more of their product.” The media is still “super dominated by the, like, idealistic kind of person . . . tall, thin arms, skinny, flat stomach, long legs, a toned, like, all over, body.” This is seen on the Internet, media, award shows, and more. Lastly, Michelle was particularly incensed about how young girls – as young as 13, 14, and 15 – are presented wearing a lot of makeup and looking older, instead of celebrating the innocence of their age.

Michelle engages in social comparison with celebrities and with real women and explains that when she was growing up, celebrities provided her with motivation. As an adult, she finds this ironic because she now realizes that many celebrities do not use natural means to obtain their physiques. Even so, celebrities still motivate her. Michelle tries very hard not to have automatic negative thoughts about herself but again realizes that she has been thinking in this critical way for a while and that it is internalized, expressing an understanding of the social learning process. She has learned through psychology classes how to reframe these negative thoughts for herself, but she does still find herself being critical of others she may find unattractive. Although Michelle tries to be kind in her thought process, it does not always happen. Michelle does not see this comparison process with celebrities as putting too much pressure on herself but as a way to set high standards and goals, wanting to achieve the highest she possibly can. Additionally, Michelle looks more toward American women than Vietnamese women for what looks good because American women seem to be more open about their struggles, whereas Vietnamese women pretend that their looks are natural even if they have worked hard to obtain them.

Fashion is an important part of appearance for Michelle, and what one wears depends on the event an individual is going to and how a woman wants to come off to others. Michelle embodies several roles or personas for particular events, dresses for them, and gives these personas titles and descriptors, such as the following: (1) the “girly girl/pretty girl,” who is classy and wears dresses (not too short, though) or a skirt with a colorful blouse, and brighter colors, such as a lot of pink; (2) the “fierce girl,” who is dressed for nightlife, clubbing, or “feeling like a strong woman” and is dressed in tighter clothes, more fitting to the body and sexy but still classy, not too short, with very high heels; (3) the “tomboy” look is used when someone wants to be more “chill” and “laidback” – for this persona, an individual would wear a hoodie and sneakers, would be ready to study, and “you don’t have to worry about looking nice”; and (4) the “professional woman,” who would wear a more tailored look with collared shirts with skirts, with more natural makeup, with a “tint of pink or different shades of natural lip color for lipstick, and heels.”

Clinician's Note

In viewing these three case studies of various Asian American subcultures, it is important to note both the differences and similarities of each cultural identity. A clinician should be aware of the overall body image issues – such as the importance of face and skin tone – but understand that Asian subcultures have differing ideals for facial features. It is also critical for a clinician to understand how Asian American women feel “White but not White” and somewhere on this skin-tone continuum; this applies to cultural standards as well and should be explored thoroughly.

INTERSECTIONALITY AMONG WESTERN CULTURAL IDEALS, RACE/ETHNICITY, AND GENDER ROLES

Researchers suggest that the primary contributor to body dissatisfaction and the development of eating disorders is not acculturation but the conflict between traditional and Western values, particularly the shift of gender roles (Grogan, 2016). Other explanations suggested for varying levels of body dissatisfaction among ethnic subgroups include differences in the construction of gender roles and gender identity, institutional racism, internalized racism, and varying preferences of opposite-sex partners. For example, due to institutional racism, African American women have been raised to be strong, independent, and self-reliant and not to depend on men for economic success (Lovejoy, 2001). Further, African American women's gender identities have been found to be more androgynous than those of White women (Abrams, Javier, Maxwell, Belgrave, & Nguyen, 2016), and African American men not only prefer a larger body type for women but favorably value larger women more than do White men (Greenberg & LaPorte, 1996; Jackson & McGill, 1996).

Studies examining body image issues in ethnic populations have made the shift from comparing ethnic body images to those of the dominant White mainstream body image, seeking to understand the body image issues that pertain solely to the ethnic population being considered. In a 2014 study of African American college-aged women, researchers highlighted the importance of hair, skin tone/colorism, body type, and message sources (Awad et al., 2015). Hair was the most important body image domain for the women in the study. This included sacrifices made (financial, time, etc.) to obtain certain looks, the versatility of Black hair, and the microaggressions that accompany having Black hair. In terms of skin color, study participants identified the validation or invalidation that comes based on an individual's skin tone and whether or not it is seen as too dark. Lastly, participants indicated that the preferred body type for African American women is thick, toned, and curvy.

FOUNDATIONAL THEORIES

In working with clients who suffer from body image dissatisfaction, or even individuals who are not yet aware of their dissatisfaction, it is very important to understand the many ways in which individuals view their bodies and can construct a body image. There are many paradigms or lenses through which individuals can experience their relationship with their

bodies, such as from a societal or cultural perspective or through a developmental, a cognitive/intrapersonal, or an interpersonal lens. This section focuses on foundational theories that serve as the framework for understanding the development of body image and potential body image dissatisfaction.

Sociocultural perspective on body image

One of the most dominant theoretical frameworks for viewing and understanding body image, positive or negative, is the sociocultural model (Tiggemann & Pickering, 1996). This model holds that beauty ideals have a social origin and social context, and therefore sociocultural ideals and pressures are at the core of body image disturbance. The four tenets of the model are as follows: “(1) societal ideals of beauty exist in each culture, (2) these ideals are transmitted through sociocultural channels (e.g., relationships, media, etc.), (3) these ideals are then internalized by individuals, and (4) a person's satisfaction or dissatisfaction

with their appearance is a function of whether or not they meet the beauty ideal of the society” (Tiggemann, 2012, p. 13.) This model has most recently been extended to include such current societal trends as the drive for muscularity; tanning; excessive exercise; and the importance of social media, particularly as it relates to teenage use and “fitspiration/fitspo” (the use of pictures of fit people and inspirational sayings/catchphrases with the purpose of encouraging individuals to achieve their fitness goals).

Social comparison theory

Mechanisms that have been identified as major mediators between receiving societal messages and body dissatisfaction are the internalization of thin ideals and the process of social comparison. Internalization of thin ideals involves accepting and adopting societal ideals as personal goals, whereas social comparison involves comparing one's appearance against idealized media images and finding oneself lacking (Tiggemann, 2012). According to social comparison theory, people compare themselves to idealized images, and in doing this, they usually denigrate themselves instead of the ideal (Festinger, 1954). This theory proposes that, within the context of a culture that endorses thinness and attractiveness, individuals have the tendency to compare themselves with others; it is the amount to which they do or do not do this that accounts for differing levels of body image disturbance (Thompson, Heinberg, Altabe,

& Tantleff-Dunn, 1999). The social comparison process has become so prevalent that it is considered a primary, rather than a secondary, information-gathering phenomenon (Marsh & Parker, 1984; Ruble, 1983). Individuals choose universal comparison targets (comparing a specific physical attribute with strangers) or particularistic comparison targets (comparing self with immediate peers or group; Grogan, 2016). Individuals also perform upward (when the target is perceived as superior to the individual) and downward (when the target is perceived as inferior to the individual) comparisons. For example, adolescent girls are often socialized to believe that appearance is an important basis for self-evaluation and for evaluation by others (Thompson et al., 1999). This belief may follow adolescent girls into young adulthood.

Self-ideal discrepancy theory

The self-ideal discrepancy theory further explains the comparison process individuals go through. Typically used to understand the role of self-perceptions in the developmental psychopathology of disordered eating, self-ideal discrepancy theory assumes

that individuals hold beliefs about (1) who they are (the actual self), (2) who they would like to be (the ideal self), and (3) who they ought to be (the ought self; Ewell, Smith, Karmel, & Hart, 1996). The self-guides of the ideal and ought self can be from

the perspective of the self or influenced by others. When the actual self is discrepant from these self-guides, an individual may experience emotional distress and be “motivated to attain a match between their actual self-concept and an internalized ideal” (Thompson et al., 1999, p. 134) through self-regulatory

Tripartite model

In addition to having a social origin and a social context, cultural beauty ideals are transmitted through sociocultural channels and internalized by individuals, as proposed by the sociocultural perspective on human appearance and body image (Tiggemann, 2012). Sometimes referred to as the *tripartite model*, the three most important identified sociocultural transmitters of beauty ideals are peers, parents, and the media (Thompson et al., 1999). Whether or not a person meets these ideals creates satisfaction or dissatisfaction with appearance (Tiggemann, 2012). Of these sociocultural transmitters, the most powerful one identified through extensive correlational, experimental, and meta-analytic

behaviors. Strauman and colleagues (1991) argued that the social environment may contribute to the magnitude of body-specific self-discrepancies by creating thinness-favoring self-guides and activating such guides.

evidence has been the mass media. A great deal of research has been conducted on the mass media and how it affects the body image of preadolescent girls, adolescent girls, college-aged women, and boys and men. Prior to 2013, most of these studies focused on how individuals process messages relayed through TV programs, magazines, and music videos. More currently, this research has been expanded to include not only viewing images on Internet sites but interacting with other individuals on social media networks, thus expanding the tripartite model to include social media. This is addressed more in-depth in the section on media influences.

COGNITIVE-BEHAVORAL PERSPECTIVES ON BODY IMAGE

The cognitive-behavioral (CB) perspective is an integrative viewpoint emphasizing the combination of social learning and conditioning processes and the cognitive mediation of behaviors and emotions (Cash, 2012). Through the cultural socialization process, individuals acquire and internalize basic body image attitudes that reflect the norms, standards, and gender-based expectations of physical attractiveness, unattractiveness, femininity, and masculinity. Cultural messages can influence how one evaluates one's own body image and prescribe the time and effort one should invest in attempting to attain societal expectations. These body-altering means include dieting, exercising, bodybuilding, using beauty and fashion products, and engaging in surgical and medical procedures. Interpersonal experiences that influence an individual's body image attitudes include expectations, opinions, and verbal and nonverbal communications from family, friends, and peers that convey beauty standards and self-evaluation and self-comparison. Parents role model the degree to which beauty standards are valued in the family, and siblings, particularly brothers, often engage in appearance-related teasing and denigration. Appearance-related teasing from peers is common and can predispose one to body image dissatisfaction.

Cultural socialization process

Within the CB model is the notion of cultural socialization, which explains that cultures and subcultures around the world attach values and meanings to human appearance (e.g., beauty, etc.). These values and meanings are transmitted to people within the culture through messages that may be informal (through friends and family) or formal (through well-constructed advertising, etc.).

Body image attitudes

The central construct of the CB model is body image attitudes. The model proposes that these attitudes are the combination and result of an individual's cognitive, emotional, and behavioral processes within an environmental context. Body image attitudes are the result of cultural socialization. The two basic attitudinal elements are *body image investment* and *body image evaluation*.

Body image investment is the importance an individual places on his or her appearance. Further, when one is heavily invested in his or her appearance, body image schemas are developed. These schemas are “cognitive generalizations” a person makes about his or her overall appearance. Body image evaluation is the beliefs, both positive and negative, about and appraisals of an individual's appearance that result in body satisfaction or body dissatisfaction.

Influences on body image attitudes are divided into two categories: historical and proximal factors. Historical factors are past experiences and attributes that influence how an individual comes to think or feel about his or her body and include such components as cultural socialization, interpersonal experiences,

According to the CB model of body image, individuals engage in adjusted and self-regulatory behaviors to deal with distressing body image thoughts and emotions and temporarily escape, reduce, or regulate body image discomfort (Engle, Cash, & Jarry 2009). Adjustive, self-regulatory behaviors include avoidance and body concealment, appearance checking, appearance correcting, seeking of social reassurance, and compensatory strategies. Little research in the area of coping related to body image has been done. Cash, Santos, and Williams (2005) identified three strategies for dealing with body image threats or challenges using the Body Image Coping Strategies Inventory: experiential avoidance, appearance fixing, and positive rational acceptance. Avoidance and appearance fixing have been shown to be linked to less adaptive body image attitudes, more body image dysphoria, and poorer psychosocial functioning. Another area is that of appearance self-management, a self-regulating body image behavior that allows one to control evaluative body image consequences by concealing or correcting certain physical characteristics or avoiding self-conscious thoughts and emotions. This would include such activities as everyday grooming, hairstyling, applying cosmetics, wearing jewelry, and choosing certain clothing.

These messages convey standards and expectations around appearance, particularly in terms of gender-based expectations. Once these culture-based standards are internalized, the cultural messages “foster the acquisition of basic body image attitudes” and how individuals react to their own appearance (Cash, 2012, p. 41).

physical characteristics and changes, and personality variables. These historical factors instill fundamental body image attitudes, including core self-schemas, in relation to an individual's physical appearance.

Proximal influences are current life events that serve as activating agents on pre-existing thoughts, emotions, interpretations, conclusions, and internal dialogues related to an individuals' physical appearance. Such life events may include mirror exposure, weighing oneself, shopping for clothing, exposing one's body, exercising, wearing certain clothing (i.e., restrictive or revealing), and obtaining social feedback or scrutiny. The private body talk or internal dialogues that result from activating agents and cognitive processing are often habitual, faulty, and dysphoric and include such errors as distorting, making biased social comparisons, overgeneralizing, overpersonalizing, magnifying perceived defects, and minimizing assets (Alleva, Lange, Jansen, & Martijn, 2014).

In the CB model, historical influences on body image attitudes include physical characteristics and personality factors. How well a person's physical appearance matches cultural standards

of attractiveness influences how that individual is perceived and treated by others, thus affecting his or her body image attitudes. An individual's "goodness of fit" to a cultural ideal changes as one grows and develops. Individuals are continually adapting to physical changes and adapting their body image attitudes throughout the life span. Personality factors can foster resilience or create risk for developing body image problems. Strong social supports and a positive self-concept may buffer against threatening events, whereas poor self-esteem, lack of social support, public self-consciousness, an insecure attachment system, poor gender-role attitudes and values, and perfectionism may serve as risk factors. Public body consciousness (similar to body surveillance) is the tendency for individuals to see

themselves as an object and for those individuals to focus on their observable appearance and behaviors. Public body consciousness can lead to an increase in one's self-monitoring and an increase in the processing of appearance-related information. The personality trait of perfectionism may lead individuals to invest self-worth in physical ideals that are not only hard to achieve but may leave a person feeling discontent when the ideal is not reached. Lastly, research suggests that women who advocate traditional gender attitudes in relationships with men are prone to invest more in their appearance, have maladaptive beliefs about their appearance, and internalize cultural standards of beauty more completely.

FEMINIST PERSPECTIVE ON BODY IMAGE

The feminist perspectives on body image contend that the normative body dissatisfaction experienced by so many women and girls is not a function of individual pathology but is a societal, gendered issue (McKinley, 2012). In a society such as the United States, in which thinness is the ideal and this ideal is often internalized, women's bodies are valued to the point that they become objects and a locus of control, rather than focusing on a woman's abilities or characteristics. Internalizing this objectification may make women and girls more vulnerable

Objectified body consciousness

In addition to a social origin of meaning, women live in and engage in a social context that influences their body image. According to the feminist perspective on body image, the social context for women living in Western societies, such as the United States, is one in which women's bodies are objects to be watched and evaluated as to how they fit cultural standards. Girls and women learn to watch their bodies from the outside and to depend on others for approval (McKinley, 2012). They view themselves through the lens of others, rather than from their own perspective or feelings. In this way, girls and women adhere

to body dissatisfaction (Myers, Ridolfi, Crowther, & Ciesla, 2012). Within the body image field, there is continued debate as to whether adhering to feminist beliefs, such as men and women are equal, protects an individual from experiencing body dissatisfaction. Whereas Murnen and Smolak (2009) found that a feminist identity offered protection from extreme body dissatisfaction, Myers et al. (2012) concluded that the level of an individual's feminist beliefs does not protect against upward comparisons.

to an external locus of control rather than an internal one. They give power to others to the point that they need external validation and no longer value their internal view of themselves. Specifically, the objectified body consciousness theory of feminist psychology espouses that a person's discontent with his or her body is a function of social context, not individual pathology, and is a result of gendered power structures (McKinley, 2012). Women and girls are taught to objectify themselves and participate in body surveillance, internalization of cultural body standards, and appearance-control beliefs.

EFFECTS OF NEGATIVE BODY IMAGE

Research indicates that there are many effects of negative body image on an individual's self-appraisal, self-esteem, wellness,

Body surveillance

Body surveillance is the notion that people pay attention to how they appear to others and how they are perceived, and they think more about how their body looks than how it feels (Fitzsimmons-Craft et al., 2015; McKinley & Hyde, 1996). Through body surveillance, women survey their bodies to see if they are adhering to relevant cultural standards. When a

Internalization of cultural standards

Through a process of internalization, women and girls tend to connect the achievement of cultural body standards with their sense of self-worth; therefore, when the standards are not achieved, women feel shame. When they do achieve cultural body standards or get close to achieving them, women and girls feel empowered. The internalization of cultural standards has been applied to the sexualization of girls in popular culture and how this influences the internalization of sexualized gender

Appearance-control beliefs

Appearance-control beliefs are the notion that individuals can indeed attain cultural standards if they just put in enough effort. Further, a person must believe that such cultural body standards are attainable in order to judge himself or herself on whether or not these standards have been met. Research on objectified body consciousness in diverse women suggests that European American women conduct higher levels of body surveillance than African American or Latino women and that a

Influences of media on body image

The negative effects of the mass media on body image, body dissatisfaction, disordered eating, and depression are well investigated and documented (Tiggemann, 2012). It is

and mental health. A few of the major findings are discussed in the sections that follow.

standard is not met, they feel bad about themselves. Women may also engage in such behaviors as habitual self-monitoring of the body, an activity that has been related to increased shame and anxiety (Holland & Tiggeman, 2016). Participating in body surveillance has been found to predict body dissatisfaction at a significant level (Fitzsimmons-Craft et al., 2015).

schemas. Girls and women are sexualized in movies, music videos, video games, song lyrics, athletic apparel ads, and many other forms of media. McKenney and Bigler (2016) found a positive relationship between internalized sexualization and body surveillance and body shame. As internalized sexualization increased, so did participation in body surveillance and body shame.

relation exists between skin-tone surveillance and body shame in African American women (Grogan, 2016). Research pertaining to age and objectified body consciousness has found higher levels of body surveillance and body shame in undergraduate women than middle-aged women (Braun, Park, & Gorin, 2016). Further, in undergraduate women, research suggests that body surveillance is related to body satisfaction and predicted body esteem (Holland & Tiggemann, 2016).

understood that the promulgation of the thin ideal in such traditional media as television and magazines has led to the internalization of unattainable beauty ideals (Grogan, 2016;

Tiggemann, 2012). The processes by which these ideals are interpreted and internalized have also been studied and support the sociocultural and objectification theories described previously.

More specifically, studies indicate that exposure to ultra-thin or average-sized models results in low body satisfaction and low self-esteem (Vartanian & Dey, 2013); that magazine exposure is related to internalization of the thin ideal (but not an awareness of it), whereas television watching is negatively related to awareness but not to internalization (Marshall, Lengyel, & Menec, 2014); and that watching soap operas and music videos is related to social learning (e.g., drive for thinness and internalization of societal ideals) in girls, whereas watching of music videos was related to the drive for muscularity in boys (Halliwell, 2013). Diedrichs and Lee (2011) used social comparison theory to explain that if women were depicted in the media with body types similar to those of the general population, negative body image issues would decrease. They found through their research that this is indeed the case. Average-sized women who saw average-sized women in the media reported a more positive body image.

More recently, the study of the media's effect on body image, body dissatisfaction, and disordered eating has centered around new forms of media, such as the Internet and social networking sites, including Facebook, Instagram, Twitter, and Myspace. Research has shown that the more time an adolescent woman or young girl spends on Facebook, the more likely she is to endorse the thin ideal, have decreased weight satisfaction, and participate in body surveillance and appearance comparison (Tiggemann & Miller, 2010; Tiggemann & Slater, 2013, 2014). Further, the more an adolescent woman checks her Facebook profile, the more likely she is to have greater body dissatisfaction and a higher drive for thinness (Fardouly & Vartanian, 2014). Similarly, negative correlates were suggested for those with greater numbers of Facebook friends. For undergraduate students, a greater number of Facebook friends was found to be related to an increased drive for thinness and greater appearance comparison (Kim & Chock, 2015), and for young girls, it was found to be related to higher levels of dieting behaviors, drive for thinness, body surveillance, and internalization of beauty ideals (Tiggemann & Slater, 2013, 2014). More specifically, engaging in photo-based activities on Facebook, such as sharing and posting photos of yourself and friends and viewing, liking, and making comments on photos, results in such body image concerns as higher endorsement of the thin ideal, basing self-worth on appearance, drive for thinness, weight dissatisfaction, self-objectification (Meier & Gray, 2014), and appearance comparison (Kim & Chock, 2015).

The content of music videos and cable television has also been studied. Railton and Watson (2005) contend that pop music videos, with a primary commercial agenda, strive to display a sexualized body that can be seen as an object of desire or fantasy and that the representations of White women and Black women are very different. In a very thorough comparison and analysis of Kylie Minogue's "Can't Get You Out of My Head" video and Beyoncé Knowles's "Baby Boy" video, they show how White women are defined in a more asexual manner, whereas Black women are defined in a more hypersexual manner. Further, Railton and Watson (2005) suggest that Black women are portrayed as primitive, animalistic, uncontrolled, and uncontrollable, whereas White women are portrayed as controlled, restrained, and unavailable, even when performing acts of seduction and sexual attraction. Thus, African American women are either hypersexualized or are portrayed as sexless, without consideration for other possibilities (Watson, Robinson, Dispenza, & Nazari, 2012).

When discussing media representation, it is important to consider discrepancies between culture and ethnicity. Asian American women are presented with a double bind, in that they are presented with the body ideals of two cultures – traditional body ideals and those of dominant American European ideals as represented in the mainstream media. Although investigations on the body image of Asian American women are increasing, little is known regarding how the media affects Asian American body image (Lau, Lum, Chronister, & Forrest, 2006). Researchers express concern over the lack of Asian American images in the media, the predominance of European American images, and how this may threaten Asian American women's body image and self-concept (Grogan, 2016). For example, a content analysis of 1,300 TV advertisements in the United States showed twice as many European American models as Asian models, depicting a sense of social invisibility and unimportance in the eyes of the dominant culture (Taylor & Stern, 1997). In a 2006 study of values acculturation, media internalization, and overall body satisfaction, Asian American women who reported higher internalization of media ideals showed higher body image dissatisfaction (Lau et al., 2006).

Several studies have reported higher body dissatisfaction in Hispanic adolescent and young adults who watch and read more mainstream media than those who do not. The influence of Spanish-language media may be more complex than that of the mainstream media. According to dual-role theory, Spanish-language media can either inspire assimilation into mainstream values, or it can advocate one's ethnic heritage and community (Dalisy, 2012). Some research depicts women feeling that Spanish-language media present an alternative ideal to the mainstream media, whereas other research reports women feeling exposed to the same restrictive ideal of mainstream media (Dalisy, 2012).

In a study of Hispanic American and Asian American women, most of the Hispanic American participants indicated that there is little to no representation of Hispanic Americans in the U.S. media and very small variation in terms of what is represented (Pula, 2014). Participants indicated that the American media mostly show White, young, skinny, pretty women in their 20s to 30s and that what little representation does occur is so poor that it is difficult to identify a woman's race or ethnicity due to ambiguous physical characteristics so that viewers cannot tell if a person portrayed is Hispanic, Black, Middle Eastern, or Asian. Participants relayed that this supposed inclusivity is confusing and inaccurate. Asian American participants also indicated little to no representation and very small variation in what is represented. They went on to state that when the American media try to market to various ethnicities, it is a very token, Americanized version of that culture. Participants found this to be an irony because, on the one hand, they want to see more cultural representation, but on the other hand, they do not want it to be a stereotypical representation just for the sake of diversity, which comes across as disingenuous and offensive. Further, portrayals of Asian American women that do exist are not accurate in that they usually show stereotypes, show them in an unfavorable light, and show them trying to look beautiful in terms of the American definition of beautiful. Two Asian American participants indicated feeling that the media is moving in the right direction in terms of race and showing more diversity. For one participant, this diversity also included age, shape, and size. As evidence, the participants cited the Dove Beauty campaign and the television show "The Mindy Project." Regardless of this positive movement, both participants expressed disappointment in these diverse women being "Americanized."

MENTAL HEALTH ASPECTS OF BODY IMAGE

A person's body image has been associated with self-esteem and feelings of self-worth, particularly when one participates in social comparison and internalization processes. This section elucidates the importance of understanding the relationship between body image and body dissatisfaction with such mental

Relationship among body image, anxiety, and depression

Almost half of all girls and women studied in the United States report global negative evaluations of their bodies (Grogan, 2016; Holland & Tiggemann, 2016; Thompson et al., 1999). Body dissatisfaction and negative body image have proven to be risk factors for clinical eating disorders, disordered eating, low levels of self-esteem, depression, and anxiety (Grogan, 2016). Each of these mental health issues can have an effect on an individual's quality of life. They can affect an individual's ability to engage in normal life activities such as attending school, establishing and maintaining friendships, participating in romantic relationships, pursuing college and job opportunities, and living to one's full potential. Negative body image and body dissatisfaction present safety issues, such as progressing to a full-blown eating disorder, progressing to a more clinical level of mood disorder requiring medication and/or hospitalization, self-injury, and suicidality.

health issues as anxiety, depression, clinical eating disorders, and suicidality. Clinicians must be aware of these relationships and, therefore, the importance of diagnosing and treating body image issues when they first arise.

When working with individuals who present with body image issues, body dissatisfaction, or clinical-level eating disorders, it is critical to understand the relationship between their body image concerns and symptoms with suicide risk. Among psychiatric conditions, individuals with eating disorders, particularly AN, have the highest observed suicide mortality rate (Selby et al., 2010). Adolescents and adults who engage in purging and binge eating show an elevated rate of suicide attempts (Forrest, Zuromski, Dodd, & Smith, 2017; Selby et al., 2015), suggesting that both full and subclinical eating disorders may be correlated with suicidal behaviors (Brausch & Decker, 2014). Further, in the dermatological field, dissatisfaction with an individual's cutaneous body image, or mental perception of skin appearance, can negatively affect a person's mental health. Skin disorders with serious cosmetic implications, such as acne, can lead to feelings of isolation, social exclusion, stigmatization, and thoughts of suicide (Gupta & Gupta, 2013).

ASSESSMENT AND TREATMENT OF BODY IMAGE/BODY DISSATISFACTION

There is currently no diagnosis or individual classification for body image disturbance, body dissatisfaction disorder, or body image disorder as described in this course in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*; American Psychiatric Association [APA], 2013). However, body image, or body image disturbance, is commonly confused with body dysmorphism and is also considered a critical component

Body image/body dissatisfaction versus body dysmorphic disorder

Body dysmorphic disorder (BDD) is often confused with body dissatisfaction. However, BDD is a preoccupation with one particular area of the body (or several areas) to the degree that thoughts are intrusive, unwanted, hard to control, and time-consuming. It is defined in the *DSM-5* as a "preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others" (APA, 2013, p. 242). The disorder also includes "excessive repetitive behaviors" or thoughts for, on average, "3-8 hours per day" (APA, 2013, p. 243). It is important to understand that these perceived defects are slight or altogether imagined, yet they consume the individual and drive him or her to perform such behaviors as comparing oneself to others, checking his or her reflection in the mirror, excessive grooming, camouflaging the perceived defect with makeup or other beauty products, seeking reassurance, and sometimes picking at the designated site. In general, such medical specialists who make a BDD diagnosis are dermatologists, plastic

in the diagnosis of eating disorders. Clinicians need to be well versed in recognizing the symptoms of body image disturbance in order to ensure correct intervention with or without a *DSM-5* diagnosis present because body image concerns can be addressed prior to the development and even circumvent a more severe diagnosis being made.

surgeons, and orthodontic/cosmetic dentists. A recent study of the prevalence of diagnosis in various medical settings revealed that only 1.9% of BDD individuals were adults in the general community, whereas 13.2% were patients involved in general cosmetic surgery, and 20.1% were patients involved in rhinoplasty surgery (Veale, Gledhill, Christodoulou, & Hodsoll, 2016). Lastly, it is important to note that BDD is categorized in the *DSM-5* as an obsessive-compulsive and related disorder, which reflects the obsessive nature of the perceived imperfection requiring preoccupation with the issue for extensive time on a daily basis. This distinguishes it from body dissatisfaction, which in most cases represents global views and attitudes about one's body relative to others or an idealized comparison, which may or may not have an obsessive quality. It also is possible for body dissatisfaction and a BDD to co-occur (e.g., someone is dissatisfied with weight/shape and obsessed about a facial imperfection).

Eating disorders

Body image dissatisfaction is a critical component of such diagnoses as AN or BN and is emphasized in several diagnostic criteria. Criterion B in the AN diagnosis requires an individual to have "an intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight" (APA, 2013, p. 338). Criterion C in the AN diagnosis requires an individual to feel a "disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight" (APA, 2013, p. 339). Further, when an individual is in partial remission from AN, he or she will no longer meet Criterion A (low body weight) but will still meet Criterion B or C. Similarly, Criterion D in the BN diagnosis states that "self-evaluation is unduly influenced by body shape and weight" (APA, 2013, p. 345). The purpose of a differential diagnosis is to rule out other possible causes of AN or BN diagnosis.

A behavioral or mental health provider would not want to misdiagnose an individual with an eating disorder that may be caused by another issue. Certain medical conditions, such as hyperthyroidism, malignancies, and acquired immune deficiency syndrome, can cause serious weight loss. Similarly, individuals with major depressive disorder, schizophrenia, or substance use disorders may experience significant to severe weight loss; however, they do not usually exhibit the fear of gaining weight required in an AN diagnosis. The differential diagnosis between AN and BN is that whereas individuals with BN will exhibit the same desire to avoid weight gain and the same concern with weight and body shape as someone with AN, the individual experiencing BN will not exhibit the "less than minimally normal" low body weight of someone experiencing AN.

In prior versions of the *DSM*, BED did not have its own diagnosis and was diagnosed as a nonspecific eating disorder – not otherwise specified (EDNOS). With the publication of the *DSM-5*

in 2013, BED was recognized as a specific disorder with its own diagnostic criteria. There are five criteria that include specific binge eating behaviors, such as recurrent episodes of binge eating, episodes associated with eating in a discrete amount of time and a lack of control during episodes, marked distress, and episodes occurring at least once a week for 3 months, among others. A significant difference in the diagnosis of AN and BN compared with BED is the lack of a cognitive criterion related to body image disturbance (Grilo, 2013). These criteria in AN and BN focus on the influence of body shape or weight concerns on an individual's self-evaluation – as noted in Criteria B, C, and D described previously. This lack of a cognitive criterion for BED is receiving criticism in the field, and clinicians and researchers

Body image assessments

Despite the lack of a formal body image disturbance or body dissatisfaction diagnosis, there is a proliferation of body image assessment scales, totaling approximately 50. These can be categorized by what characteristic one wants to measure – an affective component (anxiety, distress), a state or trait issue, cognitions that form appearance beliefs, perceptions of body size, or body image behaviors (e.g., avoidance or checking behaviors). Deciding upon which assessment to use depends on the clinician's framework for treatment, the symptomology expressed by the client, the purpose of treatment, and the desired outcomes of treatment, among many other factors. Five of the most widely used standardized assessments are the following:

- Sociocultural Attitudes Toward Appearance Questionnaire (SATAQ-3 and SATAQ-4; Thompson et al., 2011).
- Body Parts Satisfaction Scale (BPSS; Berseheid, Hatfield, & Bohrnstedt, 1972).
- Physical Appearance Comparison Scale (Thompson et al., 1999).
- Body Image Disturbance Questionnaire (Cash, Phillips, Santos, & Hrabosky, 2004).
- Objectified Body Consciousness Scale (McKinley & Hyde, 1996).

Sociocultural Attitudes Toward Appearance Questionnaire (SATAQ-3 and SATAQ-4)

The Sociocultural Attitudes Toward Appearance Questionnaire (SATAQ), developed by Heinberg, Thompson, and Stormer (1995), is one of the most widely used measures that evaluate the influence of sociocultural factors on body image and appearance ideals. The SATAQ-3 (Thompson, van den Berg, Roehrig, Guarda, & Heinberg, 2003) is comprised of four subscales – Information, Pressures, Internalization-General, and Internalization-Athlete – and was used with numerous cultures: Italian, Greek, Jordanian, Spanish-speaking, Chinese, Brazilian, Australian, and more. Due to the limitations that it was too focused on the influence of the media on appearance ideals, the fact that it was developed to evaluate female ideals exclusively, and that it focused more on the physical characteristics embodied by an athlete, the SATAQ was revised in 2014. Research shows that proximal influences, such as family and peers, have more of an effect on an individual's body image than the media. The SATAQ-4 (Schaefer et al., 2015) was revised to focus on the thin ideal for women and the muscular ideal for men. It comprises four subscales:

- Internalization: Thin/Low Body Fat subscale (in females) or Muscular/Athletic subscale (in males).
- Pressures: Family subscale.
- Pressures: Peers subscale.
- Pressures: Media subscale.

In 2016, the SATAQ-4 was revised to add an assessment of one's desire for attractiveness, make the measurement of muscular ideal internalization more precise, and broaden the scope of measurement of appearance-related pressures. This revision resulted in two instruments: a 31-item SATAQ-4R-Female and a 28-item SATAQ-4R-Male instrument Schaefer, Harriger,

recommend that it should be added as a diagnostic specifier in future revisions of the *DSM*. Emerging research is pointing to the presence of a body image construct in individuals suffering from BED. Without this criterion in the diagnosis, the disorder is relegated to only a behavioral issue. It is important for clinicians and public health providers who work with BED individuals to understand this gap in the diagnostic criteria and to remain alert to its presence in individuals they may be treating. The overvaluation construct differs from body dissatisfaction in that shape/weight becomes the primary source for how an individual judges himself or herself and develops his or her sense of self-worth (Mond, Mitchison, & Hay, 2013).

Heinberg, Soderberg, & Thompson, 2016). Both instruments have the same seven subscales:

- Internalization: Thin/Low Body Fat.
- Internalization: Muscular/Athletic.
- Internalization: General Attractiveness.
- Pressures: Family.
- Pressures: Peers.
- Pressures: Media.
- Pressures: Significant Others.

See Appendix A for the scale.

Body Parts Satisfaction Scale

The BPSS was originally created in 1972 by Berscheid and colleagues for a *Psychology Today* survey of readers. It was validated in 2014 and has been used widely. The scale assesses affective body dissatisfaction and has been used to conduct research on the media, body image, sexual orientation, gender identity, sexual dysfunction, and disordered eating. It measures 24 body areas on a scale of 1 (extremely satisfied) to 6 (extremely dissatisfied). It has further been validated on mixed-race samples of African American, Mexican American, Asian American, and Native American women (Petrie, Tripp, & Harvey, 2002). In 2012, the BPSS was revised and validated for men as a 25-item scale (McFarland & Petrie, 2012). See Appendix B for the scale.

Physical Appearance Comparison Scale

The Physical Appearance Comparison Scale, created in 1991 by Thompson, Heinberg, and Tantleff (Thompson et al., 1999), was revised in 2014 by Schaefer and Thompson. The original scale was a 5-item scale, and the revised scale is composed of 11 items assessing the appearance-comparison experiences of men and women in a wide array of settings. The original scale was limited in that it was designed specifically for women, it measured appearance-comparison behaviors at parties or in social situations (not addressing other environments in which this behavior can occur), and the reverse scoring proved to weaken reliability. The revised scale is gender neutral and more inclusive of social settings. It also now assesses for body weight and shape issues, which are not only related to body image but also to eating pathology (Schaefer & Thompson, 2014). See Appendix C for the scale.

Body Image Disturbance Questionnaire

The Body Image Disturbance Questionnaire (BIDQ) was created to measure more than just negative body image (Cash et al., 2004). The BIDQ assesses for body image dissatisfaction, distress, and dysfunction or impairment, equating to body image disturbance. The seven items in this scale measure appearance-related concerns, mental preoccupation with concerns, and impaired functioning as a result of these concerns in many facets of life (work, social, etc.). An additional five open-ended questions serve as a qualitative measure of one's distress. See Appendix D for the scale.

Objectified Body Consciousness Scale

The Objectified Body Consciousness Scale follows the feminist perspective of objectified body consciousness and measures the level to which women view their bodies as objects (McKinley &

Hyde, 1996). The 24-item scale is comprised of three subscales: body surveillance, body shame, and appearance-control beliefs. In a 2017 study of the psychometric properties of this scale, the authors found the body surveillance and body shame subscales to be reliable and valid but that the control beliefs scale needs more analysis. It is suggested that either a modified version with only these two subscales is used or that the full scale is used

but control belief items are not included in computing the total (Moradi & Varnes, 2017). See Appendix E for the scale.

Clinicians may use all five of these assessments separately or in combination with other tools to determine their clients' specific symptoms and best treatment outcomes. Further information on these assessment scales can be found in the Resources section.

TREATING INDIVIDUALS WITH NEGATIVE BODY IMAGE/BODY DISSATISFACTION

As addressed in the assessment section, when a clinician is treating body image disturbance/dissatisfaction, he or she must first understand all aspects of the diagnosis before forming a treatment plan. For example, is the body image dissatisfaction a stand-alone issue or a component of another diagnosis, such as a clinical eating disorder or body dysmorphia? Only once this has been assessed and fully understood can a treatment plan be formed. It is also critical that mental health clinicians who are not trained in body image issues or eating disorders consult with such specialists before completing a diagnosis. The most common evidence-based approach for treating body image dissatisfaction is cognitive-behavioral therapy (CBT). Based on the diagnosis, symptoms, behaviors, and cognitive

Cognitive-behavioral therapy

CBT incorporates psychodynamic and behavioral therapies to examine patterns of thinking and beliefs that are the root cause of distorted and irrational thoughts and behaviors. These maladaptive, distorted thoughts are often labeled as faulty cognitions or cognitive errors. In CBT, a clinician works with a patient to identify negative patterns of thought, such as negative self-talk; identify triggers of negative thinking; and begin replacing these patterns with more healthy ones. Some typical cognitive distortions are all-or-nothing thinking (e.g., "I'm overweight; therefore, I'm not marriage material"), mindreading (e.g., "I know my boyfriend wishes I would lose 10 pounds"), and personalization (e.g., "Everyone is looking at me"). Patterns of thinking are confronted pertaining to interpersonal

Acceptance and commitment therapy

The primary goal of ACT is to tolerate anxiety-inducing situations and thoughts, rather than changing or disputing them. The skills taught through ACT are mindfulness, acceptance, and value-based living. Through mindfulness, an individual learns to be present in the moment (particularly anxiety-inducing moments) and observe and experience thoughts, feelings, and sensations as they arise. Acceptance lessons focus on helping an individual accept his or her body dissatisfaction struggle, rather than strive to avoid, control, and distract from thoughts, feelings, and behaviors. With the goal of decreasing an individual's emotional attachment to negative thoughts, ACT teaches individuals to

Exposure and response prevention

Exposure and response prevention (ERP) is a behavioral approach to addressing body image concerns. ERP can be used for clinical eating disorders, obsessive-compulsive disorders, or as a component of treating body dissatisfaction. In this modality, the goal is for the client to practice distress tolerance. A clinician would help a client identify rituals, such as excessive mirror checking or social comparison, and avoidance behaviors, such as avoiding going shopping or avoiding going to the pool because both experiences are too uncomfortable. Once a list of such distress-inducing situations is created and these experiences

Psychoeducation

Through the psychoeducation process, a clinician helps explain such cognitive mechanisms as cognitive distortions, how they are erroneous, and how they may be serving a different purpose for the client (e.g., helping them stay in a place of fear rather than putting themselves out in a judgmental situation). Psychoeducation can also include teaching self-compassion and self-care and explaining the prevalence of body image disturbance and eating disorders, as well as common symptoms.

processes presented by the client/patient, psychological treatment modalities are often combined with other modalities, such as exercise, medication, and working with a dietician/nutrition specialist. Other psychological issues that are often treated in conjunction with body dissatisfaction are depression, anxiety, low self-esteem, and shame. The treatment modalities discussed in this section are intended for patients who are medically, nutritionally, and psychiatrically stable. There are four main approaches for treating body image dissatisfaction/disturbance: CBT, acceptance and commitment therapy (ACT; Hayes & Long, 2013), exposure and response prevention (ERP), and psychoeducation.

and intrapersonal relationships, family relationships, peer relationships, and societal pressures. New skills are learned in therapy and applied to real-life situations (Selinger & Neziroglu, 2017). CBT is the preferred treatment for both BED and BN. A 2016 meta-analysis of predictors, moderators, and mediators of treatment outcomes following CBT across eating disorders concluded that cognitive and behavioral change early in treatment led to better outcomes (Linardon, de la Piedad Garcia, & Brennan, 2016). Another finding showed that when treating individuals with BN, better behavioral outcomes were reached when dietary restraint was reduced. The meta-analysis also showed that CBT was a successful treatment option across age, gender, body weight, and history (Linardon et al., 2016).

separate labels (e.g., "I am fat") and thoughts (e.g., replace with "I am having the thought that I am fat"), with the goal of increasing one's sense of self beyond the body. With value-based living, the goal is to identify values, other than appearance, that are important to an individual. A clinician would guide an individual through the exercise of clarifying his or her values and what he or she is really seeking, such as human connectedness, rather than appearance. This helps the client shift the focus from symptom reduction to living life according to what he or she really values (Selinger & Neziroglu, 2017).

are organized from most challenging to least challenging, the clinician would challenge the client to expose him- or herself to one of these situations several times (e.g., twice per week) to practice dealing with the anxiety-inducing situation. The clinician would also teach the client strategies for eliminating, reducing, and resisting rituals, beginning with monitoring the frequency of when such behaviors occur. The client and clinician would methodically work on each situation (Wilhelm, Phillips, & Steketee, 2013).

Psychoeducation may also focus on the connection between comorbid mental health issues such as anxiety, depression, low self-esteem, and obsessive-compulsive thinking and behaviors. Other modalities used to treat body image disturbance and eating disorders include dialectical behavior therapy (DBT; Linehan et al., 2015), dance therapy, music therapy, equine therapy, family therapy, interpersonal psychotherapy (IPT), motivational interviewing, meditation, and psychopharmacology.

Because body image disturbance and eating disorders are so closely aligned with such mental health issues as depression and anxiety, a client may need assistance from medications such as a serotonin reuptake inhibitor or an anxiolytic. This can be determined only by a physician or psychiatrist but is often done in consultation with a client's therapist. Table 4 provides a brief overview of possible treatments.

Table 4: Possible Treatment Approaches	
Diagnosis/Issue	Treatment Approach/Modality
Anorexia nervosa (AN)	CBT/DBT/IPT + family therapy + relapse prevention
Binge eating disorder (BED)	CBT
Body dysmorphic disorder (BDD)	CBT + ACT
Body image dissatisfaction (BID)	CBT
Bulimia nervosa (BN)	CBT + relapse prevention
Note. Adapted from Selinger, A., & Neziroglu, 2017; Linardon, J., de la Piedad Garcia, X., & Brennan, L., 2016; Linehan, M. M., et al., 2015.	

Treatment scenario 1

A young woman, calling herself Shae, contacts an individual provider for help with body dissatisfaction concerns. Upon conducting an intake assessment with Shae, the provider learns that the woman has a number of concerns related to body image, body dissatisfaction, and obsessive beliefs about beauty and the importance of being considered "beautiful" in social settings. Shae has struggled with issues of low belonging since childhood, and she had a difficult adolescence with regard to facial complexion, and some residual scarring is visible on her cheek. She believes that, in general, her body shape is unsatisfactory with regard to weight and body shape, although her BMI registers as normal weight for her height. She indicates that she does not engage in binge eating episodes, although she will vomit or use laxatives approximately once per month in an effort to control her weight. However, due to the slight scarring on her face, she spends an excessive amount of time staring at her face, particularly the affected area. She thinks obsessively about the issue, totaling up to 3 to 4 hours daily, about ways to try to cover the area with makeup, hide her face during conversations, or potentially seek plastic surgery to remedy the scarring. She has sought numerous consultations with dermatologists and surgeons, all of which have assured her that her overall skin condition is good and that any efforts to correct the issue could lead to worse potential scarring. Shae also states that she is dissatisfied with other areas of her face, although her cheek is the primary concern. Upon completion of the assessment, the provider decides that Shae's primary concern relates to BDD. This is because most of her body dissatisfaction is centered on her face, she spends excessive time focusing on her face and the implications of her looks,

and she engages in behaviors relevant to the body concern (consulting physicians, attempting to cover the area with makeup). Although Shae has additional body dissatisfaction, she is below the threshold for an eating disorder. Her vomiting and laxative use are of concern but are below the threshold for a diagnosis, and her body dissatisfaction causes distress but has not led to extreme efforts to change her weight. Although all of these issues should be taken into consideration in the preparation of a treatment plan, a proper course of action would first involve some psychoeducation about BDD, the obsessive nature of Shae's thinking and behavior about the facial concern, and discussion of the negative health consequences of purging behaviors. Further treatment for Shae would then center on CBT and ACT. The provider could use elements of CBT to challenge the inaccurate beliefs Shae has about her face (e.g., testing whether people actually notice the scarring) and consideration of whether the scarring has had any real impact on her social relationships or, conversely, whether her social relationships would be better if the scarring was improved. Elements of ACT could also be incorporated into treatment to help Shae determine if the scarring is really the cause of her distress or whether it's her dissatisfaction with her scarring that is the real cause of her distress. Discussion about the inability to change this aspect of her appearance, especially in relation to other values she has in her life, may help Shae to recognize that appearance is just one part of life and a part of life that is only as important as we make it. Finally, some inclusion of exposure and response-prevention techniques may be warranted to help Shae reduce the time she spends on compulsive behaviors.

Treatment scenario 2

Jillian is an adolescent who presents, along with her parents, to an outpatient program based at a hospital. Her parents express that their primary concern is that their daughter has been withdrawn, and she is increasingly isolating herself. During her program interview, Jillian expresses that she is struggling with pervasive feelings of worthlessness and sadness, primarily stemming from dissatisfaction with her body shape and weight. She has been experiencing distress at home and at school, and she indicates that she has experienced bullying focused on her weight, with a particular subset of peers making comments about her weight approximately two to three times per week. Jillian says that her number-one goal is to lose weight, and she believes that if she loses her excess weight, her peers will accept her. Further questioning during the interview reveals that Jillian has been engaging in food binges approximately twice each week, a behavior that is then followed by vomiting in all cases. The bingeing-and-purging behavior has been taking place for almost a year. The clinicians in the program objectively assess her weight and height and find Jillian to have an overweight BMI given her weight relative to her height; however, she does not qualify as obese. Finally, Jillian has been engaging in

other problematic behaviors, including sneaking alcohol from her parents' home bar, self-cutting for the last 6 months, and experiencing mild suicidal ideation for the last 2 months. After the assessment, the treatment team determines that Jillian's case is best conceptualized by a diagnosis of major depression that is co-occurring with BN, and she is expressing additional impulsive behaviors of concern. In Jillian's case, a course of treatment focused on CBT would be a reasonable approach. CBT techniques could be used to help Jillian identify and reconsider negative thoughts about her body image concerns and how they relate to her depression symptoms. CBT could also help her identify new ways to reframe bullying experiences at school, such that negative interactions with peers are viewed as having less impact on real self-worth and social acceptance than adolescents realize. In Jillian's case, some alternative treatment approaches could also be considered. Although CBT is effective in treating BN, interpersonal therapy is often comparably effective. In this case, given the interpersonal nature of some of Jillian's concerns, an interpersonal therapy approach could help her understand how interpersonal experiences interplay with her body dissatisfaction. DBT could also be a candidate treatment

approach because DBT is effective for impulsive behavioral concerns, has shown effects with eating disorders (Lenz, Taylor, Fleming, & Serman, 2014), and has interpersonal components that may help Jillian in her peer interactions. Finally, because

Jillian reported suicidal ideation, additional care should be taken to assess and monitor suicidal ideation to ensure that it remains mild and that suicide plans, preparation, and intent do not develop.

CONSIDERATIONS FOR CLINICIANS

It is very important for healthcare and mental health practitioners to be aware of the signs and symptoms of body image issues, subclinical eating disorders, and clinical-level eating disorders. These individuals are often the first line of defense in diagnosing body dissatisfaction and preventing a clinical-level eating disorder from occurring. To be this aware, an individual should know the *DSM* criteria for diagnosing an eating disorder.

Training

But how does an individual obtain such training? You've already begun! By completing this course, you have become a more informed practitioner. Healthcare providers and clinicians who want to specialize in treating body image issues and eating disorders can take numerous additional steps, the first being always to continue to educate yourself. Included in this course is a list of resources that enumerates seminal readings on the topic, as well as websites for national and international associations, hospitals, academic institutions, nonprofits, and treatment centers. Healthcare professionals can avail themselves of additional training through graduate school programs, professional associations (e.g., American Counseling Association, American Psychological Association, National Association of Social Workers, etc.), and through formal certification programs.

Although there are no accredited certifications in the area of body image, there are several in the field of eating disorders. As a caveat, be aware that there are numerous body image coaching certifications, which may or may not be taught

Conclusion

Body image is a person's subjective evaluation of his or her physical form and is a universal experience permeating culture, race, age, gender identity, sexual orientation, socioeconomic status, geographic location, disease, and physical ability. These constructs often intersect, creating a complex individual psychology and identity. In completing this course, one can see how widely negative body image or body dissatisfaction can affect an individual's sense of self-worth and mental health. These issues should not be taken lightly by physicians, nurses, social workers, counselors, educators, therapists, or parents. Even when negative body image does not progress to a clinical eating disorder, it often leads to anxiety and/or depression and a lifetime of battling internal processes when participating in

Understanding these criteria allows an individual to be more alert and aware when a client or patient begins to display warning signs. A practitioner should also understand the faulty cognitions and negative global thoughts that can accompany poor body image, such as, "If I were thinner, people would like me more," or, "No one will ever think I'm pretty."

by a mental health professional and are not accredited by a professional mental health association. The International Association of Eating Disorders Professionals offers a Certified Eating Disorders Specialist certification. Other applicable certifications are the Fellow of the Academy for Eating Disorders, Certified Eating Disorders Therapist, and Eating Disorder Dietician.

Hospitals and treatment centers often offer formal training for continuing-education units or for internships. For example, the Center for Eating Disorders at Sheppard Pratt Hospital (Baltimore, Maryland) provides a clinical internship as well as free monthly lectures for professionals. The Renfrew Center Foundation hosts an annual conference, as well as routine webinars and teleconferences. Other helpful associations include the National Eating Disorders Association (NEDA) and the National Association of Anorexia Nervosa and Associated Disorders. Despite seeming to focus only on eating disorders, most of these organizations also focus on body image concerns.

such daily activities as eating, shopping (for groceries or clothes), getting dressed, reading a magazine, browsing the Internet, watching a movie or TV show, exercising, and interacting with family and friends. These processes include participating in social comparison, as well as the widespread objectification so prevalent in the mass media. It is important for health professionals to be aware of the potential for body image and body dissatisfaction issues and recognize that attention to these issues is warranted because they play a significant role in reducing one's quality of life, distracting individuals from other subjects they could be focusing upon, and burdening individuals with tremendous mental work, as well as potentially being a precursor to a clinical eating disorder.

APPENDIX A

Sociocultural Attitudes Toward Appearance Questionnaire 4

Directions: Please read each of the following items carefully and indicate the number that best reflects your agreement with the statement.

	Definitely Disagree	Mostly Disagree	Neither Agree nor Disagree	Mostly Agree	Definitely Agree
1. It is important for me to look athletic.	1	2	3	4	5
2. I think a lot about looking muscular.	1	2	3	4	5
3. I want my body to look very thin.	1	2	3	4	5
4. I want my body to look like it has little fat.	1	2	3	4	5
5. I think a lot about looking thin.	1	2	3	4	5
6. I spend a lot of time doing things to look more athletic.	1	2	3	4	5
7. I think a lot about looking athletic.	1	2	3	4	5
8. I want my body to look very lean.	1	2	3	4	5

	Definitely Disagree	Mostly Disagree	Neither Agree nor Disagree	Mostly Agree	Definitely Agree
9. I think a lot about having very little body fat.	1	2	3	4	5
10. I spend a lot of time doing things to look more muscular.	1	2	3	4	5
Answer the following questions with relevance to your FAMILY (include parents, brothers, sisters, relatives):					
11. I feel pressure from family members to look thinner.	1	2	3	4	5
12. I feel pressure from family members to improve my appearance	1	2	3	4	5
13. Family members encourage me to decrease my level of body fat.	1	2	3	4	5
14. Family members encourage me to get in better shape.	1	2	3	4	5
Answer the following questions with relevance to your PEERS (include close friends, classmates, and other social contacts):					
15. My peers encourage me to get thinner.	1	2	3	4	5
16. I feel pressure from my peers to improve my appearance.	1	2	3	4	5
17. I feel pressure from my peers to look in better shape.	1	2	3	4	5
18. I get pressure from my peers to decrease my level of body fat.	1	2	3	4	5
Answer the following questions with relevance to the MEDIA (include television, magazines, the internet, movies, billboards, and advertisements):					
19. I feel pressure from the media to look in better shape.	1	2	3	4	5
20. I feel pressure from the media to look thinner.	1	2	3	4	5
21. I feel pressure from the media to improve my appearance.	1	2	3	4	5
22. I feel pressure from the media to decrease my level of body fat.	1	2	3	4	5

Note. From Thompson, J. K., Schaefer, L. M., Burke, N. L., Heinberg, L. J., Calogero, R. M., Bardone-Cone, A. M., ...Vercellone, A. C. (2011, September). Development and validation of the 4th version of the Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ-4). Poster presented at the annual Eating Disorder Research Society Meeting, Edinburgh, Scotland.

APPENDIX B

Body Parts Satisfaction Scale

For each of the body parts listed below, indicate your current level of satisfaction using the scale below. There are no right or wrong answers, so please respond honestly based on how you currently feel.

	1	2	3	4	5	
	Extremely Dissatisfied			Extremely Satisfied		
1. Overall facial attractiveness	_____					13. Hands
2. Hair	_____					14. Feet
3. Eyes	_____					15. Size of abdomen
4. Ears	_____					16. Buttocks
5. Nose	_____					17. Hips (upper thighs)
6. Mouth	_____					18. Legs and ankles
7. Teeth	_____					19. Height
8. Voice	_____					20. Weight
9. Chin	_____					21. General muscle tone/development
10. Complexion	_____					22. Chest/breast
11. Shoulders	_____					23. Size of sex organs
12. Arms	_____					24. Appearance of sex organs

Note. From Berscheid, E., Hatfield, E., & Bohrnstedt, G. (1972); Petrie, T. A., Tripp, M. M., & Harvey, P. (2002).

APPENDIX C

Body Parts Satisfaction Scale for Men (BPSS-M)

For each of the body parts listed below, indicate your current level of satisfaction using the scale below. There are no right or wrong answers, so please respond honestly based on how you currently feel.

	1	2	3	4	5	
Extremely Dissatisfied						Extremely Satisfied
1. Hair						14. Leanness of back
2. Complexion						15. Muscularity of back
3. Leanness of face						16. Muscularity of neck
4. Overall face						17. Overall body build
5. Weight						18. Overall leanness of body
6. Leanness of shoulders						19. Overall level of body's muscularity
7. Macularity of shoulders						20. Overall size and shape of body
8. Leanness of arms						21. Overall muscle tone/definition of body
9. Macsularity of arms						22. Leanness of upper legs
10. Leanness of stomach/abdomen						23. Muscularity of upper legs
11. Muscularity of stomach/abdomen						24. Leanness of lower legs
12. Leanness of chest/upper torso						25. Muscularity of lower legs
13. Muscularity of chest/upper torso						

Note. From Berscheid, E., Hatfield, E., & Bohrnstedt, G. (1972); Petrie, T. A., Tripp, M. M., & Harvey, P. (2002).

APPENDIX D

Physical Appearance Comparison Scale – Revised

Directions: People sometimes compare their physical appearance to the physical appearance of others. This can be a comparison of their weight, body size, body shape, body fat, or overall appearance. Thinking about how you generally compare yourself to others, please use the following scale to rate how often you make these kinds of comparisons.

	Never	Seldom	Sometimes	Often	Always
1. When I'm out in public, I compare my physical appearance to the appearance of others.	1	2	3	4	5
2. When I meet a new person (same sex), I compare my body size to his/her body size.	1	2	3	4	5
3. When I'm at work or school, I compare my body shape to the body shape of others.	1	2	3	4	5
4. When I'm out in public, I compare my body fat to the body fat of others.	1	2	3	4	5
5. When I'm shopping for clothes, I compare my weight to the weight of others.	1	2	3	4	5
6. When I'm at a party, I compare my body shape to the body shape of others.	1	2	3	4	5
7. When I'm with a group of friends, I compare my weight to the weight of others.	1	2	3	4	5
8. When I'm out in public, I compare my body size to the body size of others	1	2	3	4	5
9. When I'm eating in a restaurant, I compare my body fat to the body fat of others.	1	2	3	4	5
10. When I'm with a group of friends, I compare my body size to the body size of others.	1	2	3	4	5
11. When I'm at the gym, I compare my physical appearance to the appearance of others.	1	2	3	4	5

Note. From Schaefer, L. M., & Thompson, J. K. (2014).

APPENDIX E

Objectified Body Consciousness Scale

For each item, please circle the answer that best characterizes your attitudes or behaviors.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Agree	Strongly Agree
1. I rarely think about how I look.	1	2	3	4	5	6	7
2. I think it is more important that my clothes are comfortable than whether they look good on me	1	2	3	4	5	6	7
3. I think more about how my body feels than how my body looks.	1	2	3	4	5	6	7
4. I rarely compare how I look with how other people look.	1	2	3	4	5	6	7
5. During the day, I think about how I look many times.	1	2	3	4	5	6	7
6. I often worry about whether the clothes I am wearing make me look good.	1	2	3	4	5	6	7
7. I rarely worry about how I look to other people.	1	2	3	4	5	6	7
8. I am more concerned with what my body can do than how it looks.	1	2	3	4	5	6	7
9. When I can't control my weight, I feel like something must be wrong with me.	1	2	3	4	5	6	7
10. I feel ashamed of myself when I haven't made the effort to look my best.	1	2	3	4	5	6	7
11. I feel like I must be a bad person when I don't look as good as I could.	1	2	3	4	5	6	7
12. I would be ashamed for people to know what I really weigh.	1	2	3	4	5	6	7
13. I never worry that something is wrong with me when I am not exercising as much as I should.	1	2	3	4	5	6	7
14. When I'm not exercising enough, I question whether I am a good person	1	2	3	4	5	6	7
15. Even when I can't control my weight, I think I'm an okay person.	1	2	3	4	5	6	7
16. When I'm not the size I think I should be, I feel ashamed.	1	2	3	4	5	6	7
17. I think a person is pretty much stuck with the looks they are born with.	1	2	3	4	5	6	7
18. A large part of being in shape is having that kind of body in the first place.	1	2	3	4	5	6	7
19. I think a person can look pretty much how they want to if they are willing to work at it.	1	2	3	4	5	6	7
20. I really don't think I have much control over how my body looks.	1	2	3	4	5	6	7
21. I think a person's weight is mostly determined by the genes they are born with.	1	2	3	4	5	6	7
22. It doesn't matter how hard I try to change my weight; it's probably always going to be about the same.	1	2	3	4	5	6	7
23. I can weigh what I'm supposed to when I try hard enough.	1	2	3	4	5	6	7
24. The shape you are in depends mostly on your genes.	1	2	3	4	5	6	7

Note. From McKinley, N. M., & Hyde, J. S. (1996).

Resources

Websites

- **Body Image and Self-Esteem, presented by the Nemours Foundation's Center for Children's Health Media**
Website: http://www.kidshealth.org/teen/your_mind/body_image/body_image.html
Provides information on accepting your body, liking your body, and taking care of your body. It also provides information on depression, eating disorders, and seeking therapy.
- **Girls Inc.**
Website <https://girlsinc.org/blog/>
The blog section of the Girls Inc website offers specific information on girl development; mental health; healthy sexuality; and bullying, harassment, and sexual assault.
- **National Association for Self-Esteem**
Website <http://www.self-esteem-nase.org/Self-esteem-booster>
Provides information on how self-esteem is developed, ways to boost self-esteem (activities and lessons), and self-esteem resources.
- **National Eating Disorders Association (NEDA)**
Website <https://www.nationaleatingdisorders.org/>
Provides information on treatment options, education for professionals, webinars, and resources for parents and families.
- **Positive Body Image**
Website <http://www.positivebodyimage.com>
- **The Story on Self-Esteem at KidsHealth website** (for young children)
Website http://www.kidshealth.org/kid/feeling/emotion/self_esteem.html

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National Programs

- **Brave Girls Want Endangered Bodies NYC**
Website <http://newyork.endangeredbodies.org>
This site is aimed toward activists and provides information on body politics. There is a page for sharing body stories, information on BMI, and contacts for their global locations.
- **Dove Self-Esteem Project**
Website <https://www.dove.com/us/en/dove-self-esteem-project.html>
This diverse site offers a plethora of information on positive body image, media influences on self-esteem and body image, activities for teens, social networking, cyberbullying, and more.
- **Hardy Girls Healthy Women**
Website <http://hghw.org/>
This site offers a Girls Advisory Board; Girls Coalition Groups; Girls Rock Awards; and trainings for educators, guidance counselors, parents, and others who work with girls to give adults the knowledge, tools, and resources to empower girls to change their world.
- **SPARK Movement**
Website <http://www.sparkmovement.org/>
SPARK arms activists, educators, community leaders, and girls themselves to foster coalition and partnerships in order to ignite and support a global young feminist movement.
- **Uniquely ME, the Girl Scout/Dove Self-Esteem Program**
Website http://www.iacpyouth.org/Portals/0/Content_Files/uniquelyMe_OneSheet.pdf
Provides information on the Uniquely Me program created by the Girl Scouts of USA and Dove.

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BODY IMAGE AND DISSATISFACTION: THEORIES AND CULTURAL CONSIDERATIONS

Final Examination Questions

Select the best answer for each question and complete your test online at **EliteLearning.com/Book**

- The term for an individual's perception of his or her physical form that may be positive or negative is?
 - Body image.
 - Body dysmorphia.
 - Body mass index.
 - Body comparison.
- Research indicates that early body dissatisfaction and negative body image are risk factors for:
 - Attention deficit disorder.
 - Social phobias.
 - Clinical eating disorders.
 - Sexual dysfunction.
- The ideal body shape for men in the United States is a(n):
 - V-shape.
 - Pear shape.
 - O-shape.
 - Apple shape.
- To understand the complexities related to body image that Black women face, it is recommended that clinicians move away from a focus on weight-specific issues and focus more on:
 - Comparison with White women.
 - Media portrayals.
 - Age-specific concerns.
 - Cultural standards.

25. In traditional Hispanic/Latino cultures, plump or round-shaped bodies are valued because they represent health and:
 - a. Education.
 - b. Wealth.
 - c. Dominance.
 - d. Freedom.
26. The social comparison process is a primary information-gathering phenomenon that involves:
 - a. Adherence to the recommended BMI for one's height.
 - b. The importance of social media.
 - c. Performing a comparison against an idealized image.
 - d. Believing that societal ideals of beauty and thinness exist.
27. Self-ideal discrepancy theory has three main ideals: the actual self, the ideal self, and the:
 - a. Fantasy self.
 - b. Dream self.
 - c. Ambitious self.
 - d. Ought self.
28. The tripartite model identifies the three most important transmitters of sociocultural ideals as:
 - a. Peers, parents, and media.
 - b. Cultural origins, media, and politicians.
 - c. Teachers, parents, and siblings.
 - d. Media, teachers, and culture.
29. According to the cognitive-behavioral model of body image, adjustive and self-regulatory behaviors include:
 - a. Body surveillance.
 - b. Appearance checking.
 - c. Upward and downward comparisons.
 - d. Internalization of thin, model-like ideals.
30. The process in which shared expectations such as cultural standards and gender-based expectations are created is known as cultural:
 - a. Competence.
 - b. Accommodation.
 - c. Socialization.
 - d. Assimilation.
31. Paying attention to how one is perceived by others and placing greater importance on how one looks rather than feels is known as:
 - a. Body surveillance.
 - b. Cultural compliance.
 - c. Preoccupation with appearance.
 - d. Appearance control.
32. Research indicates that exposure to ultra-thin models through magazines results in:
 - a. Rejection of the thin ideal.
 - b. Denial of societal ideals.
 - c. Decreased social anxiety and phobias.
 - d. Internalization of the thin ideal.
33. Among psychiatric conditions, the highest observed suicide mortality rate is found in individuals diagnosed with:
 - a. Social phobias.
 - b. Anorexia nervosa.
 - c. Antisocial personality disorder.
 - d. Tourette's syndrome.
34. Intrusive, unwanted, hard-to-control thoughts pertaining to one particular part of the body is a key diagnostic criterion for:
 - a. Binge eating disorder.
 - b. Anorexia nervosa.
 - c. Bulimia nervosa.
 - d. Body dysmorphic disorder.
35. Which is a major difference in anorexia and bulimia nervosa diagnoses compared with binge eating disorder?
 - a. There is a lack of a cognitive criterion on the influence of body concerns.
 - b. There is a preoccupation with a particular part of the body.
 - c. There is an obsessive-compulsive component pertaining to two or more body parts.
 - d. Bulimia nervosa is not recognized as a disorder in the DSM-5.
36. Which body image assessment has four subscales and measures the internalization of standards promoted by the media?
 - a. Sociocultural Attitudes Toward Appearance Questionnaire.
 - b. Physical Appearance Comparison Scale.
 - c. Body Satisfaction Scale.
 - d. Ideal Body Stereotype Scale.
37. The most common evidence-based approach for treating body image dissatisfaction is?
 - a. Dialectical behavioral therapy (DBT).
 - b. Cognitive-behavioral therapy (CBT).
 - c. Interpersonal therapy (IPT).
 - d. Acceptance and commitment therapy (ACT).
38. Tolerating anxiety-inducing situations and thoughts, rather than changing or disputing them, is the primary goal of?
 - a. Dialectical behavioral therapy (DBT).
 - b. Cognitive-behavioral therapy (CBT).
 - c. Interpersonal therapy (IPT).
 - d. Acceptance and commitment therapy (ACT).
39. Practicing distress tolerance to help a client identify rituals and avoidance behaviors is the main goal of?
 - a. Dialectical behavioral therapy (DBT).
 - b. Cognitive-behavioral therapy (CBT).
 - c. Exposure and response prevention (ERP).
 - d. Acceptance and commitment therapy (ACT).
40. To date, the number of certifications available for behavioral health clinicians in the area of body image is?
 - a. 0.
 - b. 2.
 - c. 6.
 - d. 10.

Chapter 3: Ethics in Behavioral Health Documentation: Reasons, Risks, and Rewards

3 Contact Hours

Release Date: March 28, 2019

Expire Date: March 28, 2024

Upon successful completion of this course, continuing education hours will be awarded as follows:

- **Social Workers and Psychologists: 3 Hours**
- **Professional Counselors: 3 Hours**

Faculty

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INTRODUCTION

Learning objectives

After completing this course, the learner will be able to:

- ♦ Explain the rationale for high-quality documentation.
- ♦ Describe the content of good clinical documentation.
- ♦ Identify aspects of clinical documentation that present potential ethical problems.

- ♦ Recognize documentation risks specific to digital record keeping.
- ♦ Describe decision making in ethical documentation.

Course overview

Although documentation has been described as one of the most important skills in behavioral health practice, most clinicians receive minimal training in this aspect of their work (Sidell, 2015; Reamer, 2018b). The lack of knowledge and skill regarding documentation is a potential liability. For this and other reasons, documenting according to ethical standards is relevant to all clinicians. With technological advances, digital documentation has become increasingly the norm; however, electronic health records and other forms of electronic communication pose their own ethical risks in documenting services.

For social workers, counselors, marriage and family therapists, and psychologists, documentation is equally important before, during, and after a clinical encounter. A common adage states: "If it isn't written, it didn't happen." Although documentation serves multiple essential purposes, it is fraught with risk and liability.

Sidell (2015) advises that proper documentation is one way to protect both clients and practitioners. Alfred Kadushin, a pioneer who authored seminal works on the social work encounter, suggests that "the interview begins before it starts" (Kadushin & Kadushin, 2013, p. 125), meaning that clinicians often formulate impressions and speculations about clients or patients before they ever speak to them in person. For example, paperwork is often completed by an intake or clerical staff worker long before the clinician actually meets with clients in person for the first time. This preliminary documentation may direct the assessment and treatment process. What is written about the client may appropriately assist the practitioner or, conversely, it may provide a detour from providing the best treatment. Imagine that a medical technician inaccurately records a patient's blood pressure and that the patient is put on medication for hypertension unnecessarily, has a reaction to the medication, and dies. In response to the tragedy of an unnecessary death, the family sues the practitioner and practice agency; as a result, several lives are changed forever. Although this example is an extreme worst-case scenario, equally harmful documentation missteps are possible in the behavioral health field. Consider the following example:

A social worker on a specialty cardiac unit speaks with a client who is tethered to a left ventricular assist device (LVAD) while waiting for a transplant. In her attempt to be accurate in documenting their conversation, she charts the client's exact words: "Sometimes I just want to pull the plug." She continues to assess for suicide and deems that the patient is not in imminent risk but just feels understandably discouraged sometimes. She charts, "We processed his emotions and ambivalence living with an LVAD." When other team members read her note, a psychiatric emergency evaluation is arranged, upsetting the patient even more. He tells the social worker, "You knew what I meant. I wasn't going to kill myself. I will never confide in you again!"

What might the social worker have done differently to avoid the upsetting response to her documentation? She had the option of not recording the client's exact words and charting more about exploring his discouragement and frustration. She could have included more about her suicide assessment and her conviction that he was not a danger to himself. So in this instance, either documenting more or documenting less could have influenced the outcome considerably.

Practitioners usually know what is minimally required in documentation; however, what is least required may differ significantly from what is recommended or optimal. Optimal documentation includes information that is relevant to the clinical services being provided and that addresses legal, ethical, and administrative obligations. Agency practice and time demands often result in practitioners documenting only what is required. This practice may leave the agency and practitioner open to scrutiny and risk and, at the same time, shortchange the client's services. This intermediate – level course

will help practitioners approach documentation in a way that is guided not solely by what is mandated, but by what is mutually beneficial to all stakeholders in the documentation process: the practitioner, the agency, the funding source, and most of all, the clients.

Graduate training rarely includes course content on documentation skills (Leon & Pepe, 2013; Savaya, 2010; Swain & Rice, 2009). Sidell recommends that social workers begin their careers well prepared to document, but most often they do not. The years 1920 to 2008 saw the publication of only six textbooks about case documentation, and limited attention is given to the subject in practice textbooks (Sidell, 2015). Although social work education requires that the field placement or practicum experience teach documentation skills, documentation requirements may differ according to the agency setting and may or may not be equally applicable across professional settings and roles. Too often, practitioners are left to learn the complexities of appropriate documentation on the job, and individuals who supervise their work may have received equally limited training. Leon and Pepe (2013, p. 116) suggest that one way to remedy this problem is to provide more continuing education workshops that help to "develop and maintain those essential skills," specifically the legal, ethical, and professional accountability in appropriate documentation, as well as what should be included in each note, plan, or document. Their study on the effects of a two-part continuing-education documentation workshop for hospital psychosocial staff members (the name they have given to licensed master-level practitioners) showed a significant increase in staff knowledge of documentation in the areas of progress notes and discharge summaries. In addition to knowledge, continuing education also improved practitioners' confidence in completing the documentation, an important factor in effectively writing the documentation.

These authors point out the scarcity of research on reliable and valid documentation measures and underscore the need for more continuing education and research in this area. Based on their evaluation of an earlier documentation workshop, Dziegielewski, Green, and Hawkins (2002) also demonstrated a need to train individuals in all disciplines on issues of documentation regardless of their professional license. To help fill the void in training on documentation found by several authors, this course illuminates the complex nuances of writing for the clinical record and assists the practitioner in determining when, what, and how much to document. In addition, summaries related to documentation from the codes of ethics of the American Association of Marriage and Family Therapy (AAMFT), the American Counseling Association (ACA), the American Psychological Association (APA), the National Association of Social Workers (NASW), and National Board for Certified Counselors (NBCC) are included in the Appendix.

This course is intended for both novice and seasoned human service and healthcare professionals, including social workers, mental health counselors, marriage and family therapists, and psychologists. The purpose of this course is to introduce the reader to the importance of ethical and intentional clinical documentation. The course provides strategies for adhering to ethical guidelines and for avoiding risks related to documentation. Participants will gain increased confidence and skill in providing clinical and ethical documentation that simultaneously benefits and protects the consumer, the agency, and the practitioner.

The course presents participants with the information necessary to understand the rationale, risks, and rewards of documentation. This knowledge is particularly relevant for protecting practitioners from litigious complaints and for protecting consumers from unwarranted and potentially harmful inaccuracies in the documentation of presenting issues and services delivered, particularly with respect to the risks inherent in documentation that makes use of technological advances.

THE RATIONALE FOR DOCUMENTATION

Pope (2015) makes a poignant and powerful statement about the importance of documentation, going so far as to say that clinical records have “life-changing power.”

A record's facts, inferences, conclusions, gaps, inaccuracies, wording, and tone can affect whether a person keeps custody of a child, gets a security clearance, receives life-saving help in a crisis, or secures needed accommodations at work for a disability. When a record's security is breached, the content – diagnosis, medications, clinical history, and a patient's most sensitive and private information – may find its way to an array of people and organizations, perhaps exposing the patient to gossip, ridicule, identity theft, exposure of private information on social media, and worse. For example, after learning that an employee hates her job and boss, a company may “reorganize” so that the employee's position is no longer needed. If records of a clinical psychologist's own therapy leak out, it might damage the psychologist's alliance with his or her own therapist and could influence current and future patients' decisions to consult another therapist. A battered woman's husband may discover that she was seeing a therapist, despite his threat that he would kill everyone in their family if she did so (p. 348).

Frederic G. Reamer (2018b), one of the architects of the current National Association of Social Workers (NASW) Code of Ethics, describes documentation as one of the most important skills in behavioral health practice. The clinical need for thorough, accurate, and timely documentation to ensure quality service delivery cannot be overemphasized. In addition, given the growing demands of managed care and utilization review, documentation is increasingly more important in healthcare settings as accountability, clinical accuracy, and treatment outcomes determine funding and the level of authorized services. Significant changes in the way that clinical services are provided require an update and development of new standards addressing the implications of technological advances on practice (Reamer, 2018a). The 2018 NASW Code of Ethics reflects the impact of technology on practice, including storing, retrieving, and documenting client data, particularly in electronic health records.

The following vignette illustrates many of the reasons for good clinical documentation, as well as some of the ethical risks, fears, mistakes, and myths of documenting in the helping professions:

A therapist is seeing a middle-aged man who initially presented for assistance regarding marital conflict. The man has admitted to multiple affairs during the 19-year marriage and, although he denies overuse of alcohol, the therapist suspects he also has a substance addiction. After approximately 2 months of therapy, during which the client does not demonstrate a high level of engagement, he offhandedly reveals that he is under a grand jury investigation for Federal Trade Commission violations in his role as CEO of a small company. He adamantly denies any wrongdoing and reports that the investigation is just another nuisance in a life of annoyances.

The therapist immediately starts thinking:

- What if I am subpoenaed in this grand jury investigation? What records will they demand?
- Is he seeing me only to look good for court proceedings?
- Maybe if I don't write much, my records won't be subpoenaed.
- What did I write? Maybe I should look over my notes tonight and take out anything that could hurt him or me. My suspicion of substance abuse really could hurt or help him in court.
- Maybe I could put some notes in a private folder and put others in an “official” chart. They can't subpoena the private notes.

- What drives documentation? Who is it for? Whose interest does it serve?

Record keeping is a safeguard for both the practitioner and the client. Good clinical documentation primarily meets the needs of the client, practitioner, and agency; however, it is also intended to meet the needs of the supervisor, professional boards, regulatory organizations, and accrediting bodies. O'Rourke (2010) provides a unique perspective in describing the record as an “exercise of observation and interpretation of the clients' behavior” (p. 29). As such, it affords the practitioner power, often focusing solely on the client, not on the interaction between the client and clinician. Access to records – by clients, agencies, and courts – serves to diminish this power by providing a window into the behavior of the practitioner. The power resides in the recorded information.

Kagle and Kopels (2008) suggest that clinical record keeping has primary, secondary, and sometimes tertiary functions. The primary function is to satisfy accountability; the secondary purpose is to support practice and professional education. Tertiary functions of record keeping involve research and data analyses.

Barnett and Molzon (2014) identify some of the purposes of documentation and record keeping as:

- Helping the busy clinician remember important information about the client's treatment from session to session.
- Keeping all of the members of the treatment team informed to help them coordinate services.
- Making sure that a client who leaves treatment and then returns has continuity of care.
- Recording, for purposes of risk management, all of the services provided, consultations received from other providers, the decision making process of the clinician, the role the client played in treatment, and the treatment outcomes.
- Promoting the provision of high quality services.
- Meeting the requirements of the clinician's code of ethics.
- Complying with laws, regulations, and institutional policies.

In addition to the above, it is important to note that record keeping represents practitioners' values as well as those of the agencies in which they work. Thus, it is important for practitioners to abide by their profession's ethical and legal guidelines for documentation as well as practice.

How does the record represent agency or practitioners' values? The values of beneficence, nonmaleficence, autonomy, justice, and fidelity are often cited as basic principles undergirding ethical decision-making standards of care in behavioral health. Common questions include:

- Do the records reflect those values?
- Is what is documented in the best interest of the client (beneficence)?
- Does the documentation do no harm (non-maleficence)?
- Does it reflect fidelity (loyalty, integrity, truthfulness)?
- Do the records indicate protection of a client's self-determination (autonomy) and fairness, nondiscriminating language, and equal service (justice)?

Good record keeping entails more than the dreaded paperwork required by agency regulations, although required paperwork often serves the same purposes as good documentation in client records. Bodek (2010) offers seven purposes of documentation, all of which have ethical implications:

1. To document professional work.
2. To serve as the basis for continuity of care by the treating provider.
3. To serve as the basis for continuity of care for subsequent providers.
4. To manage the risk of malpractice complaints and assist in the defense of such complaints.
5. To comply with legal, regulatory, and agency requirements.

6. To facilitate quality assurance.
7. To facilitate coordination of care among members of the treatment team.

Clinical rationale

Record keeping is both a process and a product. Although overlap exists, the process of recording generally serves as a guide for the clinician and client; the clinical elements in a client's record can provide guidance for the practitioner concerning the direction of the client's ongoing or future therapeutic work, and the product of documentation serves as proof of this clinical interaction for administrative purposes. The American Psychological Association's (APA) *Record Keeping Guidelines* (2007) state that through record keeping a provider assures good care, assists collaborating professionals in delivery of care, ensures continuity of professional service, chronicles needed supervision or training, provides requisite documents for reimbursement, documents decision making (especially in high-risk situations), and manages litigation risk.

Ideally, the process of documenting serves as a quality assurance tool by making clinicians reflect upon and evaluate their clients and their work. Quality record keeping of clinical services is valuable in facilitating quality treatment. "Through the recording process, which involves selecting, reviewing, analyzing and organizing information, the practitioner comes to a better understanding of the client-need-situation" (Kagle & Kopels, 2008, p. 10).

Diagnostic impressions

Records typically include the client's relevant history and the clinician's diagnostic impressions – usually recorded within the first few sessions. Some practitioners prefer not to attach labels to people, particularly their clients. Although this approach may seem altruistic in some ways, it can be misguided. Providing a presumptive diagnosis may assist the practitioner in developing a blueprint for treatment and guidance in selecting best practice interventions for that particular disorder. Bodek (2010) warns that the lack of a thorough initial assessment is likely to result in inadequate or inappropriate treatment. In many instances, the client may actually appreciate a label that validates what he or she is experiencing, just as a patient who goes to the doctor wants to know "what's wrong." Identifying the problem will help determine the treatment and cure. However, strengths-seeking, solution-focused, feminist, and humanistic practitioners prefer to look at what is "right" about the client's functioning and behavior and often view diagnoses as pathologizing what could

Clinical guidance

Clinical documentation has typically aligned with the "medical model," a colloquial term for the taxonomy of causalism, in which a linear causality of pathology is sought and described. The term "medical model" is in contrast to social work concepts of holism. *The Social Work Dictionary* (Barker, 2014) defines the *medical model* as:

An approach to helping people that is patterned after the orientation used by many physicians. This includes looking at the client as an individual with an illness to be treated, giving relatively less attention to factors in the client's environment, diagnosing the condition with fairly specific labels, and treating the problem through regular clinical appointments (p. 264).

Although the holistic strengths-based view is compatible with the profession's most fundamental principles of practice, it is incompatible with the traditional disease-oriented focus of the medical profession. The medical model is further reflected in the traditional problem-oriented medical record (POMR), which documents treatment according to each "problem/diagnosis" assigned to a client. Practitioners are forced to focus on problems rather than solutions.

There are clinical, administrative, and legal domains of providing mental health services, all of which are related, overlapping, and affected by ethical documentation. Each of these related domains, and the rationale for their documentation, is discussed in turn.

In addition to being the compilation of case history and activity, records provide a planning tool for future interventions with a client (Martin & Moriarty, 2012). Most practitioners have large caseloads and need to rely on records for keeping track of case information and details. Notes allow the clinician to discern patterns of behavior or interpersonal styles that can direct treatment. Through ongoing documentation, patterns of behavior are uncovered that provide evidence of need for additional assessments, referrals, and collaterals. Clinical documentation can also be utilized for monitoring and tracking treatment progress. Extreme views on the importance of documentation suggest that the quality of the record will reflect the quality of the care.

Certainly, documenting is an important tool for the training and education of behavioral health providers in clinical skill development. Professional social work, for example, has historically relied on the case method and process recording as a means for training students in "communication and relationships, and processes of assessment, intervention, and evaluation" (Kagle & Kopels, 2008, p. 17). These methods allow for the analysis and processing of interactions and provide a basis for improvement, additional education, and directions for future studies.

otherwise be considered adaptive behavior. Some reluctance to diagnose may also stem from a practitioner's lack of confidence and competence in diagnostic skills.

In light of the managed care environment, a diagnosis may be considered a necessary evil because reimbursement for services from health-insurance companies can be secured only for a billable diagnosis. Before authorizing treatment, some managed care organizations may also require documentation of client need based on diagnosis. Those clinicians reluctant to diagnose because they feel it is too pathologizing might try to reframe diagnosing as providing the rationale for the clinician's and client's choice in treatment approaches, including strengths-based, client-centered treatments. Clinicians who choose not to accept insurance reimbursement are still professionally obligated to provide adequate documentation of services provided.

The medical model relies almost exclusively on documentation to reflect patients' needs, services, and progress (Leon & Pepe, 2013). This causal model, as described by Zachar and Kendler (2007), is "rooted in infectious diseases with one clear etiologic agent," and "is simply inappropriate for complex conditions such as psychiatric disorders" (p. 557). Clinicians face challenges documenting in ways that represent a shift from a medical model to a health-oriented paradigm (Weick, 2009). Behavioral health, particularly social work, extends the medical model to add contextual information relevant to the patient's needs, services, and progress.

Of course, diagnostic impressions are not just clinical diagnoses, and a thorough assessment of the client's situation is not captured with only a diagnostic label.

One approach that is often employed as a framework for documentation is person-centered planning. In the traditional medical model, practitioners tend to decide the course of treatment based on their assessment of what is best for the client. Decisions are not always made collaboratively, and the practitioner-client relationship often fosters dependency rather than self-reliance. When using a person-centered approach

to treatment and documentation, practitioners work in a collaborative manner that validates clients' experiences and desires for their own treatment, thus improving treatment outcomes (Adams & Grieder, 2014). Documentation is written using the principles of wellness and recovery, along with data from both the practitioner and the client. Hence, outcomes are based on the dynamic changes that occur and not solely on predetermined outcomes such as medication compliance, abstinence, or stability (Adams & Grieder, 2014).

Administrative rationale

A practitioner believes that to be consistent with a "strengths-based perspective" she should never document anything that could be perceived as negative about her clients' behavior or ideation. As a result of a serious car accident, she is out of work for several months. The practitioner assuming her caseload reviews the client records and is at a loss as to the purpose of the therapy and the progress of the clients for whom he is now responsible.

One of the primary functions of documentation is to "provide a record of the encounter between client and provider" (Kane, 2001, p.56).

This record is used for clinical purposes and, increasingly, for administrative purposes. Third-party requirements such as the funding stipulations of managed care or regulatory bodies for accreditation are often the driving force behind documentation. Additionally, funding sources are demanding more evidence-based practice (EBP) and outcome-oriented interventions. Documentation practices are becoming "more aligned with EBP so that treatment activities provided by workers and the treatment outcomes observed in clients are clearly documented" (Martin & Moriarty, 2012, p. 521). Increasingly, funding streams require proof of EBP for approval and reimbursement of services. Funding sources look for accountability of monies allocated through evidence of service effectiveness. Three areas in which EBP is supported by documentation are client needs and presenting factors, services (treatment activities), and client outcomes (Martin & Moriarty, 2012). Luepker (2012) points out that, in addition to meeting the contractual obligations with third party payers, "a clear record of events facilitates writing appropriate reports about patients" (p. 2).

A major administrative reason for documentation is to satisfy managed care utilization review requirements. Records are reviewed prospectively for authorization of services, concurrently for monitoring services, and retrospectively for billing purposes or report writing. Interestingly, ethical concerns have increased in the managed care milieu as the restrictions imposed by "managing" care are perceived as "limiting" care and the temptation to embellish records to justify even minimal care presents itself as an option. Critical incidents often showcase the advocacy skills that are needed to confront the funding restrictions that govern what is considered necessary and what is authorized (Kane et al., 2002). When securing continued services, the clinician must advocate for the client, rather than inflating the records or the problems documented within them.

Program accountability

Administratively, records provide accountability on several levels: to the client, funding sources, the agency, regulatory bodies, and the profession. In an ideal world, records might also provide quality assurance. Usually, no one is observing services offered. Thus, records may provide an indirect window through which to observe and monitor the quality of service. Records also provide the means for securing resources; that is, documenting "billable" services substantiates reimbursement and can also justify the need for additional services.

Good documentation provides cumulative data that can be used to demonstrate gaps in service delivery or in the continuing education needs of staff. The data can be employed to evaluate program effectiveness and demonstrate successes. Accrediting

Although they should be concise and appropriate, details in the notes are necessary and provide context to what transpired. The service plan, along with other forms of documentation, is a shared vision between the practitioner and the client. This shared plan lessens the power imbalance between practitioner and client. Also, with a shared vision and service plan, clients who ask to see their records are less likely to be surprised by what is documented (Adams & Grieder, 2014).

and regulatory bodies rely almost exclusively on records to provide oversight and assessment of agency efficiency and quality. This aspect of documentation lends itself to a high risk of ethical violation as staff may be instructed or encouraged to "write for the reviewer," and the temptation to falsify or alter records is high. The unethical practice of backdating notes or embellishing data to secure funding or accreditation may be rationalized by thinking, "If we don't get the funding, we can't continue providing service."

Records also meet the needs of the management team, as they are often used to assist in workload planning and distribution, and for internal reviews to evaluate compliance with both internal and external stipulations.

Supervision

Good record keeping not only protects the client and the process, but also facilitates the practitioner's professional development. A supervisor's review of records is a valuable tool for evaluating and remediating the practitioner's knowledge and skills (Luepker, 2012). In a strong supervisory relationship, the supervisor will use the supervisee's documentation to highlight noteworthy aspects of a particular case or assess the practitioner's caseload (Kagle & Kopels, 2008). In contrast to the more common use of records to demonstrate inadequacies, this approach uses the record constructively to encourage reflection and ultimately improve practice.

Sidell (2015) emphasizes that documentation should always be a topic in supervision. It should be valued as a skill, equal to any clinical skill in the worker's repertoire. Furthermore, vicarious liability concerns should cause supervisors to document every supervisory encounter with supervisees. However, documenting the supervision itself is a commonly neglected task. Although supervisors may demand thorough documentation of clinical encounters from their supervisees, supervisors often give far less attention to documenting their own work with staff. In the spirit of parallel process, supervision sessions should be documented for the same reasons that client interaction is documented. Supervisors should document time, date, and content of supervisory sessions. Social work administrators should document any discussions pertaining to ethical decision making (Reamer, 2005b).

All supervision encounters should be documented (Association of Social Work Boards, 2009; Barnett & Molzon, 2014; Munson, 2012). Recording supervision protects supervisor, supervisee, agency, and, indirectly, clients. According to Barnett and Molzon, documentation of supervision can:

- Help reduce the chance of misunderstandings occurring.
- Help increase accountability on the part of the supervisee.
- Be an excellent aide for both parties when reviewing to track progress both of the supervisee's clients and the supervisee's professional development.
- Serve an important risk management role in providing a tangible record of what has transpired in supervision and the supervisor's efforts to provide high quality clinical supervision (2014, p. 1057).

Themes noted, cases discussed, educational needs, and supervisor's impressions and recommendations are all appropriate content for a supervision note. Documenting supervision for licensure purposes is particularly important for potential audits.

Sidell (2015) proposes a guide to structure supervisory notes using the acronym **SUPERS**:

- S** – Supervisee-initiated items.
- U** – Useful feedback or suggestions from the supervisor.
- PE** – Performance expectations that have been discussed.
- R** – Recommendations for future goals.
- S** – Strengths of the supervisee (p. 191).

Sidell also provides a sample format for documenting group supervision that records date, participants, topics explored, follow-up, and next meeting.

Administrative compliance

An insurance reviewer denies additional services for a client seen in private practice. Upon appeal, the reviewer states that the clinical record contains insufficient information regarding the number of sessions used for treating the particular diagnosis. Additionally, no changes in diagnosis or treatment plan were explained. The appeal for additional services is denied.

Of the seven purposes of documentation identified by Bodek (2010), the last four could be viewed as administrative in nature. Again, these purposes are:

- To manage against the risk of malpractice complaints and to assist in the defense of such complaints.
- To comply with legal, regulatory, and agency requirements.
- To facilitate quality assurance.
- To facilitate coordination of care among members of the treatment team.

Legal rationale

The profession of social work has not escaped the increasingly litigious reach of our society. Astute record keeping is the best protection from baseless claims (Luepker, 2012). Careful documentation may mean the difference between a legal judgment for or against a worker or an agency (Moline, Williams, & Austin, 1998; Swain & Rice, 2009). Legally, records protect the therapist by demonstrating that the treatment provided was within the professional standard of care. Thorough records assist in clarifying and justifying questionable actions by the therapist or agency. In fact, the NASW (NASW Assurance Services, 2018) lists documentation clarity in the practitioner's notes as one of the organization's tips for avoiding malpractice. Reamer (2006) gives an example in which a plaintiff may file a lawsuit against a social worker, claiming the worker was negligent about properly obtaining informed consent before releasing confidential information. Accurate and timely documentation of obtaining informed consent is the only protection the clinician has. Swain and Rice (2009) assert that "professional accountability, justification of services and protection from legal or professional sanction rely in no small part upon the adequacy of practitioners' records" (p. 68). However, such emphasis encourages providers to write defensively (insurer-focused) instead of clinically (client-focused).

Obtaining informed consent is not a perfunctory and merely obligatory part of documentation. There are actually risks associated with it. Although it is a legal and ethical requirement in health care, true informed consent is difficult to obtain and substantiate. The level of understanding and decision-making capacity of the client can vary across time and situations. Although a client may give consent for disclosure of information, for example, that disclosure may inadvertently backfire, possibly causing the client harm. Clients may be harmed by released health information that is improperly disclosed by the third-party recipient or when the information is used against them in court proceedings. Even when properly released and disclosed, the information now made public may have residual effects for the client. In our digital world, informed consent should now include explanation for clients regarding the use of technology "to gather, manage and store protected health and other sensitive information" (Reamer, 2018a, p. 75).

Consider this example:

In discussing copayments with a group of colleagues, one mental health clinician at an agency that offers no sliding scale or reduced fee revealed that when a copayment is very high (e.g., \$50) and the client is obviously struggling financially, she often reduces the copayment, taking less money for herself as a result. However, she enters the higher amount (which she didn't take) in her records and keeps knowledge of the reduced fee between herself and the client. The agency is still reimbursed for the session by the insurance company for the usual amount, which does not include the copayment.

This scenario presents risks on all three levels: clinical, administrative, and legal. Clinically, the worker is trying to do something helpful for the client, but Reamer (2001) suggests that altruism is frequently at the root of the unethical situations in which practitioners find themselves. What if other clients somehow discover this practice and perceive it as preferential treatment? Will they expect the same? Will the client interpret this as having a "special" relationship with the clinician? Will the client feel indebted to the clinician for the reduced fee? Administratively, the mental health clinician's actions could be seen as deceptive bookkeeping practices. If the worker's supervisor learns of the practice, might she question other documentation provided by the worker? Legally, could an argument be made that insurance fraud is being perpetrated?

Liability insurers report that the most frequent licensing board complaints stem from perceived conflicts or damages resulting from divorce. When therapists are involved in seeing couples, this risk is salient. To obviate this risk, it is recommended that practitioners "create a documented record of resistance to disclosure" (NASW Assurance Services, 2018, p. 1). This added informed consent requires signatures from all parties, permitting the practitioner to resist disclosing records in good faith. In couples therapy, this statement of neutrality protects the practitioner from being drawn into "taking sides" (e.g., of having records subpoenaed to harm the other partner). In essence, the statement explains that the practitioner is an "unbiased intermediary ... and shall not act as an advocate for or against any party" (NASW Assurance Services, 2018, p. 1).

Consider this example:

A couple with two young children was being seen for marital therapy. Although the counseling appeared to be going well, when one partner revealed infidelity, the other filed for divorce. The counseling was terminated and a child custody battle ensued. Hoping to prove the spouse to be an unfit parent, one partner wanted to use information known to be in the therapist's notes about an emotional outburst by the other partner that occurred during a session. The therapist's records were subpoenaed. In this case, with the help of her liability lawyer, the therapist was able to resist the subpoena on the basis of the informed consent/statement of neutrality and resistance to disclose that was signed at the beginning of the couples' treatment.

In determining what is reasonable and customary for the public to expect from a particular profession, the courts look to the "industry standard" for guidance. Most "standards of care" are outlined by a profession's code of ethics. Several organizations' professional codes of ethics are recognized as the industry standard within the helping professions. These include the codes issued by the APA, the NASW, the American Counseling Association (ACA), the American Psychiatric Association (APsA), the American Association for Marriage and Family Therapy (AAMFT), the Association for Specialists in Group Work (ASGW), and the National Board for Certified Counselors (NBCC).

Many clinicians like to keep two sets of notes on clients: one for the official record and a second set with personal comments,

interpretations, and cues for clinical intervention. This second set of notes is commonly referred to as “personal notes” or “shadow records” (Sidell, 2015) for legal purposes, but the distinction between the official record and personal notes varies by state. Most states make no distinction, and thus both sets of records are subject to subpoena; states that recognize a distinction do not require that personal notes be considered under a subpoena. Practitioners are advised to check their state’s law on what is considered part of the “mental health record.” Sidell (2015) advises that the safest risk management approach is to destroy informal notes after using them as aids for recording the official notes in the case file.

Subpoenas are often anxiety-producing for practitioners, but erring on the side of documenting too little or too much can exacerbate the situation. It is advisable to keep all documentation, including electronic communications, for protection in a lawsuit. It is also important not to make any changes to the record after receipt of a subpoena.

Certain risk management strategies will help reassure the practitioner who fears revealing records in legal proceedings. Managing risk in documentation involves four areas:

1. Content.
2. Language.
3. Credibility.
4. Access.

Suggestions for risk management in documentation offered by Reamer (2005a) and Swain and Rice (2009) are shown in Figure 1.

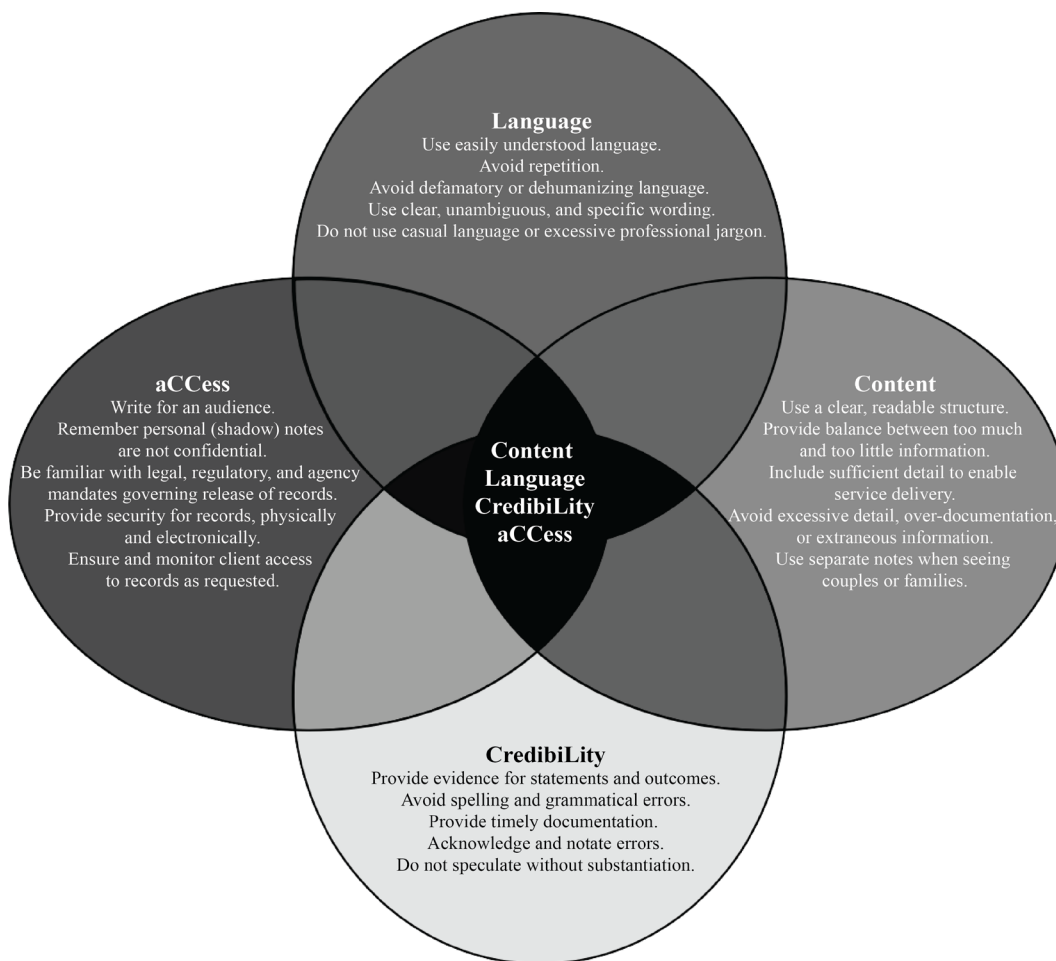
Sidell (2015) gives specific examples of “people-first language” to avoid any hint of defamation or discrimination. For instance, most contemporary practitioners are aware that the emphasis should be on “having” a condition, rather than “being” a

condition and would write, “He has a mental health condition” instead of “He is mentally ill,” or “She has a diagnosis of autism” instead of “She is autistic.” However, more vague references might escape even the most conscientious worker, who might write, “He was born with a birth defect,” instead of the preferred, “He has a congenital disability” (Sidell, 2015, p. 49). Further, Mitchell (2007) warns against using “conclusionary terms,” meaning modifiers without substantiation, such as deeming a client “disorganized” or “aggressive” or “uncooperative” without evidence. Professional opinions need to be verifiable.

Finally, because documenting psychotherapy has evolved from the medical model, it is the accepted standard in most clinical work to keep accurate, timely, and sufficient records. Both what is written and what is not written can be potentially problematic. Malpractice claims can be brought based on acts of commission (actions taken) and omission (actions not taken). Documentation can verify what has or has not taken place in a therapeutic encounter, and the risk of legal repercussions extends also to what is or is not written in the documentation itself. In resolving legal claims, courts may consider issues of malfeasance and nonfeasance. Malfeasance is when an action is performed in a flawed way, such as conducting an incomplete suicide assessment; nonfeasance is when a required action is not performed at all, such as not performing a suicide assessment when indicated. Only solid documentation can exonerate a practitioner from the suspicion of malfeasance or nonfeasance or protect a client’s best interests.

Simply put, good records benefit the client, the clinician, the agency, and the profession. They “serve and protect all parties” (Reamer, 2005a, p. 328).

Figure 1: Risk Management Documentation Strategies



CONTENT OF DOCUMENTATION

Good documentation requires organization, decision making, critical conceptualization, and effective writing. Good clinical documentation contains specific elements of organization and writing (Bodek, 2010).

According to Kagle and Kopels (2008), good clinical records will demonstrate these fifteen principles:

1. **Balance:** Of the valued but competing goals of accountability, practice improvements, efficiency, and client privacy.
2. **Focus on the mission:** With content relevant to the agency mission or program objectives.
3. **Risk management:** Achieved by good compliance with agency policy, legal standards, practice guidelines, and professional ethics.
4. **Accountability:** With a focus on service delivery, impact, and outcome.
5. **Abridgement:** Exclusion of information that is not pertinent to purpose, goals, or outcome of service.
6. **Objectivity:** Presentation of information that is fair and impartial, and that includes observation, sources of information, criteria used in assessment, and appraisal.
7. **Client involvement:** Documentation of the client's role in all aspects of the process.
8. **Sources:** Provision of sources for all information.
9. **Cultural context:** Inclusion of cultural factors influencing the client situation or service.
10. **Access:** Information written with the assumption that anyone may have access to it.
11. **Usability:** Organization of records, usually chronologically, in a reader-friendly way.
12. **Currency:** Records kept current with periodic reviews and updates.
13. **Rationale:** Provided for all service decisions.
14. **Urgent situations:** Full documentation of emergencies or crises.
15. **Exclusion:** Of irrelevant, extraneous, opinionated, or speculative information.

The minimally required content for good clinical documentation in a case record would include agency-specific templates and formats, such as documentation of informed consent and confidentiality limits, case notes, assessments, and diagnostic codes (Reamer, 2005a,b). Sometimes agencies provide templates for certain parts of a case record (e.g., consents, releases of information, assessments) to increase the uniformity of the record; however, the quality of case notes in particular is largely dependent upon the individual clinician's skill in documentation apart from his or her interviewing skills and ability to elicit the information that is necessary and relevant to the therapy. Discerning what is sufficient, necessary, and relevant for documentation is as much a practitioner skill as learning therapeutic techniques. The clinician's interpretation of information to document, and the method by which to document it, determines the quality of the documentation. Practitioners should document with the expectation that a much wider audience than expected may read what is written. The

Overall chart organization

Chart organization and content may differ across settings. Agencies usually require specific and structured information, whereas private practitioners have more flexibility concerning order and organization.

Bodek (2010) provides a framework for organizing a patient record for healthcare settings and advises that a file folder exclusive to each patient be maintained. The folder would consist of:

- Demographic information, including insurance and referral information.
- Intake information, including assessment, evaluation, and initial history.
- Service or treatment plan.

content of excellent clinical documentation provides insight into client needs, justifies and chronicles the course of intervention, and demonstrates progress and outcomes.

Mitchell (2007) takes the stance of charting for the reader. He proposes basic principles to create a useful record for colleagues and clients:

1. Language should be clear and specific, avoiding irrelevant statements or excess verbiage.
2. Whenever possible, use the client's own words. Write what is heard.
3. Write what could be comfortably shared with the client.
4. Records must be written logically. Ensure that charting has some relevance to the presenting problem or the guiding treatment plan. If charted information is not pertinent to either, it should not be included. "Usefulness requires specificity, and vague writing might be construed as indicating incompetence." (p. 31).
5. Avoid modifiers (such as "soon" or "sometime") that are abstract or could leave room for doubt.

Put simply, according to Mitchell (2007): Records should be understandable and accountable.

Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not specify what is required in a medical record, according to Groshong and Phillips (2015), the following must be included to meet behavioral health guidelines:

- Billing information and payment records.
- Formal evaluations.
- Collateral contacts, including release of information (ROI) for all.
- Records from other providers with ROI.
- Counseling session dates, with start and stop times.
- Modalities and frequency of treatment.
- Medications.
- Diagnoses.
- Functional status (activities of daily living [ADL], ability to work, interpersonal capacity).
- Medical/physical problems.
- Community contacts, including phone calls, emails or texts.
- Treatment plan and goals.
- Symptoms and prognosis.
- Progress in each session.
- Disclosure forms and informed consents signed by the licensed professional and client.
- Presenting problem(s) or purpose of visit.
- Referrals to and results of formal consultations.
- Progress notes sufficient to support responsible clinical practice for the type of orientation/ therapy used.

All digital medical records should be backed up regularly and kept in encrypted format, with frequent changes in passwords. Although there can be both a medical record and psychotherapy notes, information cannot be put into psychotherapy notes to avoid putting it into the medical record (Groshong & Phillips, 2015).

- Progress notes.
- Referrals or consultations made, collateral reports, and test results.
- Correspondence from other practitioners.
- Correspondence with patient or collaterals.
- Billing records.
- Informed consents/authorizations or other privacy-related information releases.

Consents and authorizations do expire, so records should contain original and updated forms so that the history of consent to services, communications, and any other relevant aspects of treatment are evident (U.S. Department of Health and Human Services [HHS], 2013). In addition, it is recommended that

a HIPAA compliance folder for each patient be maintained separately from the patient's clinical record and psychotherapy notes.

Another organizing framework, offered by Sidell (2015), for a thorough clinical record includes these five categories:

1. Identifying information.
2. Consents and releases.
3. Assessments and treatment plans.
4. Progress notes and service reviews.
5. Communication with and about clients.

In the early days of psychosocial intervention, the purpose of documentation was client service delivery. As patients' rights gained prominence in the 1980s, the importance of clients' rights to privacy was recognized. The 2003 implementation of HIPAA's Privacy Rule actually legalized parameters of documentation content, such as confidentiality, informed consent, and distribution.

The Health Insurance Portability and Accountability Act regulations have affected how client records are organized and what may be included. Documentation is often considered synonymous with record keeping; however, documentation encompasses many aspects, formats, and types of record keeping. To distinguish among the various types of records, the following definitions are offered:

- **Mental health records:** These are patient records related to the evaluation or treatment of a mental disorder. These records include, but are not limited to, substance abuse (drugs and/or alcohol) records (Moline et al., 1998, p. 174). Typically, behavioral health documentation is noted in a separate section of the electronic health record (EHR).
- **Patient medical records:** These are records maintained in any form or medium, by or in the custody of a healthcare provider, which relate to a patient's health history or diagnosis, or the treatment provided. Patient records do not include information given in confidence by a person other than another healthcare provider or the patient.
- **Psychotherapy notes:** Psychotherapy notes, according to HIPAA regulations, are notes recorded in any medium by a healthcare provider who is a mental health professional that (a) document or analyze the content of conversations that took place during a private counseling session or a group, joint, or family counseling session and (b) are separated from the rest of the client record. Psychotherapy notes (as compared to medical records) do not include medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; or any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date (HIPAA Survival Guide, 2003). Several mental health provider associations have debated this ruling. The Health Insurance Portability and Accountability Act specifies that "psychotherapy notes are held to a higher standard of protection because they are not part of the medical record and never intended to be shared with anyone else" (Bodek, 2010, p. 16). If it were true that psychotherapy notes were not intended to be shared, there certainly would be less cause for concern.

In addition to the client record, a HIPAA compliance folder for each client must be maintained. Furthermore, HIPAA specifies that psychotherapy notes are to be kept separate from the

Informed consent

An informed consent has been called the "quintessential document" in the provision of mental health services (Bradshaw, Donohue, & Wilks, 2014). In addition to being one of the first documents to comprise a record, it is one of the best risk-management tools. Informed consent in today's healthcare milieu demands details not previously considered, including potential benefits and risks of engaging in treatment, the

rest of the individual's medical record, including the HIPAA compliance folder (Bodek, 2010). This regulation sets up a baffling conundrum in that healthcare facilities usually maintain a single consolidated medical record for each client that includes all consultations, including behavioral health interventions. As a result, the therapist may maintain his or her own clinical or shadow notes, which may be considered "personal," but are nevertheless subject to the same legal scrutiny as the official record. Some states protect personal notes from legal discovery, yet keeping such notes does pose a risk. Mitchell (2007) describes a case in which a practitioner naïvely kept the second set of notes in a foreign language as protection. Of course those notes could be translated. Other practitioners may conclude that "what they don't know won't hurt me" and keep the personal notes a secret. If asked under oath if all records have been provided, however, the consequences of perjury and ethical misconduct may be worse than what was written in the notes.

Some clinicians argue from a minimalist perspective that the less that is written, the less there is that can hurt the clinician or the client. Under the guise of protecting client confidentiality, these clinicians may err on the side of maintaining too little documentation. Some practitioners have argued against keeping detailed records, based on the contention that confidentiality can be best protected as a way to avoid litigation with no documentation at all, particularly if the client requests minimal documentation. This argument may be shortsighted in the present digital and litigious era; in fact, lack of documentation could potentially make a practitioner more liable and simultaneously do a disservice to the client.

Other clinicians may err on the side of too much documentation, thinking that more is better. This practice may also be problematic in that superfluous information may confound what is crucial to the client's treatment.

It is difficult to imagine that behavioral health practitioners can remember every detail about a client without referring to their records. For example, imagine the therapeutic rupture that would result if a therapist in session confused one client's history with that of another client. The clinician's review of his or her thoughtful records prevents such an unnecessary error. Imagine the reaction of a patient who visited his physician and found that nothing was charted about his medical history, current complaints, or prescribed medications. Likewise, in behavioral health, good record keeping can help establish rapport as a client sees that what he has to say is worth noting, literally and figuratively.

Record-keeping content and especially format may vary considerably across settings. Agencies dictate the format. The APA's revised guidelines for record keeping suggest that for practitioners, in agencies or private practice, "records document the nature, delivery, process, and results of services" (Drogin, 2010, p. 237).

Therefore, three kinds of content should exist across settings:

1. General file information, such as demographics and reasons and goals for service.
2. Substantive contacts, including date and duration with client and collaterals; the context and approach to services; tests and progress.
3. Supplemental information, such as assessment results, measurements or tests, and client journals or drawings.

nuances of technology use, limitations on confidentiality, and mandated reporting. "Failure to obtain or document consent can result in serious consequences, including problems in the therapeutic relationship and legal action" (Bradshaw et al., 2014, p. 3).

Relevant history

Social work emphasizes treating people in context. This is known as the person-in-environment approach and relies on gathering and documenting relevant history from the patient and collateral sources. Psychosocial assessments that include a client's history, along with tools such as genograms, document the context for establishing a case formulation of a client's current functioning. The combination of medical and psychosocial information provides an important history that contributes to the clinician's understanding of the patient's current level of functioning. Information relevant to the client's life history includes childhood development, cultural identities and intersectionalities, school, family and other significant relationships, employment, socioeconomic status, sexuality, and substance abuse. Exploration of the presenting problem requires an examination

Progress notes

Progress notes are written documentation detailing every session. Although progress notes are highly susceptible to error, good progress notes protect practitioners against future litigation regarding misdiagnosis or treatment. What constitutes a good progress note? A good progress note not only proves that an encounter took place, but also details the type and effect of treatment so that any reader can ascertain a client's issues, diagnosis, and progress in therapy. Progress notes should include information about each session's content or topics, relevance to treatment plan objectives and goals, and use of interventions and their outcomes. Progress notes should reflect the current status (based on the therapist's clinical observation during the session) of a client's diagnosis, the medical necessity of services, and progress or setbacks in relation to treatment objectives and goals (Wiger, 2011).

Sidell (2015) cites Kagle and Kopels (2008), who recommend that progress notes should include the following information:

- Any new information about the client's needs.
- The practitioner's assessment of the client's status with regard to needs.
- The client's actions or activities related to the service plan.
- Services provided by the practitioner.
- Evaluation of progress.
- Any changes necessary in meeting the goals of the service plan.

Frequency of progress notes varies by setting and agency policy (Sidell, 2015). Building on Kagle and Kopels (2008), Sidell (2015) reports that practitioners should:

- Document critical incidents within 24 hours.
- Document significant changes in client needs as soon as possible, within 3 days at the latest.
- Regularly note indicators of progress toward service goals following every third contact.
- Record contact with other service providers regarding active cases weekly.
- Update progress notes regularly, following every third service contact or at least monthly.
- Update notes before any planned practitioner absence, case transfer, release of information or case review.

Although these guidelines might seem overwhelming to the hurried practitioner, who has 5 minutes between sessions to record his or her notes, they are an aspirational goal for documenting. A medical analogy can illustrate the importance of such attentive record keeping: For a patient receiving a medication, the failure of the practitioner to record the setbacks, limitations, progress, plans, adverse effects, and clinical observations might cause the treatment to be futile or, worse, dangerous. The chances of the practitioner being accused of negligence would be high.

To satisfy managed care insurers, progress notes are "expected to provide information about the client, the implementation of the intervention, and goal progress or attainment" (Kane et al.,

of the history of the problem, including the onset, context, and events triggering current help-seeking (Luepker, 2012).

A well-documented assessment, however, presumes that the documenter has interviewing skills that will elicit the important information needed in good documentation (Leon & Pepe, 2013). Yet it also depends on the practitioner knowing what and how to document.

The bio-psychosocial-spiritual assessment is the foundation of a clinical record. It encompasses multiple areas of history and functioning of the client. Essentially, the assessment unpacks the presenting problem, describes it in context, documents relevant developmental, family, medical, interpersonal, educational, employment, and social history, and identifies client strengths and limitations, including risk and protective factors.

2002, p. 204). Notations are best if documenting observable or measurable behavior.

Acceptable progress notes would include five elements:

1. The contact.
2. The client's behavior and/or affect.
3. Client reactions to interventions.
4. Reactions of others.
5. Significant events (Kane et al., 2002).

Ethical dilemmas in documentation arise in a managed care environment when protecting client confidentiality conflicts with disclosing sufficient information to satisfy managed care requirements.

Progress notes are often organized in one of two recognized formats: SOAP (Subjective, Objective, Assessment, Plan) or DAP (Data, Assessment, Plan). Another format serves to help in training novice workers: STIPS (Symptoms, Topics of discussion, Interventions, Progress and plans, Special issues). These structured/semi-standardized formats assist providers in focusing documentation.

The following is a case example designed to demonstrate good documentation of a session:

Samantha is a client who has been receiving counseling from Darlene, a seasoned practitioner, for the past year. Samantha sought out Darlene's services at the recommendation of her attorney following the state's removal of her three children, ages 4, 6, and 9, due to severe neglect. At the start of treatment, Samantha explained that at the time of her children's removal she was experiencing severe depression precipitated by the children's father abandoning them and Samantha's mother dying within the same month. The children's removal further exacerbated her depression. Fourteen months later Samantha has stabilized, and reunification with her children has begun. It is expected that the children will return to her full custody in about 3 months.

Samantha is looking forward to the transition, but she is also scared and anxious about being overwhelmed with parenting responsibilities. Samantha meets with Darlene weekly, and Darlene is in regular contact with Samantha's caseworker and attorney, as well as the children's therapists. Samantha and Darlene have discussed openly the limits of confidentiality in her therapy, and Samantha sometimes chooses to withhold information from Darlene that might reflect negatively on her in her client record because she knows that other professionals involved in her family's care will see it. She has been reluctant to share the extent of her anxiety about the upcoming transition; however, Darlene is familiar with these types of reunifications and is able to normalize Samantha's concerns and introduce salient interventions without Samantha having to feel overexposed. At their most recent session, they discussed Samantha's relationship with her boyfriend, who has recently lost his job and is at risk of losing his apartment, and anticipated

possible changes to the relationship as the children return home. In addition, they reviewed self-soothing and relaxation techniques for Samantha to use during times of increased anxiety, problem-solved parenting dilemmas, and discussed some of Samantha's friendships.

The following is an example of the progress note for this session using the SOAP format:

- S** – Client reports looking forward to her children returning home and says that her boyfriend and friends are excited for her. She reports that her weekend visit with the children went very well, although she is worried that her 9-year-old has been getting into a lot of trouble in the foster placement.
- O** – The reunification efforts have included increasing Samantha's unsupervised time with all 3 children at once. A primary social support of Samantha's is experiencing stressors that have impacted the relationship. Samantha did not confirm or deny that she is experiencing increased stress. Samantha is concerned about her oldest daughter.
- A** – This time of reunification typically includes an increase in parental stress. Although Samantha did not endorse feeling an increase in stress based on previous discussions, I suspect this is because she does not want to do or say anything that will jeopardize the reunification. As the experience of increased stress was normalized, Samantha wanted to revisit previous stress management skills. She continues to show determination in demonstrating behaviors that would lead to reunification. She thoughtfully engaged in a discussion about analyzing various social supports and their usefulness to her during this important time. The session ended with Samantha asking for help in problem-solving her concerns about her oldest daughter.

Information from others

Documenting information received from collateral contacts varies according to the purpose of the information and the manner and setting in which it is received. In forensic assessment, third-party information is particularly important (Otto, Slobogin, & Greenberg, 2007; Heilbrun, NeMoyer, King, & Galloway, 2015). Likewise, child-custody evaluations and investigations of domestic violence rely on third-party informants (Bow & Boxer, 2003; Bow & Quinell, 2002). Documenting third-party information is a significant aspect of clinical record keeping in these situations.

Parents or other caregivers are almost always involved in coordinating a child's care in terms of scheduling appointments or coordinating with other providers. All of these contacts must also be recorded in a client's record.

However, clinicians will also encounter collateral information under less life-altering circumstances. For example, a relative of a client leaves a voicemail for the therapist providing unsolicited, potentially important, possibly damaging, information. In such a case, is it necessary for the clinician to document anything?

The decision concerning whether to document material received by collateral informants is based on clinical, legal, and therapeutic determinants. Consider the following case scenario:

The grandmother of a 23-year-old client contacts her grandson's therapist and leaves a voicemail advising that he is having a sexual relationship with a 16-year-old girl, who is also the babysitter for his young child. The girl's parents, who recently learned of the situation, are enraged. The grandmother wants the therapist to intervene, but doesn't want her grandson to know that she is the one who told the therapist. State law delimits age of consent at 16.

Does the therapist have to document the call? Should she? This information may be clinically important, and it is a potential legal bombshell. The therapist's records could be involved

- P** – Continue to meet with Samantha weekly to prepare for the upcoming reunification; fortify stress management and social and parenting skills.

How did Darlene navigate the various confidentiality concerns in this progress note? Confidentiality was protected by disclosing no identifying information about collaterals. The language is not harming, discriminatory, or judgmental, and contains a tone of identifying progress and strengths.

Is there, however, room for improvement? Two areas might warrant reconsideration:

1. The Objective section note is more about Samantha than the process that took place in the session and/or what the practitioner did; and
2. The Plan could be more specific in terms of demonstrable plans or outcomes. What will preparation for the upcoming reunification consist of? What stress management tools will be provided? Which parenting or social skills will be the focus? These questions might be covered in a treatment plan, and referral to that treatment plan would be appropriate.

Wiger (2011) outlines common problems with progress notes, including vagueness, irrelevant information, and inability to elicit essential information from uncooperative clients, all of which can lead to ethical issues. In addition, taking shortcuts in documentation, such as not charting a separate note for each member attending a group or family therapy session, can be problematic.

A simple framework for objectively assessing clinical notes is that another reader should be able to discern:

- What brought the client to seek help?
- What was done about that presenting problem?
- What were the interventions and results?
- What was the disposition? (Martha St. Enterprises, Inc., 2009).

if there is a civil suit. A practitioner might be tempted to ignore the unsolicited information. However, not discussing or documenting the call also carries risk. To cover all bases, it would be prudent for the therapist, first, to recognize that she does not have a duty to keep the grandmother's disclosure confidential. If the grandmother had spoken directly to the therapist instead of leaving a message, the therapist could have advised the grandmother that her disclosure is not confidential. In addition, without the consent of the client, the therapist can neither confirm nor deny that her grandson is a client. Next, the therapist should discuss the phone call with her client and document the results of that discussion. The therapist is then in a better position to assess the reliability of the information, its potential significance for the therapeutic work, and the liability risk.

Consider, also, the following scenario:

An agency that provides trauma treatment to children recognizes that to be truly trauma-informed the staff needs education and support. They arrange to have a social worker, also an employee, provide an educational debriefing group weekly to paraprofessional staff about trauma-informed practice. It is clearly delineated that this service is not therapy or counseling. Most of the staff do not have advanced clinical degrees and know little about trauma-informed practice. A participant in the group asks to talk to the social worker after the group and reveals her serious depressive symptoms. The social worker is sufficiently concerned to have the person identify supports but intentionally does not assess for suicide lethality since that would be outside the scope of this assigned duty. He is also concerned about the suitability and competence of this person to do the work and worries that she is a potential harm to clients. He seeks consultation from another social worker, wondering if he has a "duty to warn" administrators about possible impairment of the

colleague and if he has an ethical obligation to protect against suicide. Since this is not a therapeutic group and is not being documented in a clinical record, he doesn't know if he has the obligation to document the serious discussion with the individual somewhere.

This situation represents a moral issue, with legal and ethical nuances. Legally, the worker is under no obligation to "warn" or to document. Duty to warn requires that the worker have a fiduciary relationship with the other person. In this case, the

Unnecessary information

Kane (2001) states that documentation should be:

1. Accurate and helpful.
2. Thorough and complete.
3. Legible.
4. Timely.
5. Without editorializing comments.

Editorializing comments may be the most concerning for liability purposes. Consider this progress note by a clinician treating an 11-year-old boy for separation anxiety:

Used non-directive play therapy with Josh today. His drawings indicate isolation and reclusiveness and never include his mother, who one would expect might be present in the pictures to represent security. After meeting with mother today, it is understandable that Josh doesn't have her in his pictures as she seems to have her own anxiety issues and Josh gets easily agitated around her.

What is potentially harmful about this note? It may be clinically correct that Josh's separation anxiety is connected to his attachment with his mother, and it is generally accepted that mothers provide security to children. Therefore, the comment "who one would expect might be present in the pictures to represent security" might be acceptable. However, if Josh is the client, should the clinician be giving a diagnostic impression of the mother, as in "she seems to have her own anxiety issues"? The clinician is making an evaluative statement without any corroborating information. Unnecessary information increases liability risk, as irrelevant information may breach client privacy.

What might go wrong as a result of this documentation, even if it is true that the mother has been diagnosed with or treated for anxiety? The mother might say, "Well, I've been treated for anxiety myself, so it's no wonder Josh has problems." This information may be relevant to Josh's condition in that his own anxiety is both learned and inherited, but it is important for the clinician to reflect on whether it is necessary to document the statement and if documenting it could be a risk. In fact, it is not necessary to document the statement. Furthermore, documenting it could indeed be a risk. What if the pediatrician or school personnel or another therapist reads the records? What if the father, in a custody dispute, subpoenas the records and uses the comment about the mother to prove she is not fit to have custody? One clinical statement, although likely to be true,

worker has not entered into a fiduciary relationship; he has no responsibility for the participant. In essence, he is a coworker. His license or code of ethics does not mandate responsibility in this instance. Morally, the worker may feel concern and act as any caring colleague might in providing resources, support, or connection, which he has done. In addition, the worker decided to periodically check in with the colleague as a kind of watchful waiting and, if the situation seemed to escalate, was prepared to bring it to the attention of supervisors.

has gone terribly awry. The mother's privacy has been violated. Reamer (2008) suggests that such editorializing is tantamount to defamation of character and potential grounds for malpractice or other litigation. Information included in records should not be gratuitous or extraneous to the situation. Savaya (2010) cautions against including distorted, inaccurate, excessive, or irrelevant information. Standard 3.04 of the NASW Code of Ethics counsels that documentation must be accurate, timely, and reflective of services provided, as well as protective of client privacy. These goals can be accomplished by recording only information that is "directly relevant to the delivery of services" (NASW, 2018).

Recall the four categories of risk management in documentation suggested by Reamer: content, language, credibility, and access. Mitchell (2007) advised against using conclusionary terms, modifiers, or abbreviations. Problematic notes might use modifiers such as "seems," which could create doubt, or adjectives such as "extremely," which would suggest opinion rather than fact.

Moline and colleagues (1998) describe the minimum and maximum content criteria for treatment records, including what not to document or keep in the file. Material that might prove embarrassing to the client or to the therapist – such as information that might easily be misinterpreted by another reader – is best left out of documentation. Such information might include personal opinions, discussion about a third party (hearsay), sensitive information that is irrelevant, specific information about client family members, or past criminal behavior.

Mental health practitioners who are self-employed as consultants or work independently in private practice should keep case notes, although these notes are not subject to agency or supervisory scrutiny. Independent practitioners should adhere to guidelines established by the state regulatory body in which they are licensed and/or their professional organization (Green & Simon, 2012). Although keeping case notes is an important task for all practitioners, what to include varies based on a multitude of factors. In general, the record is "written for different purposes and different readerships, which results in competing tensions in its construction" (O'Rourke, 2010, p. 125). In sum, regardless of the setting, recording is a demanding but vital task in the delivery of clinical services.

ETHICAL ISSUES IN RECORD-KEEPING AND DOCUMENTATION

Using case examples, this section will present specific dilemmas in record keeping and documentation. Issues unique to private practice, clients' access to records, and electronic records and use of technology will be explored.

Case scenario

A long-term client reveals in detail to her practitioner that decades ago she committed a capital crime. Of course the practitioner, who believes the client, is concerned about her duty to report this incident. She is assured by her supervisor that, to honor confidentiality, she is under no obligation to report the crime. However, the issue of documenting the discussion is a cause for disagreement. The practitioner believes she should document something about it, but the supervisor advises her to "pretend you never heard it." What should the practitioner do?

In this case, determining the purpose of the documentation is paramount. Yes, the revelation is a legal issue, but it is also a clinical issue. Pretending it did not happen does a disservice to the client, who obviously wants to address it. Documenting that it occurred without identifying detail might be the most judicious decision. Attending to the process of the revelation in the present without concentrating on details of the past would be sufficient for current and subsequent evidence of clinical discussion. An example of this is, "Client revealed seriously regrettable behavior from decades past. Client was visibly shaking while discussing it. The reason for the current focus and need for future exploration and resolution will have to be determined."

The note indicates the seriousness of the discussion and its clinical importance, while still protecting the client. Subsequent therapists could pick up on this note and know the client is experiencing current distress over a past incident. What to do with that distress could be a treatment focus.

In addition to knowing what to include, Pope (2015) identified the five most challenging areas in record keeping: confidentiality, informed consent, legal requirements, third-party payers, and the implications of research findings on documentation. The importance of content and security of records also becomes more obvious with certain clientele, as in cases of interpersonal

Storage, release, and disposal of records

Whereas most codes of ethics address documentation and record keeping, some ethical codes extend their coverage to include topics such as the storage, disposal, and release of records. The Appendix outlines the relevant standards and principles covered by several professions' codes of ethics. The NASW reports that the why, when, and where of keeping clinical records is a complex issue facing social workers (Robb, 2003). Clinicians have four basic questions:

1. How long should clinicians keep records?
2. Where should records be stored?
3. What are guidelines for electronic records?
4. What are the consequences if records are prematurely destroyed?

The NASW Insurance Trust recommends indefinite retention of records (Robb, 2003), although state laws may stipulate differently. There is potential fallout from disposing of records too soon, since an injured party can file suit decades after alleged malpractice. In some instances, such claims may stem from the moment an aggrieved party first recognizes harm, not necessarily from when the harm took place. Although the APA record-keeping guidelines (2007) no longer distinguish between "full" and "summary" records, it is recommended that, even if a practitioner destroys records at the legally permissible time, he or she should keep discharge summaries or reports. Practitioners are also advised to review insurance contracts to meet contractual deadlines for record retention.

All records should be stored in a locked location and accessible only to those who have a need to know. Electronic records need additional security precautions. These precautions include password-protected computers and, for added protection, the storing of records on computer drives not linked to the Internet. Keeping records of deceased clients is important, as they could be helpful in potential litigation. It is prudent to be familiar with federal statutes regarding records, such as HIPAA and the drug and alcohol use confidentiality regulations (the Code of Federal Regulations, Title 42, Part 2 [42 C.F.R. Part 2], known as 42 CFR Part 2, or "Part 2"), and with state laws and regulations pertaining to records (e.g., storage, retention, client access). Federal law governing public health (United States Code, Title 42, §§290dd-2 [1992]) and the above-mentioned federal regulations that implement it guarantee the strict confidentiality of information about all persons receiving substance abuse prevention and treatment services (Cornell Legal Information Institute, n.d.).

Despite the best attempts to store records appropriately, problematic situations can arise and questions as to what happens if they are damaged or destroyed become a major

Altering records

Consider the following scenario:

A client is being seen for erratic behavior, including angry outbursts. The practitioner documents that the client's diagnosis is undetermined, and that there is a history of schizophrenia in the family. The client reports that a previous psychiatrist diagnosed him with schizophrenia. The client later requests his records and, when he sees this notation about schizophrenia, demands that it be stricken from the

violence (Bradshaw et al., 2014). Systems designed to protect clients, particularly women and children, rely on accurate and secure information. Cases involving homicidal or suicidal intent, abuse, or violence require detailed information regarding safety plans, mandated reporting processes, and monitoring of potential threats. Some providers might intentionally avoid *documenting* or even *reporting* criminal "duty to report" behavior.

Omitting such important information is not only a liability risk for the agency, but indicates negligent practice on the part of the provider, potentially harming the client or family.

Both paper and electronic records can be damaged by fire, flood, or storms. Natural disasters like tornadoes and hurricanes can result in serious damage to important documents. Counsel for the NASW advises that social workers decrease the risks associated with natural disasters by backing up and recovering data and reconstructing or destroying records (Felton & Polowy, 2017). Contingency plans should be made so that records can be accessed during an emergency. It should be noted that obtaining the services of a restoration company requires a HIPAA business associate agreement (BAA; HHS, 2017a). Reconstructing records may entail compiling information from other sources such as filed claims, billing records, correspondence from collateral contacts, previous providers, or off-site server storage for EHRs. If records are reconstructed or restored, notation must be made to reflect the change and reason for it. Clients should also be informed and may actually be of assistance in reconstructing records with history.

If records are in need of destruction, proper disposal has to comply with HIPAA confidentiality regulations. Documentation of what records were destroyed and how they were destroyed should be kept in new documentation along with pictures that record the damage (Felton & Polowy, 2017). If an outside vendor is used to destroy records, again, a BAA must be obtained.

Storing data using a cloud server can certainly help in backup and restoration, but also carries potential confidentiality breaches and privacy risks (Sidell, 2015). Devereaux & Gottlieb (2012) point out that although "the cloud" has become commonplace, little has been written about how this technology may expose practitioners to unforeseen and previously nonexistent risk. The authors give as an example the situation in which a practitioner may purchase record-keeping software for scheduling and recording. If all goes well, off-site data storage improves efficiency and security, but when an inevitable shutdown or interruption occurs, "the practitioner would be unable to access patient records, contact information, or scheduling calendars rendering him or her unable to manage his or her practice for an indeterminate amount of time" (p. 629). Additionally, if a provider chooses to switch cloud software or companies, proprietary restrictions could cause difficulties with the transfer of data. Researching and implementing best practices regarding cloud computing is judicious for supporting vindication in case of a breach. Sidell (2015) warns that "cloud computing should not be used for any information one would not wish to share with a competitor or with the government" (p. 158). In many instances, there is no way to ensure that data will be kept confidential and protected in these situations. This area needs further research and the creation of ethical guidelines.

record. He does not want any mention of schizophrenia in his chart. What does the practitioner do?

Is altering records risky? Could such an alteration be construed as fraud? There is a difference between altering records and correcting records (Zur Institute, 2016). Reasons for correcting records include mistaken notations regarding any part of the charting, such as assessment, diagnosis, client behavior, therapist intervention, plans, or wrong words or terms. Clearly, corrections are justified in these instances because they are in

the best interest of the client. Accuracy is crucial in providing and maintaining appropriate service delivery. Inaccurate records can result in litigation.

However, if a client requests an amendment to the record, is making the change justified? The answer is that performing this action is justified only if there is a compelling and valid reason for it. Imagine that a therapist gets a court-ordered subpoena to turn over records on a client. She reviews the record and notices several comments potentially damaging to the client's effort to retain custody of her child. The therapist removes these comments in a way that makes the original record illegible. Or the notes are redacted without any indication as to why this has been done. This action could be deemed to be inconsistent with the standard of care of documentation, in addition to being unethical and possibly illegal – a type of fraud through omission or concealment.

With today's forensic technology and timestamping of EHRs, records that have been changed, by hand or electronically, can easily be detected.

In the same scenario, as the therapist reviews the record before complying with the subpoena, she notices that she got an important detail wrong in the assessment because, at the time, she misunderstood a part of the family's constellation. In this instance, not only does she have the right to correct the information, but perhaps also the obligation to do so.

Service reimbursement or extension

A client submitted claims for reimbursement to her insurance company. The company then requested all original notes on the client for the past 10 years. They specifically did not want a summary, but copies of the notes. The practitioner was reluctant to comply.

The NASW Code of Ethics (2018) specifically addresses ethical breaches regarding documentation and client records. Standard 4.04 speaks to dishonesty, fraud, and deception. Documentation is one area in which dishonesty, fraud, and deception might occur. Clinicians must document only that which is true. Embellishing symptoms to ensure insurance reimbursement is an example of a "white lie" that a practitioner might argue is necessary to secure needed services. The risk is high. Reamer (2018b) suggests that the slippery slope begins when social workers, out of a sense of altruism, exaggerate needs to procure reimbursement or falsely bill under a family member's insurance to extend services. In addition, more blatant forms of deception in documentation exist in exaggerated or misleading claims of effectiveness, falsified records, and deliberate fraudulent insurance submissions, such as documenting and billing for individual sessions for each person seen in a group. "White lies" or other forms of deception are detrimental and could have deleterious ethical and legal implications for the practitioner and, ultimately, the client.

Kane and colleagues (2002) describe the challenges of documentation in a managed care environment. With managed care, emphasis is on limited services that are brief, cost-effective, and empirically based. It is a "pragmatic, medical model derived approach to intervention. Based on cost, need, the outcome of service, and *rigorous documentation* [italics added], providers are reimbursed" (p. 200).

An ethical challenge for providers is when the rigorous documentation that is called for relies on a pathology focus, which is in direct opposition to empowerment and strengths-based approaches inherent in humanistic counseling intervention. A provider finds himself in a position in which a focus on deficits may determine continued service and reimbursement. The ethical risk of overstating a problem with the altruistic goal of securing service for the client is evident.

Pope (2015) suggests that the importance and complexity of third-party issues in clinical documentation cannot be overemphasized with regard to uses, misuses, and unintended

Because a standardized way of correcting a record does not exist, consulting an agency legal department is a common way to determine the necessary steps for addressing corrections to a record. Strike-throughs with initials are one way, and providing a dated amendment to an asterisked section is another. Documenting the reasons for the change provides support and explanation for the clinician's actions.

In the scenario regarding the client's demand that any reference to schizophrenia be deleted, is there a compelling reason to agree to the client's request? It could be argued that the therapeutic alliance and the client's peace of mind could be threatened if the request is not met. However, if the therapist deletes the information, she must explain why. Did she make a mistake? Was the information inaccurate? The simple answer is "No." Noting that the client had reported a previous diagnosis of schizophrenia by a psychiatrist and that there is a family history of the illness is relevant to the client's care and pertinent to maintaining a complete record. In this instance, documenting the client's reaction to seeing his records and his request to remove information may be the most appropriate course of action. In actuality, the therapist in this case did delete the information, leaving a blackened space, with a notation that the redaction was at the request of the client after seeing his records. Future providers or third parties reading that record are sure to be mystified about what information was hidden by the redaction.

consequences. Third-party payers often expect a certain theoretical approach and require that records reflect content that indicates use of that model. This pressure can create ethical tension for practitioners, causing divided loyalties or conflicts of interest. It is as if the client becomes the third-party payer instead of the consumer receiving services (Pope, 2015).

Ethical breaches can be inadvertent, such as accidentally leaving a file open on a computer or a paper chart open on a desk where someone can view it. This type of violation is represented legally as *misfeasance*. Records might contain unintentionally inaccurate or incomplete information or improper storage of records (*misfeasance*), knowingly recorded false information (*malfeasance*), or absence of required information such as an informed consent (*nonfeasance*).

The following scenario was presented by a social work therapist in a large private practice:

It has come to my attention that there are some billing practices that appear fraudulent. For example, there is an office manager in charge of billing at our office. It is not an electronic note system. Everything is handwritten, turned in, and then billed to the insurance system or EAP. The number of therapists in our office has grown exponentially, and not all providers have been credentialed and paneled through each insurer. Because of this, it appears that services are being billed under other credentialed providers. Most recently, it appears that a psychologist, licensed as an LPC, had a Medicare client who was transferred to me because Medicare will not approve the LPC. I am approved as an LCSW. I know the LPC has other Medicare clients and I think they are being billed under me. If I address this with the owner and steps to correct billing are taken, what is my obligation to tell the insurance company or clients? Since the private practice owner takes care of credentialing, how culpable am I if that is part of the owner's responsibility?

This scenario is an example of what is known as "lending a license." How culpable is the practitioner who never saw the client? The LCSW in this situation may indeed have some responsibility, and could risk her own approval rating with the insurance company, in addition to a potential sanction by the licensing board. In addition, the agency is not meeting insurance provider requirements, which could lead to possible revocation of payments.

Documentary evidence

Documentation can make or break a legal case. According to Barsky (2012), many legal proceedings are increasingly relying on “documentary evidence.” Barsky defines documentary evidence as:

... any document presented and allowed as evidence in a trial or hearing. Although historically, documents referred solely to information written down on paper, documentary

evidence may also include information stored on cameras, video or audio recorders, smart phone, computers, the Internet, or similar media (p. 216).

The most common documents written by practitioners that are used in court are affidavits and reports. A checklist for documenting legal reports is shown in Table 1.

Table 1: Checklist For Legal Reports

Language	Content	Format
<ul style="list-style-type: none">• Clear, concise, reader-friendly• Disclaimers such as “reported by,” when knowledge is indirect.• Unbiased – no language that is judgmental, ethnocentric, or opinionated.	<ul style="list-style-type: none">• Sufficient background and information to which the practitioner can testify confidently.• Facts, opinions, and recommendations differentiated.• Explanation for charts/tables; opinions substantiated by research.• Facts relate to legal issues of the case.	<ul style="list-style-type: none">• Easily understood tables, charts, appendices.• Easy to follow through ordered sequencing and headings.• Overall professional quality.

Note. Adapted from Clinicians in Court, by A. Barsky (2012). New York, NY: The Guilford Press.

Group notes

Each client seen in group, family, or conjoint therapy must have his or her own clinical record. It is not advisable to write one (the same) note for each person and put the identical notes in separate charts; this form of documentation is inaccurate and incomplete because it is not specific enough to the individual client's treatment. Additionally, clients who are seen in both individual and group sessions should have separate notes about their individual and group participation that in no way reveal the identity of other group members, thus protecting other parties in the group if an individual's records have to be disclosed (Bodek, 2010). Notes documenting group or family sessions should include the clinician's observation about the client's functioning in the group or family session, observing particularly the individual client's involvement in the process. Bodek (2010) sums up group documentation succinctly:

The progress/session note for each person in the group, conjoint or family therapy, should focus on that individual's mental status, behavior, participation and functioning in the session, and their reaction and responses to the themes and processes that arose during the sessions. It should avoid to the extent possible, mentioning any identifiable material from or about other particular members of the group, couple, of family, unless this is necessary for clarity (p. 20).

If it is not feasible to record a note in each group participant's individual record, it may be acceptable to keep a group record, adding to individual files intermittently or to highlight something significant (Sidell, 2015). However, since the group file is also considered a legal document, releasing such a composite group record could violate confidentiality; careful attention to redacting others' information is necessary.

Correspondence to or about clients

Letters to clients should be written carefully, with attention to purpose, and they should contain only information that is necessary and permissible, with the knowledge that this letter

could be read by anyone and used in court proceedings. All such correspondence should be produced formally, typically on letterhead, and in business format (Sidell, 2015).

Client access to records

A man sought counseling from a social worker to help him copy with a bitter divorce. The man learned from his lawyer that his estranged spouse was planning to seek sole custody of their children. The man worried that the social worker's clinical notes – which included details about the man's suicidal ideation and substance abuse – might be used against him in the custody dispute. The man asked to see the notes and then asked that they be destroyed.

O'Rourke (2010) views the clinical record as a process for monitoring of services, eventually explained and available to service users. “The very exercise of observation and interpretation of clients' behavior, and the recording of those observations and interpretation, is an exercise in power ... the spotlight is on the client, much less so on the practitioner” (p. 29). The social work value of self-determination is reflected legally in freedom of information legislation, meaning that records can be seen by clients. This legislation serves as a way to balance the power differential between clients and providers.

The NASW Code of Ethics (2018), Standard 1.08, addresses client access to records. The Standard is written based on the social work value of self-determination. Essentially, clients should have access to records, although records are ultimately the property of the agency or provider. Typically, the physical record is viewed as the property of the clinician, while the information contained within the physical record is viewed as the property of the client. Generally speaking, clients have the right to view

and obtain a copy of their records, although there may be some exceptions, such as access to records of forensic clients or in child protective services settings (APA, 2013; HHS, 2017b). Workers may lean toward paternalism when clients request records, out of concern that reading clinical notes might trigger adverse reactions in clients. Ultimately, the client does have the right to see the record, even though clinically he or she may be seeking only feedback and reassurance, which can be provided without reviewing specific documentation.

Patient access is a current and controversial issue. Not without opposition, OpenNotes (Johns Hopkins Hospital, 2017) is a national initiative working to give patients better access to the clinical-visit notes written by their doctors, nurses, and other clinicians. Medical clinics and primary care offices increasingly are installing patient portals to allow patients to view their complete medical charts online. Following that trend, some medical centers, as part of an ongoing effort to make care more transparent, have begun posting the mental health notes in patients' electronic medical records, allowing the patients immediate access to the summaries at home (Kowalczyk, 2014).

In general, practitioners are legally and ethically bound to release records to clients. The Health Insurance Portability and Accountability Act stipulates access rights for patients to:

1. View records in a timely manner.
2. Request changes to their records.
3. Know who else has seen the records (HHS, 2017b).

Circumstances do exist in which records can be withheld. Even so, withholding or not releasing records in a timely manner, or releasing records when not permitted, can subject the provider to a licensing complaint, HIPAA complaint, sanctions, or lawsuits.

A particularly challenging issue is parental access to records. Often parents feel entitled to know the course and progress of treatment. Practitioners must abide by the laws of the state in which they practice when, for example, needing to obtain a signed release from the child client after a certain age. Balancing the parental demands, clinical desire for parental involvement, and therapeutic alliance with the client poses a risk for ethical breach.

The Legal Defense Fund of the National Association of Social Workers states:

It is important that social workers have a foundational understanding that parents generally have the right to access the medical and mental health records of their minor children. This is considered a parental right and interfering with this right should only be considered after assessing the child's emotional condition and relationship to each parent and based on sufficient knowledge of the applicable legal standards for denying parental access to records as well as

Documentation in a digital world

An inquiry to an Ethics Committee stated:

I am using an electronic records program and want to use dictation for notes. I'm wondering if anyone has done research regarding using a smart phone microphone and whether there are any HIPAA concerns. There is something I read that made me concerned about the digital file being sent to Apple or Samsung, but I'm not sure.

This situation is certainly unique and contemporary. It represents both the ease and risk of technology. In days past, dictating to a transcription service was taken for granted, with little concern for privacy. Returning to "dictating" now takes on a different perspective. In this case, the Ethics Committee consultant advised against using this application because some information is shared with Apple or Samsung from certain applications to assist with Artificial Intelligence functions such as Autocorrect and Smart Reply, which might involve cloud storage. It was recommended that a third-party recording app might be safer and more transparent, in that the user agreement could be a type of informed consent.

Case scenario

A counselor working in a women's prison re-entry program was assisting her client with dressing appropriately for job interviews. She arranged for the client to get a haircut. Since the client had a type of haircut in mind, the therapist sent a magazine picture of the hairdo and a picture of the client to the hairdresser via email.

Could this ostensibly helpful action be a breach of confidentiality using technology? Of course it is. Even if the client was aware of it, the client's safety is primarily the practitioner's responsibility. The client's status as a former inmate receiving adjustment services is now available to anyone with whom the hairdresser opts to share the information.

Mental health practitioners are increasingly making use of various forms of digital technology in their professional lives. The APA recognized that technology would change so fast that references to specific forms of technology might have to be revised frequently. Thus the choice was to eliminate specific references to types of technology in favor of broad-based terms and suggestions for security and protecting confidentiality, such as separate "psychotherapy notes" in an electronic health record. From marketing a practice on a website to using avatars in counseling, use of digital technology and social media has changed the face of the counseling profession. Frederic G. Reamer, quoted in Pace (2014, p. 4), suggests that the use of technology "fundamentally alters the helping relationship." He

the appropriate procedures to follow. State health privacy laws may also provide procedures and/or standards for providing and denying parental access. ... (NASW, n.d.)

Legally, social workers ordinarily covered by HIPAA may deny parents access to children's treatment under certain circumstances:

1. Reasonable suspicion of abuse or neglect.
2. Danger of substantial harm as a result of records disclosure.
3. Separate psychotherapy (shadow) notes.
4. Voluntary parental agreement.

In such cases, documenting justification of the denial is paramount. In addition, the clinician must have another licensed healthcare professional, who is not directly involved in the denial, review the decision to deny access. Documentation of consultation with colleagues or an ethics committee regarding the denial is advised.

Clients can now access their own health information through platforms to the EHR. Although this access can enhance patient-provider communication, barriers still exist, especially with respect to access to sensitive or clinical notations (Nelson & Stagers, 2018).

has researched the ethical challenges that can result from such digital-based interventions as video counseling, email chat, social networking, texting, phone apps, and self-directed Web-based healing modalities, going so far as to suggest that it is not inconceivable that a practitioner may never see a client in person (Reamer, 2013).

Documenting services provided online or via telephone, and client's access to such documentation, has evolved more quickly than standards to guide or regulate the practice (NASW, 2017).

Using the axiom of "start where the client is," a practitioner might justify engaging with adolescents via their preferred medium of electronic communication (Reamer, 2013). However, the following scenario illustrates the ethical risk and emphasizes the need for informed consent that outlines the confidentiality and access limitations that using technology may pose:

A family-based social worker often texts his teenage clients to arrange appointments. After regular duty hours, one of the teenagers sent him a text hinting that she would attempt suicide that night. He didn't see the text until the next morning.

Texting has become more frequent in clinical practice. In spite of the imminent risk to client privacy and breach of confidentiality, some clients, especially adolescents, prefer this mode of communication. Practitioners using texting as a form of communication should have a clear policy outlining when texting will be used or is acceptable (NASW, 2017). Informed consent should also address and cover this risk. Should texts be included in the health record? The short answer is "Yes." Whether to include the exact text or a summary of text discussion is at the discretion of the provider, but there should be some record of text communication. Texts, much like email, need to reflect the values, ethics, and mission of the practitioner's profession (NASW, 2017; Reamer, 2018b; Sidell, 2015).

Current guidelines for the use of technology are discipline-specific, and clinicians wishing to use technology in their practices should ensure that they are following their profession's ethical and legal standards.

Consider the following scenario:

A practitioner has been seeing a client once a week for counseling. During the most recent visit, the client reveals that he has been experiencing increased depression, manifesting as low energy and loss of interest in his usual activities, and he has been giving away some of his belongings because he "just doesn't need them anymore." The practitioner asks the client if he is considering suicide,

and the client answers that he has had passing thoughts but does not have a plan. The practitioner and client engage in creating a safety plan, and the client asks about texting the practitioner between sessions. The practitioner, in an attempt to be helpful, agrees that the client can contact her between sessions. During the week, the client experiences increasing thoughts of suicide and texts the practitioner around 2:00 a.m. one morning. What should the practitioner do?

The above scenario is complicated and illustrates what can happen when texting occurs in the professional relationship. Although the practitioner was trying to be helpful, the whole situation could have been avoided had the practitioner outlined specifically in her policy when texting was appropriate, and for what purposes, or by simply not allowing texting to occur. Now the practitioner has blurred the boundaries with the client, and the client's safety is of concern. This scenario can become even more complicated, both ethically and legally. For example, consider the ramifications if the practitioner texts the client and the client indicates that he is suicidal, or worse, does not text the practitioner back, or if the practitioner fails to see an urgent text. How does the practitioner assess the safety of the client? What is the ethical responsibility in this scenario? Is the practitioner legally responsible for the client's well-being at this point? These issues are multifaceted and, again, could be avoided by not engaging in texting within the professional relationship. At the very least, the clinician needs to ensure that she includes all text messages in her documentation and case files. When practitioners decide to engage in texting with clients, their policies should be provided to clients during the first session, and they should obtain informed consent.

Using email with clients poses other challenges that need to be addressed with the clients. Although convenient for a number of purposes, including completing necessary paperwork before sessions, scheduling, or answering simple questions without playing "phone tag," email carries inherent confidentiality and boundary risks. The need for informed consent, with its attendant implications and risks, has already been discussed. The added protection of an encryption program, as well as the use of a password or code words or an electronic signature system that verifies clients' identities, could also be considered (Sidell, 2015). Both texting and emailing clients can pose ethical dilemmas and place practitioners at potential risk for favoritism, conflicts of interest, and boundary confusion (NASW, 2017). Furthermore, it is never possible to ensure that the intended person is receiving an electronic communication. Again, referring to professional guidelines for technology, along with ethical and legal standards, is key to effective and appropriate documentation.

The majority of agencies are moving toward electronic record keeping. The assumption is that an EHR "will save time, provide real-time access to patient information at the point of care, facilitate the work of the clinician, provide decision support capabilities, support clinical care and research, and improve quality and safety of care" (Nelson & Staggers, 2018, p. 93). The burgeoning field and profession of Health Informatics encompasses the development and monitoring of electronic health applications (Nelson & Staggers, 2018). Private practitioners usually are not required to use electronic record keeping, but many are choosing to do so via various platforms and software packages. Financial record keeping is equally as important as clinical record keeping. Accuracy in billing records is a risk management safeguard against client complaint. It is recommended that such records include date and type and duration of service provided, with associated charges and dates of receipt of payment or third party reimbursement. Complications arise when modifications are made to fee arrangements, such as sliding scales or other considerations regarding ability to pay. Documentation is particularly important

for avoiding misunderstanding or the appearance of preferential treatment.

Cyber-liability is now a concern for behavioral health providers. The most salient risk in electronic record keeping is computer security and breach of client confidentiality when records are stored on agency servers or personal computers. Malpractice insurers list several ways in which technology breaches can put practitioners at risk, including losing a laptop computer or flash drive with stored client information, faxing or emailing information to the wrong recipient, or falling victim to cyber hacks on a data management system. Even if a data storage service loses the information, the practitioner can be held directly liable (NASW Assurance Services, 2014). In addition, using distance counseling platforms presents potential conflict of interests. Clients may assume that practitioners endorse the advertisers and sponsors on the video counseling sites (Reamer, 2013).

Electronic recording poses multiple risks. In her book on social work documentation, Liz O'Rourke (2010) paints a grim picture:

The power of databases to enable information about us to be shared by others in ways over which we have no control raises the spectre of Foucault's Panopticon ...the all-seeing Panopticon was a means to observe, control and discipline behavior ... The social work record may be seen as part of the Superpanopticon which is scrutinizing the service user, but at the same time it may also be a means to scrutinize the practitioner. (p. 31)

Indeed, applying the metaphor of a panopticon (a building, usually a prison, designed in such a way that people can be observed at any time without their knowledge) to electronic documentation emphasizes that both the client and therapist need to consider that the information contained in a record may be viewed at any time by unknown parties. This awareness should serve to regulate what the therapist records about a client. Although extreme in nature, this metaphor does illustrate the importance of the caution practitioners need to apply when creating client records. The assumed scrutiny speaks to the need for proactive risk management protocols in record keeping and documentation. Both paper-based and electronic records are subject to breaches if access is easy (Bradshaw et al., 2014). Thus, the focus should be on securing records, either physically or through such technology as encryption (NASW, 2017).

Although Reamer (2013) also speaks about the ethical risks of electronic documentation, he advises social workers to document electronically in the same way that they would make a paper record, because encrypted electronic records are actually more secure than traditional charts. He does caution that any clinical encounters via electronic media (email, text, social networking, or telephone) should be charted in the case record.

Behavioral health practitioners working for agencies rely on the institution to provide computer network security systems. With respect to private practitioners, of course, software programs or platforms must be HIPAA compliant and records should be encrypted. In addition, practitioners are advised to ensure that their liability coverage includes digital documentation protection. Liability and billing insurers may recommend certain programs for private practitioners to use for electronic record keeping.

Despite the extensive reach of HIPAA regulations, standardized measures for monitoring electronic records and dissemination of confidential information have yet to be developed (Bradshaw et al., 2014). Quality assurance (QA) programs have focused on service implementation and outcomes, with less focus on managing the quality of records.

Just as the process of record keeping poses ethical risks, so too does the documentation of ethical dilemmas, decision-making processes, and resolutions. See the Resources section of this course for additional guidance on this issue.

Publication

A unique aspect of clinical documentation concerns clinical writing and publishing case material. Bennett (2011) illuminates the ethical dilemmas that emerge when the clinician's responsibility to respect the client's right to privacy competes "with the societal good of educating other professionals about the process of social work practice" (p. 11). Historically, publishing case material was an accepted practice, even without permission from the client, if material was heavily disguised. However, with the enactment of HIPAA regulations and effortless Internet searching, clients can easily find their therapists' publications, recognize themselves in published writing, and perceive that their rights have been violated.

No matter how many safeguards are put in place, such as the use of disguised information or the obtaining of a client's

Supervision

Supervising documentation

The following supervision scenario points to the need for recording on two levels: the worker's need to record services and the supervisor's need to record addressing the performance deficiency:

A supervisor has administrative and clinical charge over several mental health practitioners. One of them is consistently late in documentation but does exemplary clinical work. She was placed on a performance improvement plan that did not yield positive results. During her performance review, she protests that she is bringing in the most revenue from clients and is known as one of the best clinicians in the agency. She doesn't understand how timely documentation could be any more important than clinical effectiveness and bringing in money.

Although there are many areas of professionalism for the supervisor to address with this clinician, the supervisor can begin by explaining that by not providing timely documentation of her work she is failing to hold herself accountable and is also placing the clients, the agency, funding streams, and her own reputation in jeopardy. The supervisor can further problem-solve the issue with the clinician and determine various potential causes of the late documentation. For example:

- Does the clinician lack a knowledge base of what constitutes good documentation?
- Does she struggle with time management such that the task of documenting remains undone?
- Is her work with clients crisis-oriented, or does she have so many responsibilities that documentation does not rise to the top of the priority list?
- Does the clinician lack the resources necessary to provide timely documentation?

This analysis will allow a supervisor to intervene more effectively and support the clinician in ways to improve the timeliness of her documentation.

According to Rogers (2018), behavioral health practitioners who also clinically supervise face particular challenges in integrated healthcare settings. These supervisors must bear responsibility for documentation issues of confidentiality, informed consent, self-determination, and format. He goes on to distinguish among three types of documentation for mental health practitioners: progress notes, psychotherapy notes, and process notes. As noted in the Introduction to this course, most graduate training programs do not provide specific courses on documentation, nor on supervision (Leon & Pepe, 2013). These topics are often provided by continuing education that must be sought out by a particular practitioner. This issue places supervisors at risk not only for difficulties with documentation for themselves, but also for their supervisees. It cannot be assumed that supervisors have received training in either of these critical practice areas.

Documenting supervision

Reamer (2001, 2015) advises that supervisors, as evidence of oversight and monitoring, must document any supervision

permission, ethical dilemmas can still arise. The utilitarian (teleological) approach to ethics (the greater good prevails) would opt for benefitting the professional community, which conflicts with a more deontological viewpoint that would argue that publication might simply be unethical because it violates the client's privacy.

The request for permission inevitably will alter the therapeutic relationship and may pose undue influence. The client may feel coerced to agree in order to receive services. Thus, clients will not always perceive an informed consent as totally voluntary. Yet the effect of clinical writing on the treatment relationship may also be positive, particularly if the client feels his experience is noteworthy and could help others.

provided. The concept of *respondeat superior* ("the master responds"), the legal principle by which supervisors can be held liable for actions or inactions of their supervisees, demands it. Documentation of routine supervision is one protective risk management strategy.

Barnett and Molzon (2014) advise that informed consents should be a foundational agreement when beginning supervision. According to these authors, this agreement is no simple thing and should include:

Expectations, responsibilities, and obligations of both supervisor and supervisee; any fees and financial arrangements relevant to the supervisory relationship; scheduling and emergency contact information; documentation and record keeping requirements; the use of any audio and video recording; evaluation and feedback to include the expectations and requirements for successful completion of the training experience; expectations for confidentiality and any reasonably anticipated limits to confidentiality; legal requirements such as mandatory reporting requirements, expectations for use of the supervisor and when the supervisee should contact him or her; and information about how and when the supervisory relationship will be ended (pp. 1052-1053).

Barnett and Molzon (2014) also emphasize the importance of documenting each supervision session. They list several reasons for documenting supervision:

- Mitigating the possibility of misunderstandings.
- Fostering accountability for both parties.
- Tracking supervisee's progress with respect to professional development and clinical services provision.
- Managing risk by demonstrating that supervision has occurred.

The American Board of Examiners in Clinical Social Work (ABECSW; 2004) and the NASW (2013) have created guidelines for clinical social work supervision that address the documenting of supervision. Both of these organizations suggest a contractual agreement signed by both supervisor and supervisee, listing the purposes, objectives, and methods of supervision. The ABECSW position statement (2004) asserts:

The supervisor understands the responsibility to create and maintain an ongoing record of the supervision. Records must be kept in accordance with state and federal laws as well as agency policy. Accurate and thorough record-keeping is an important aspect of job management, and provides protection in case of a legal challenge to the quality of the services provided (p. 26).

The NASW *Best Practice Standards in Social Work Supervision* (2013) state:

Documentation is an important legal tool that verifies the provision of services. Supervisors should assist supervisees in learning how to properly document client services performed, regularly review their documentation, and hold

them to high standards. Each supervisory session should be documented separately by the supervisor and the supervisee. Documentation for supervised sessions should be provided to the supervisee within a reasonable time after each session. Social work regulatory boards may request some form of supervision documentation when supervisees apply for licensure. Records should be safeguarded and kept confidential (p. 18).

Supervision/consultation is important for documenting ethical decision making. It is important to consult with colleagues, including supervisors, in formulating an ethical decision, and it is equally important to consult about what to document in the process. The same principles employed to document services to clients apply equally to documenting supervision.

DECISION MAKING IN DOCUMENTATION

The following example provides a springboard for ethical decision making in documentation:

During a session a client threatened to punch her former boyfriend's present girlfriend in the face. The worker speculated whether this admission met the criteria for a duty to warn. She pondered whether to document the threat, thinking that if she didn't document it there would be no chance of either her client or herself being hurt legally. After the client willingly provided her boyfriend's number, she did call him and his girlfriend and provided the warning to both. She considers her ethical obligation met but still wonders if it is necessary to document the interchange.

These questions guide the necessity to document:

- For whom is the note written? (Is the information for the agency, the practitioner, collateral or subsequent practitioners, or the client?)
- Is it necessary? (Does the information further the goals of treatment or link other aspects of treatment?)
- Is it useful? (Does the information relate to the treatment goals, or is it extraneous?)
- Is it sufficient?
- Is it true?
- Who might read it?
- Who should/could read it?
- Are there jurisdictional statutes that require it? And perhaps the most important question:
- What might happen if I don't write it?

The concept of negative responsibility is the ethical notion that a person is equally responsible for inaction as for action. Negative responsibility plays into deciding what to document and what not to document. The skill of conceptualizing important themes without potentially damaging detail develops over time with experience.

Mitchell (2007) expands on this concept by assuming the voice of a coworker when documenting. If a coworker were to read the note, would he or she find it sufficiently clear to ensure continuity of care? A client is not served well when a coworker is challenged to interpret incomplete records. Suppose a coworker is charged with covering for a sick colleague.

She reads in the notes: "Client often acts inappropriately in session." The coworker is left wondering if the client laughs inappropriately, makes sexual overtures, or lunges across the room unexpectedly. Mitchell (2007) describes this charting as using "conclusionary terms" without substantiation and goes further to imagine a client reading such powerful, potentially damaging documentation.

Reamer (2012) suggests applying a decision making framework known as *choice architecture* to ethical decision making. This concept can also be applied to decisions about documentation. Choice architecture, which originated in the economics and business fields, has only recently appeared in the behavioral sciences literature. In this framework, choices are constructed in much the same way that steps are placed in strategic areas of

Mitchell (2007) summarizes with a somewhat satirical yet cautionary list of documentation risks that ensure litigation or charges of unethical conduct:

1. Document something that needs to be done; then don't do it.
2. Do not keep records current.
3. Do not complete assessments or develop a comprehensive treatment plan.
4. Establish policies and procedures, but do not follow them.
5. Do not review or audit your records.
6. Nurture a dependent relationship and then cut it off abruptly.
7. Combine a suicidal client with a provider who has a reputation for sexual impropriety.
8. Ignore your code of ethics (p. 18).

building construction; the placement of the steps themselves then influences the choices people make.

The concept of choice architecture can be used to assist in determining what to document in a clinical record. In choice architecture, a clinician should expect error and manage the risk. The architecture of choice in ethical decision making, when applied to clinical record keeping suggests that the clinician should ask:

- What would happen if I don't document? (What would happen if I were to do nothing?)
- Should I consult? (Who should/could be involved in this decision?)
- What if ...? (Always anticipate errors and the need for risk management.)

The default decision in building a case for documenting is to do nothing. This decision certainly has its risks, so the next step, to get feedback, is advised. The ultimate step is to expect error and manage the risk, which, after consultation, may result in the default decision.

Reamer (2001, 2007) provides an ethics audit tool to manage risk in an agency in multiple areas. Documentation, in which practitioners' documentation styles and procedures should be assessed, is one area the ethics audit addresses.

The audit notes whether documentation routinely includes these components:

- Social history, assessment, and treatment plan.
- Informed consent.
- Collateral contacts.
- Multidisciplinary consultation.
- Justification for choice of intervention.
- Critical incidents.
- Recommendations to the client.
- All contacts with clients, including type, dates, and times.
- Failed or missed appointments.
- Previous relevant medical history.
- Billing information.
- Termination notes (Reamer, 2001).

In addition, documentation should be evaluated for anything that might imply defamation of character, including libel. "Social workers can be liable for defamation if they say or write something that is untrue, they knew or should have known to be untrue, and caused some injury to the plaintiff" (Reamer, 2015, p. 141).

Evaluating the quality of documentation begins with a thorough assessment of the policies and procedures that dictate record keeping in the setting. Reamer's (2001) audit instrument assesses ethical risks in an agency. Among many areas examined is documentation. An outline used to examine the adequacy of documentation assigns points based on a continuum of no risk to high risk, focusing first on *policies*, and then on procedures to "ensure proper documentation" (p. 54). For risk-management purposes, as a general rule, notes should focus more on what the clinician did than on what the client did in a session.

Conclusion

The importance of clinical documentation rests firmly on clinical, administrative, legal, and ethical grounds. Discerning what is sufficient, necessary, and relevant to document is the ethical responsibility of the practitioner. The complexities and nuances of clinical record keeping demand an informed approach. Documenting in the digital world requires particular attention.

Clinical records serve multiple purposes in the current healthcare arena. In particular, in the increasingly complex and litigious realm of mental health practice, the balancing act required for practitioners to document sufficient, necessary, and helpful information, with risk-management principles in mind, reveals that clinical record keeping should not be taken lightly. The challenge for clinicians is to adhere to the profession's values and ethics, while documenting client information and the therapeutic encounter. Generally, documenting more process and less content is a good risk-management strategy. Records should reflect the clinician's competence, intentionality, decision-

making process in weighing options, rationale for treatment, and awareness of relevant clinical, ethical, and legal information.

Given the pivotal role of record keeping in behavioral health practice, and the fact that it often takes up more than half of a practitioner's time, creating an ethical and practical document is not adequately addressed in professional training (O'Rourke, 2010). The complex nature of healthcare documentation in the 21st century requires ongoing education.

In a review of the APA revised record-keeping guidelines, Drogin and colleagues (2010, p. 242) conclude that:

Record keeping issues are ever-present and are inextricably bound up in Ethics Code requirements, ignorance of which could lead to very serious consequences for everyone involved. The topics [of record keeping] are of pressing importance, and their complexities merit our close attention.

This course provides needed attention to the complexities of documentation.

APPENDIX

Summaries of Ethics Codes: Relevant Information Regarding Record Keeping

American Association for Marriage and Family Therapy Code of Ethics (2015)

http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx

- **Standard II: Confidentiality**
 - 2.5 Marriage and family therapists (MFTs) comply with applicable laws and professional standards with respect to storing, safeguarding, and disposing of records such that clients' confidentiality is protected.
 - 2.6 MFTs arrange for the confidentiality, storage, transfer, safeguard, or disposal of client records in the event of the therapist's move from the area, practice closure, or death in conformance with applicable laws.
- **Standard III: Professional Competence and Integrity**
 - 3.5 MFTs maintain clinical and financial records in accordance with applicable law.
- **Standard VI: Technology-Assisted Professional Services**
 - 6.2 MFTs make clients aware of the risks and responsibilities associated with the use of technology-assisted services in writing.
 - 6.3 MFTs make clients aware of limitations and protections offered by the therapist's technology in writing.
 - 6.4 MFTs ensure that documentation that is stored or transferred electronically adheres to best practices with respect to maintaining confidentiality and quality services. MFTs are to notify clients in writing of the technology's limitations and protections.
- **Standard VIII: Financial Arrangements**
 - 8.6 MFTs may not withhold records because of non-payment for services, except as otherwise provided by law.
- **American Counseling Association Code of Ethics (2014)**
<http://www.counseling.org/Resources/aca-code-of-ethics.pdf>

Section A: The Counseling Relationship

- **A.2.a. Informed Consent**

Clients choose whether or not to enter into or remain in a counseling relationship. Clients should be provided with information verbally and in writing about the counselor and what to expect from the counseling process. Counselors review in writing and verbally with clients the clients' and counselors' rights and responsibilities. Informed consent is revisited and documented throughout the counseling process.
- **A.2.b. Types of Information Needed**

All services provided by the counselor are explicitly explained to clients. Clients are informed by counselors about the counselor's credentials and experience in service provision

and the service's purposes, goals, techniques, procedures, limitations, potential risks, and benefits. Counselors explain about their management plan for a client's services upon the incapacitation or death of a counselor. Counselors ensure that clients have clear information about their records and understand the implications of diagnosis, tests and reports, fees, and billing arrangements. Clients have the right to confidentiality and to be informed of all the limitations to the counselor's maintenance of their confidentiality. Clients have the right to refuse any services and to be advised about the consequences of such action.

Section B: Confidentiality and Privacy

- **B.6. Records and Documentation**
 - **B.6.b. Confidentiality of Records and Documentation**

Counselors ensure that client records and documentation are secure and can be accessed only by authorized persons.
 - **B.6.c. Permission to Record**

Counselors must seek and be granted permission to record a client's session through electronic or other methods.
 - **B.6.e. Client Access**

Counselors provide reasonable access to records and copies of records when competent clients request that they do so. Such access is limited only when compelling information suggests that access would harm the client. All client requests for access are documented by counselors. Withholding any portion of the record is documented with an accompanying rationale. In instances involving multiple clients, counselors do not release confidential information about any other clients to the requesting client.
 - **B.6.g. Disclosure or Transfer**

Counselors disclose and transfer records to legitimate third parties only when they have obtained written permission from clients for the disclosure, unless exceptions to maintaining confidentiality are present.
 - **American Psychological Association Ethical Principles of Psychologists and Code of Conduct (2017)**
<http://www.apa.org/ethics/code/>

6. Record Keeping and Fees

● 6.01 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, disseminate, store, retain, and dispose of records related to their professional work that facilitates the provision of services, complies with legal and institutional requirements, and ensures accuracy.

- **6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work**

- Psychologists ensure confidentiality in creating, storing, accessing, transferring, and disposing of records under their control regardless of medium (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records).
- Psychologists must use coding or other confidentiality-maintaining techniques so that participants may not be identified by others who have access to the record

but do not have permission to access the participant's confidential information.

- Psychologists make advance plans for confidential record maintenance in the event of their withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

- **6.03 Withholding Records for Nonpayment**

Psychologists may not withhold records needed for a client's emergency treatment because of nonpayment.

National Association of Social Workers Code of Ethics (Revised 2017)

<https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

- **1.07 Privacy and Confidentiality**

- To the extent permitted by law, social workers should protect client confidentiality during legal proceedings. If a legally authorized body orders social workers to disclose confidential or privileged information without a client's consent, and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or seal the records so that they will not be available for public inspection.
- Social workers should protect client confidentiality in the face of requests from members of the media.
- Social workers should protect the confidentiality of sensitive information such as that found in clients' written and electronic records and should take reasonable steps to ensure that clients' records are stored in a secure location and that the records are not available to others who are not authorized to have access.
- Social workers should protect the confidentiality of electronic communications, including information they themselves provide to clients or third parties. Social workers should use applicable safeguards when using electronic communications.
- Social workers should develop policies and procedures for timely notification of clients concerning breaches of confidential information, and they should make those policies and procedures known.
- Social workers should inform clients of unauthorized access to records or information, including unauthorized access to the social worker's electronic communication or storage systems, consistent with laws and professional standards.
- Social workers should develop and inform clients about their policies on the use of electronic technology to gather information about clients. These policies must be consistent with the ethical standards of social work.
- Social workers should search and gather client information electronically only when confronted with compelling professional reasons. If appropriate, the social worker should have the client's informed consent.
- Social workers should not post identifying or confidential information about a client on any type of social media, even professional websites.

- Social workers should protect clients' records when transferring or disposing of them, being sure to protect clients' confidentiality and follow laws governing records and social work licensure.

- **1.08 Access to Records**

- Social workers should provide clients with reasonable access to records that concern them. Social workers should provide assistance in interpreting the records, as well as consultation with the client regarding records that might cause harm or misunderstanding. Social workers should not limit clients' access to their records, or portions of their records, unless exceptional circumstances exist in which such access could cause serious harm to the client. Social workers should document in clients' files their requests to see files and any rationale for withholding some or all of the records.
- Social workers should develop policies that are consistent with prevailing social work ethical standards on the use of technology to provide clients with access to their records, and they should inform clients of those policies.
- If clients are given access to their records, social workers should be sure to protect the confidentiality of other individuals identified or discussed in such records.

- **1.12 Derogatory Language**

In all written, verbal, or electronic communications, social workers should refrain from using derogatory language either when discussing clients or communicating with them directly, but should use only respectful and accurate language.

- **3.04 Client Records**

- Documentation in electronic and paper records should be accurate and reflect the services provided.
- Documentation included in the records should be sufficient and timely in order to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.
- The documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.
- To ensure future access, social workers should store records following the termination of services. Records should be maintained for the number of years required to satisfy the laws, agency policies, and contracts.

National Board for Certified Counselors (2016)

<http://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf>

- **Directive 1:** National certified counselors (NCCs) will not share information that is obtained through the counseling process without specific written consent, except in the case of clear, imminent danger to the client or others or when required to share information by a court order.
- **Directive 10:** NCCs are to create formal, written procedures for handling client records in the case of death or incapacitation.
- **Directive 16:** Test results and assessments can be released to others only with written client consent, except in the case of imminent danger or in the face of legal requirements.

- **Directive 19:** NCCs must create written practice procedures concerning social media and digital technology, which are to be provided to clients before or at the time of the first session. This information shall be incorporated with other information provided to clients before or during the initial session. The information is to include guidelines for the use of social media and must address such issues as the difference between personal and professional accounts and the practice of "friending."

- **Directive 43:** When providing opinions, NCCs are to ensure the accuracy of all written reports based on direct experience with the client or clients or on documentation from other professionals.
- **Directive 54:** All written communications, including those sent and received through digital technology, must be made part of the client's official record. These communications include those of a clerical nature, such as the scheduling of appointments. Password security and encryption must be used for all electronic therapeutic communications.
- **Directive 55:** Client records must be kept for at least 5 years, unless state or federal law requires storage for a longer period of time. Even the eventual disposal of records must take place in such a way as to ensure client confidentiality.
- **Directive 72:** NCCs must obtain a client's consent prior to the provision of services. In private practice or other similar situations, consent shall be documented in writing in a counseling services agreement, which shall become a part of the client's record.
- **Directive 74:** Client records are to be updated throughout the counseling relationship when changes occur in the treatment plan, including those relating to goals, roles, and techniques. Any updates require the client's written approval.
- **Directive 75:** The primary client must be clearly identified in the client record, as must others receiving related professional services in connection with the primary client.

Resources

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ETHICS IN BEHAVIORAL HEALTH DOCUMENTATION: REASONS, RISKS, AND REWARDS

Final Examination Questions

Select the best answer for each question and complete your test online at **EliteLearning.com/Book**

- Good clinical documentation primarily meets the needs of:
 - The client, practitioner, and agency.
 - Accrediting bodies.
 - Supervisors.
 - Professional boards and regulatory organizations.
- The medical model of documentation:
 - Is based on an agency's policy.
 - Is used only in hospitals.
 - Reflects counseling and social work ideology.
 - Focuses on impairments rather than strengths.
- Well-written progress notes may protect a therapist from ethical or legal sanction by:
 - Proving that the therapist has demonstrated excellence.
 - Validating that the treatment was clinically indicated and appropriately provided.
 - Protecting client privacy so that records cannot be used in a court of law.
 - Providing spaces to note the date and time of each session and for both the clinician and client to sign.
- In determining what is reasonable and customary for the public to expect from a particular profession, the courts look to the "industry standard" for guidance. These standards can be found in:
 - A profession's code of ethics.
 - A particular agency's policies.
 - States' re-licensure requirements related to continuing education.
 - The literature of a lobbying organization for that profession.
- Personal notes or shadow records are notes that:
 - Do not need to be stored according to HIPAA standards.
 - A student intern creates during training while shadowing a supervising therapist.
 - Include interpretation by the therapist but are not included in the official file.
 - Are included in the official file but are not subject to subpoena.
- Practitioners may be reassured that their notes are good by focusing on four areas in their documentation:
 - Content, process, countertransference, and formulation.
 - Legibility, credibility, legality, and security.
 - Content, language, credibility, and access.
 - Opinions, subjectivity, speculation, and hunches.
- Lack of documentation about a client's treatment in his or her record:
 - Protects the client by ensuring confidentiality.
 - Protects the clinician from subpoena because there is nothing to present.
 - Is acceptable if requested by the client in writing.
 - Increases a practitioner's liability if he or she becomes involved in litigation.
- The bio-psychosocial-spiritual assessment is the foundation of a clinical record. It describes multiple areas of the client's life, including the:
 - Presenting problem in context, client strengths and limitations, and relevant history.
 - Presenting problem, client's goals, treatment progress, expected length of treatment, and desired outcome.
 - Referral source, collateral information, diagnostic impression, treatment approach, and expected duration of treatment.
 - Process recording from the first session, collateral contacts, consulting practitioners, and former providers.

49. A good progress note substantiates that:
 - a. The client and therapist have a strong therapeutic alliance.
 - b. A client's history needs to be the focus of treatment.
 - c. An encounter took place and details the type and effect of treatment.
 - d. A therapist has the training and skills necessary to implement interventions.
50. The mother of a 13-year-old client texts the therapist, saying that the client is having a bad week. The mother had asked the child's pediatrician to prescribe medication, but the doctor wants to talk to the therapist first. State laws stipulate that only children 14 years old and older have confidentiality rights. The therapist should?
 - a. Document the mother's text and text the pediatrician.
 - b. Refuse to discuss the client's treatment, citing confidentiality.
 - c. Text the mother back, stating that the therapist will not communicate via text.
 - d. Document the text and get a signed release for the pediatrician from the mother and client.
51. A practitioner is seeing a woman for depression and anxiety symptoms. Between sessions, the practitioner receives a voice message from the woman's husband, who reports that the client is probably not telling the worker the "whole truth" and reveals that the client has a significant alcohol use problem. What should the practitioner do about documenting this information?
 - a. Discuss the phone call with the client at her next session and then document the discussion.
 - b. Nothing; the practitioner should ignore it both in the client's session and in the documentation.
 - c. Keep notes about the information in the voicemail in a personal or shadow file.
 - d. Immediately call the husband back and document the phone call in the file.
52. Documenting unnecessary information may breach client privacy. Which of the following is an example of unnecessary information?
 - a. Specific non-clinical information about a client's family member.
 - b. The details of the client's affective response to an intervention.
 - c. The client's report of her symptoms.
 - d. The client's medical history.
53. Information about a third party that is gratuitous, extraneous, or editorializing may be considered:
 - a. The most important part of a client's record and necessary for good therapy.
 - b. Defamation of character and grounds for litigation against a therapist.
 - c. Necessary for a complete bio-psychosocial assessment.
 - d. A breach of confidentiality only in the context of couples therapy.
54. Even if state law stipulates that clinical records must be retained for a specific time, clinicians might consider storing records indefinitely because?
 - a. Different professions have different regulations.
 - b. An injured party can file suit decades after alleged malpractice.
 - c. The client may want to come back for service years later.
 - d. Old records are often used for training novice practitioners.
55. The unethical and illegal process whereby an agency bills for a client session under a licensed practitioner's name even though the client was seen by another unlicensed provider is called:
 - a. Subcontracting.
 - b. Lending a license.
 - c. Shadow counseling.
 - d. Double dipping.
56. In an attempt to streamline record keeping in a fast-paced psychiatric inpatient unit, some clinicians providing group therapy will write one generic note and copy it to put in each patient's chart. This practice represents an ethical violation because the?
 - a. Information about group therapy is unnecessary.
 - b. Documentation is inaccurate and incomplete.
 - c. Group members are often editorializing.
 - d. Funding source may want more information.
57. A big risk of digital documentation is:
 - a. The brevity necessitated by electronic health records.
 - b. Using technology inappropriately.
 - c. Confidentiality breaches.
 - d. Lack of access for clients.
58. Henry provides administrative and clinical supervision to several mental health practitioners. Susan, one of Henry's supervisees, does great clinical work but is consistently late in documentation. She was placed on a performance improvement plan that did not yield positive results. During her performance review, Susan protests that she is bringing in the most revenue from clients and is known as one of the best clinicians in the agency. She doesn't understand how late documentation could be any more important than clinical effectiveness and bringing in money. Which of the following statements reflects the most appropriate response from Henry?
 - a. Documentation is the most important component of her clinical work.
 - b. She cannot get a bonus if she is unable to prove what she does.
 - c. Insurance companies do not care about the quality of her clinical work.
 - d. She is putting clients, the agency, and her own reputation at risk.
59. The concept of negative responsibility applied to documentation counsels that practitioners:
 - a. Are responsible both for what they document and what they do not document.
 - b. Are responsible for clients' negative reactions to what is written in their records.
 - c. Should not document information that can be interpreted negatively.
 - d. Have no liability for documenting their clinical opinions.
60. The concept of choice architecture can assist in determining what to document in a clinical record. This concept advises that a clinician:
 - a. Expect error and manage the risk.
 - b. Do nothing when in doubt.
 - c. Leave it out when in doubt.
 - d. Document as much as possible.

Chapter 4: Postcombat-Related Disorders: Counseling Veterans and Military Personnel, 2nd Edition

4 Contact Hours

Release Date: October 8, 2018

Expiration Date: December 31, 2023

Upon successful completion of this course, continuing education hours will be awarded as follows:

Social Workers and Psychologists: 4 Hours

Professional Counselors: 4 Hours

Faculty

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INTRODUCTION

Learning objectives

After completing this course, the learner will be able to:

- Describe differences between military and mental health cultural norms and their impact on how combat veterans access mental health services.
- Explain the challenges that combat veterans and their families face when transitioning, reintegrating, and readjusting from deployment.

- Describe the prevalence, diagnostic criteria, and treatments for posttraumatic stress disorder and depression among combat veterans.
- Describe effective treatments for suicidal behaviors, substance use, and traumatic brain injury among veterans with posttraumatic stress disorder and depression.

Course overview

According to the Substance Abuse and Mental Health Services Administration (2012), an estimated 36.9% to 50.2% of previously deployed military personnel and veterans present with or report a mental health problem upon return from a deployment to Iraq or Afghanistan for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The two most common among these problems are posttraumatic stress disorder (PTSD) and major depression. Lifetime prevalence rates of PTSD in OEF/OIF veterans is double that of the general population (13.8% vs 6.8%, respectively). Additionally, suicide rates have increased in all branches of service since 2008, surpassing the U.S. general population suicide rate, and have remained constant with approximately 20 veteran deaths by suicide each day (Franklin et al., 2017; VA Suicide Prevention Program, 2016). Given these rates of mental health issues in military veterans, understanding the differences and challenges of treating these individuals is an important goal for all mental health treatment providers.

Approximately 60% of military personnel and combat veterans will not seek out mental health treatment of any kind due in part to pervasive fears and stigma about receiving mental health care within the military or Veterans Affairs systems (Sharp et al., 2015; Tanielian et al., 2016) and a pervasive belief that seeking help from civilian mental health professionals is not beneficial because civilians do not understand the military context. Of those who do ultimately seek out treatment, only around one third will receive an empirically supported treatment for their mental health condition (Tanielian & Jaycox, 2008), suggesting that very

few combat veterans receive the best treatments available. The need for appropriately trained professionals with specialized knowledge of service members' experiences continues to grow as many military personnel and veterans transition home from deployment.

This intermediate-level course is designed for human services and mental health professionals, including social workers, mental health counselors, marriage and family therapists, and psychologists. The purpose of this course is to provide mental health professionals with an overview of military culture and common deployment-related health problems and an introduction to evidence-based treatments for these conditions. The course provides information on cultural issues that affect treatment with military and veteran patients and those interventions and treatments shown to contribute to the largest and most enduring outcomes for this population. Throughout the course, case examples will be used to illustrate concepts, with a particular emphasis on how to adapt and "translate" mental health interventions to better align with military cultural ideals and concepts to increase their effectiveness with military and veteran patients. Please note that patient is the standard term used in much of the existing literature and in many treatment settings, including the Department of Defense and the Veterans Health Administration, whereas client is a preferred term in many settings where behavioral health professionals work with individuals, families, and groups. These terms are used interchangeably throughout the course.

THE MILITARY CULTURE

Military personnel are routinely exposed to stressful situations, both during deployment (to a combat zone, an area supporting a combat zone, or a humanitarian mission) and while located at their home stations (where a service member lives and works and often also where their family resides). Specific to deployments, exposure to combat operations has been shown to increase the risk for subsequent mental health problems and conditions including posttraumatic stress disorder (PTSD), depression, substance abuse, and suicidal ideation (e.g., Bonde et al., 2016; Creech, Swift, Zlotnick, Taft, & Street, 2016; Koffel et al., 2016). Recent studies of Iraq and Afghanistan veterans have estimated that up to one quarter of returning personnel have at least one mental health problem, and a good portion have two or more psychiatric conditions (Ramchand, Rudavsky, Grant, Tanielian, & Jaycox, 2015). In a recent survey of deployed military personnel, up to 40% of military personnel deployed to Iraq screened positive for depression, anxiety, or acute stress (i.e., PTSD symptoms; Brancu et al., 2017).

In response to these alarming numbers, the Department of Defense (DoD), the Department of Veterans Affairs (VA), and the mental health profession as a whole have continued to significantly increase outreach, support, and treatment services to military personnel, veterans, and their families. From 2006 to 2007, the VA healthcare system implemented a rollout of nationwide training for evidence-based treatments including cognitive processing therapy (CPT) and prolonged exposure therapy (PE), with continued trainings and consultation provided for therapists who undergo training. To date, more than 7,700 DoD or VA clinicians have attended the CPT training, and more than 1,800 clinicians have attended the PE training (VA, 2016). These rollouts have increased access for veterans to receive evidenced-based treatments for PTSD. Despite these efforts, however, the incidence of mental health problems has remained constant among military personnel and veterans, with about half of those in need seeking out professional help (Brancu et al., 2017).

Contributing to this low rate of treatment seeking among military personnel and veterans are several pervasive beliefs within the military community that directly interfere with treatment engagement. Specifically, service members routinely express concerns that leaders would view and treat them differently, peers would view them as weak and have less confidence in their abilities, and seeking mental health assistance would negatively impact their career (Tanielian et al., 2016). This mental health stigma likely primarily results from a conflict between the values and norms of the military culture relative to the mental healthcare system (DeViva et al., 2016; Schreiber & McEnany, 2015; Sharp et al., 2015). Specifically, the military culture values strength, mental toughness, self-reliance, and an expectation that its members will master stress while “shaking off” injury and illness. In contrast, the traditional mental health culture values emotional vulnerability and reliance on others for assistance and is typically couched within an injury- or deficiency-based perspective (e.g., signs and symptoms of disorders). From the military perspective, which is based on an identity of strength

A multicultural approach

Culture has been defined as “all those things that people have learned in their history to do, believe, and enjoy. It is the totality of ideals, beliefs, skills, tools, customs, and institutions into which each member of society is born” (Sue & Sue, 2015, p. 138). Often described as a “warrior ethos,” military culture prioritizes the military’s mission and objectives over all else (U.S. Army, n.d.). Additionally, priorities are placed on succeeding and never admitting defeat, never quitting, and never leaving a fallen comrade behind. For many service members, being deployable at any time is an expectation; promotion and job skill building are viewed as means of enhancing competence and responsibility over mission objectives. Principles of the military culture emphasize discipline, self-sacrifice, rituals to build common identities, and group cohesion (Pryce, Pryce, & Shackelford, 2012).

The military family adapts to and regularly interacts with this military culture. “Military children” grow up in what Mary Wertsch (2006) described as a “fortress society,” a nurturing but authoritarian environment that can be isolated from the nonmilitary community. A severely wounded military person is shifted, along with his or her family, to a new culture that is frequently referred to as the “wounded warrior” culture. In many cases, wounded service members are reassigned to different units that place an emphasis on medical treatment, healing, and recovery. Although the nature of the service member’s injury will ultimately dictate the likelihood of returning to duty or being medically discharged, the primary mission of the injured service member is often focused on recovery. All military personnel are therefore driven by a shared concept of mission: For those able to serve, the mission is active duty and deployment; for those recovering from wounds, the mission is to heal.

As wounded warriors or service members end their military service, they become part of the veteran culture. At the end of their military service, whether due to retirement, separation, or medical discharge, service members shift from their military identity to integrating a nonmilitary identity. This shift might include nonmilitary employment and returning to school. In addition to possible trauma exposure during active military service, the stress of the transition from military to veteran status, combined with uncertainty about the recovery process (for injured veterans) and increased caregiver responsibilities (for family of injured veterans), can be considerable (for review, see Elnitsky, Fisher, & Blevins, 2017). The mental health professional needs to be sensitive to the culture and transition issues that the client and their family are navigating.

It is important for mental health professionals to understand all aspects of a veteran’s reintegration into civilian life. The reintegration process is dynamic and varies with each individual. Some parts of reintegration are positive for veterans; others are stressful and cause difficulties for the individual and her or his

and elitism, it is easy to see how seeking out treatment could be viewed as a sign of “weakness.”

In light of these beliefs, mental health professionals both within and external to the military invariably find themselves fighting against the stigmatization of mental health concerns and treatments, typically by attempting to change these perceptions and cultural norms so they align more closely with the perceptions and norms of the mental health system. Unfortunately, despite considerable investment in antistigma efforts, these pervasive beliefs and mental health stigma have not changed significantly (Dillon, LoSavio, & Resick, 2017; Tanielian et al., 2016). This outcome suggests that traditional approaches for reaching out to military and veteran populations have not been particularly effective. The problem of mental health stigma has stimulated considerable professional discussion and thinking, with more recent conceptualizations incorporating multicultural perspectives on mental health treatment (e.g., Bryan, Jennings, Jobes, & Bradley, 2012; Dillon et al., 2017).

family. It is important to remember that reintegration occurs in several domains including family, community, workplace, and potentially school (Elnitsky, Fisher, & Blevins, 2017). Mental health professionals should assess these different domains to gain a better understanding of where the veteran is struggling and then tailor therapy to provide the veteran with skills to help her or him in that area (detailed in the following sections). For example, if veterans are having difficulty reintegrating into their family, the provider may focus on interpersonal and communication skills. Understanding the larger picture of each individual’s reintegration will help provide the best treatments for veterans.

The ability to understand the cultural context of mental health consumers is a core professional competency across the mental health disciplines, but professionals typically limit their conceptualization of “multicultural” to such demographic variables as gender, race, ethnicity, religious beliefs, and sexual orientation. Viewing the military as a distinct culture relative to the general population is increasingly being recognized as an essential competency for working with military and veteran patients (e.g., Bryan & Morrow, 2011; Elnitsky, Fisher, & Blevins, 2017; Leppma et al., 2016). Currently, more than 22 million veterans are in the United States and Puerto Rico with approximately 3 million deployed to Operation Enduring Freedom (OEF; October 2001 to present), Operation Iraqi Freedom (OIF; March 2003 to August 2010), and Operation New Dawn (OND; September 2010 to December 2011). Veterans share several common cultural aspects; however, there is still significant variation based on each branch of service, and time and place of service will affect the experiences of veterans. From this multicultural perspective, mental health stigma is viewed as a disconnection between the rules, norms, and identities of the military and veteran populations and those of the mental healthcare system.

Many people in the field of veteran and military personnel mental health believe that further attempts to change identity-based cultural norms within the military are unlikely to be successful. However, adapting mental health services approaches to better align with military cultural norms is much more likely to result in improved access to care and service engagement. Several relatively simple strategies can improve access to care and lead to greater acceptability of mental health interventions for military and veteran clients. Similar to how they would proceed in any multicultural context, clinicians unfamiliar with military culture should share their lack of knowledge about the culture with their clients and collaborate with their clients to gain a better understanding of the clients’ military experience. The following approaches have been suggested (Bryan & Morrow, 2011; Leppma et al., 2016):

- 1. Use strengths-based conceptualizations:** Incorporating strengths-based conceptualizations consistent with the positive psychology movement fits better with the military identity than other approaches. For example, common mental health interventions (e.g., relaxation, mindfulness, cognitive restructuring) are more readily accepted when they are presented and described as occupational skills or life skills for bolstering mental toughness, hardiness, or mental agility – as opposed to being presented as clinical techniques for reducing illness or correcting a deficiency. Indeed, throughout their training, military personnel are taught many of the skills that are learned in therapy. However, translating these terms into their own language is essential for improving alliance and outcomes.
- 2. Use action-oriented interventions:** Adopting a “skills training” approach that emphasizes action-oriented interventions that show service members and veterans what to do, how to do it, and when to do it aligns with the action-oriented military culture. It is recommended that clinicians practice these skills with clients during sessions, as opposed to relying primarily on discussion-based interventions (i.e., “talk therapy”) without skills training. After a patient has learned these skills, it is important to continue to provide him or her with feedback and hone the skills until the individual has achieved competency.
- 3. Identify skill sets:** Learning about the service member’s training background can help mental health professionals to identify pre-existing skill sets and improve learning by drawing parallels with military skills and training (e.g., marksmanship, physical conditioning, survival training). Translating mental health concepts into culturally relevant ideas based on the individual’s language and knowledge sets – such as using terminology and language used in the military – can be important for the veteran. The willingness of the provider to learn and ask about different language and terms can help improve therapy as well.
- 4. Find personal growth potential:** Recognizing the potential for personal growth associated with adverse life experiences (e.g., combat exposure), rather than perceiving such events solely as “bad” life experiences, aligns with the military cultural norm of strength and mental toughness. Ask service members what they have learned about life or themselves, what new skills they have acquired or mastered, or how they have become better people as a result of aversive experiences, and frame adversity as a necessary condition for growth and development. Being a veteran comes with a cultural background that has several important protective factors and strengths. Highlighting an individual’s positive experiences in the military will provide insight into his or her strengths and skill deficits that can be used to modify treatment.
- 5. Be functionally oriented:** Adopting a more functionally oriented perspective toward treatment goal-setting, as opposed to a diagnosis-based perspective, increases the perceived value and relevance of mental health treatment. Military personnel and veterans tend to be motivated more by goals such as “being able to get a good night’s sleep,” “being able to go to a restaurant again with my wife,” or “being able to go to an amusement park with my family,” as opposed to goals such as “reducing symptoms of anxiety.” Frame treatment as the method for accomplishing these functional outcomes. For example, they can address fatigue from insomnia; explore how avoidance behaviors can place limitations on the service member and the family; address irritability and reactivity and the effects on relationships, coworkers, and employment; and discuss other symptoms that impair daily functioning or can cause distress within the family.

Case example: Sensitizing mental health services to military cultural norms

After a suicide attempt via medication overdose, Sergeant Aldo was referred for brief cognitive behavioral therapy. The therapist decided to make a crisis response plan (CRP; described later) with Sgt. Aldo so that a plan would be in place if another crisis occurs. The exchange where the therapist introduces the CRP to Sgt. Aldo follows:

Sgt. Aldo: “So if I understand this correctly, I’m in therapy because I tried to kill myself and you’re telling me an index card will help me?”

Therapist: “It’s not just an index card, it’s a survival plan that will help you when you are feeling overwhelmed. When you were deployed, did you ever just go outside the wire with no plan of what to do if things went downhill?”

Sgt. Aldo: “Well, no ... We would always have a mission plan and contingency plans.”

Therapist: “Why did you do that?”

Sgt. Aldo: “So we knew what to do on the mission to get home safely.”

Therapist: “That’s right. Having a plan in place helps you be prepared and ready to manage the mission to come home safely.”

Sgt. Aldo: “Right.”

Therapist: “So, when you’re feeling overwhelmed and like life is unmanageable, would it be useful to have a plan to help you feel less overwhelmed?”

Sgt. Aldo: “Yes.”

Therapist: “Right. So, something we can work on together is to make this plan to help you when life isn’t going the way you want it to go. This plan will be yours and will help you stay safe, just like when you were on missions. Throughout treatment, we can add to this plan and adjust to make it even better and more helpful for you.”

Sgt. Aldo: “OK, I see now.”

Therapist: “OK, is this something you’d want to work on now, or would you rather wait?”

Sgt. Aldo: “I think it makes sense to have a plan for when I leave here, so that I’m prepared.”

Therapist: “That sounds good. Let’s make a plan together.”

In this clinical example, the therapist incorporates several of the strategies for improving cultural relevance of the CRP to Sgt. Aldo. She presents the CRP as a strategy for Sgt. Aldo to employ during a future crisis rather than simply as a clinical intervention, and she ties the intervention to pre-existing military skills (e.g., mission planning). The therapist describes the intervention using military-specific language (e.g., contingency planning), as opposed to using more traditional clinical terminology (e.g., safety planning) and emphasizes in-session practice to clearly demonstrate to Sgt. Aldo what to do and how to do it.

POSTDEPLOYMENT: TRANSITION AND READJUSTMENT

The transition from deployed to home station, often referred to as reintegration, can be a difficult time for military personnel and their families. *Reintegration* has been defined as “the resumption of age, gender, and culturally appropriate roles in the family, community, and workplace” (VA/DoD, 2010, p. 1). While deployed, military personnel may be exposed to a wide range of traumatic events (such as combat, violence, injury, and

death) and therefore are at increased risk for PTSD and other mental health conditions. PTSD is typically the reintegration issue of greatest concern, perhaps because it is the most common mental health diagnosis among military personnel deployed to Iraq or Afghanistan. Prevalence estimates typically range from 13.5% to 15.8% (Dursa, Reinhard, Barth, Schneiderman, 2014), and another 20% have subthreshold PTSD symptoms (Bergman,

Przeworski, and Feeny, 2017). What is perhaps most striking about this statistic, however, is that the vast majority of deployed service members (i.e., ~85%) do not demonstrate significant symptoms of PTSD during the approximately 5-year period after their return. This effect possibly results in part from military-specific protective factors such as self-efficacy, sense of purpose, and unit cohesion, but it also is likely because humans, in general, tend to be very resilient to severe stress (Bryan & Heron, 2015; Mobbs & Bonanno, 2018; Welsh, Olson, Perkins, Travis, & Ormsby, 2015).

Upon returning from deployment, many military personnel report and/or act out psychological experiences that are similar to the symptoms of PTSD (and other clinical conditions).

Common mistakes

Several common mistakes clinicians can make when working with returning military personnel and veterans are described in the next sections. They include assuming that there has been trauma exposure during deployment or that all events associated with deployment or combat are traumatic experiences for the veteran. Another common mistake is overlooking the stress of nontraumatic experiences and the difficulties associated with reincorporating a civilian identity when the veteran has been immersed full-time in his or her military identity. Clinicians can also forget the context of the military experience and its effect on the person's physiology and behavior.

Assuming trauma exposure

Deployments entail a broad range of military activities that do not necessarily equate to combat. For instance, some veterans are deployed to combat zones (e.g., Iraq or Afghanistan), whereas others are deployed to support regions with no combat activity (e.g., Kuwait, Kyrgyzstan, Qatar). Even within combat zones, there can be considerable variability in what a veteran witnessed or was exposed to based on the region (some cities or districts were more violent than others) and/or time (some years were more violent than others). Clinicians should be cautious not to universally equate deployment with trauma. However, many individuals enter military service with a history of traumatic exposures such as child abuse and neglect or exposure to domestic violence and violent crime; therefore, exposure to trauma outside of military service should be assessed and addressed as clinically indicated.

Assuming all experiences are traumatic

Events in and of themselves are not traumatic. Instead, how the individual understands and responds to these events determines whether or not the events are traumatic. Said another way, clinicians should remember that what is traumatizing to one veteran might not be experienced as traumatic to another. It is important to remember that most individuals exposed to trauma recover naturally (i.e., without clinical intervention or the development of PTSD) and do not have long-term symptoms or dysfunction. Therefore, when a veteran reports a history of a traumatic military experience, this is important in the conceptualization of the client, but it may not indicate PTSD is present. Clinicians should learn more about how the individual construes the situations.

Assuming PTSD symptoms originated from combat trauma

PTSD and other mental health problems can arise from various experiences. Although a veteran had combat exposure and is presenting with symptoms of PTSD, it is important to understand and assess his or her traumatic experiences. For example, a veteran may have experienced military sexual trauma (MST), which includes harassment, unwanted attention or comments, threats, coercion, physical assault, or battery of a sexual nature perpetrated by the veteran's peers or superiors (whom the targeted individual may very likely depend on to keep her or him safe during military operations). The prevalence of MST is about 16% of all military personnel and veterans, with approximately 38% to 40% of female veterans and 3% to 4% of male veterans (Barth et al., 2016; Wilson, 2016). MST is a known risk factor for the development of PTSD. Mental health providers working

However, these experiences are, in fact, a typical part of their reintegration. For instance, they might be on edge or jumpier than usual, drive recklessly, have lowered frustration tolerance, or feel disconnected from others. Many of these behaviors are seen as adaptive during deployments. For example, in an area involved in military events (within the military this is referred to as a *combat theater*), it is important for military personnel to be hypervigilant because their lives may depend on their ability to respond quickly and be on guard. It is important for mental health professionals to be aware of this fact so that they do not inadvertently "over-pathologize" military personnel or combat veterans, especially those who have recently returned from deployment, which can reinforce mental health stigma.

with veterans and military personnel should not automatically assume that a combat veteran's PTSD symptoms are related to the deployment and combat situations. PTSD that develops from MST is treated by the same interventions described later. In addition, many individuals enter military service with a history of traumatic exposures such as child abuse and neglect or exposure to domestic violence and violent crime; therefore, exposure to trauma outside of military service should be assessed and addressed as clinically indicated.

Overlooking nontraumatic stressors

Military personnel experience a much greater number of nontraumatic stressors and daily annoyances or hassles than they do traumatic events (Mobbs & Bonanno, 2018). Deployed military personnel typically ranked these nontraumatic stressors as their greatest source of stress and as being more stressful than exposure to combat operations (Heron et al., 2013; Pease, Billera, & Gerard, 2016). For example, daily hassles can include such annoyances as lack of access to recreational activities, limited opportunities to communicate with loved ones, extreme climate conditions, or loud environmental noises. In fact, upon veterans' return from deployments, daily hassles are better predictors than combat exposure for symptoms of PTSD and depression, and these hassles contribute almost as equally to PTSD severity as combat exposure (Heron et al., 2013; Mobbs & Bonanno, 2018; Smith et al., 2015). Daily hassles also augment the negative effects of combat exposure on suicidal ideation (Pease et al., 2016; Thomsen, Stander, & McWhorter, 2012). Clinicians should be careful not to underestimate the impact of daily stressors as a contributor to psychological distress among military personnel and veterans.

Overlooking role transition

While deployed, military personnel are steeped in military culture; they live, eat, and play within their military identity every day. Upon returning from deployment, however, military personnel must transition out of full-time military identity and reassume a civilian identity to some extent, which can create internal tension. This transition can be likened to the culture shock that is experienced by many immigrants when they attempt to assimilate into a new culture. This struggle between military and civilian identities is especially pronounced for National Guard and Reserve personnel, who are often expected to switch from full-time military to full-time civilian. Mental health professionals should be aware that this transition also is a transition from a group collectivist mindset of the military to an individualistic view. Having a strong military or veteran identity is unrelated to psychological symptom severity or alcohol-related problems, but having a weak civilian identity is correlated with more severe symptoms, more alcohol-related problems, and greater reintegration difficulties (e.g., Ahern et al., 2015; Mitchell, Blossnich, Gordon, & Matukaitis Broyles, 2017; Pease, Billera, Gerard, 2016). Among college student veterans, a weaker sense of integration into college life and the campus community is similarly associated with increased psychological distress. Clinicians should therefore consider the role of identity as an important clinical factor.

Forgetting the context

While deployed, many military personnel are routinely engaged in fast-paced, high-tempo operations with long workdays, few days off, sporadic and unpredictable schedules, and overall immersion in an environment that is characterized by a constant sense of urgency. Sleep tends to be more sporadic, and recreational activities may be severely restricted, depending on the location of the deployment. Under such living conditions, physiological activation levels can easily be elevated. In some deployment areas, the added presence of a constant, overarching threat can further heighten physiological activation and the engaged hypervigilant state that is not only adaptive but necessary for these individuals. Within these settings, rules and expectations about behavior differ from those in a civilian context. For example, “safe” driving might be considered reckless back home, being alert and vigilant in crowded areas might be considered “paranoid” back home, or being “at the ready” by keeping a loaded weapon at all times might be considered threatening back home. After months of living within this environment, what is considered to be “normal” can change dramatically. In the meantime, the family back home is facing its own stressors and adapting to a new way of functioning. At times, major family milestones are missed by the deployed military members (e.g., seeing birth of a child, seeing their children walk or talk for the first time, experiencing the death of a parent or other family member, and so on). Both the military member and the family can become alienated from each other, and this can create additional stress on both sides.

A unique feature of modern deployments is the availability of rapid communication methods through electronic media (e.g., cellular phone, video chat, email) that enable immediate contact among family members but do not necessarily enhance family members’ understanding of each other’s perspectives or

Family life

The military lifestyle is marked by a great amount of instability and social mobility. Military families move frequently with new assignments, required trainings, and professional military education. In some cases, these changes can occur very suddenly and without much advance notice. This situation can cause considerable disruption to domestic routines and can negatively affect the entire military family. Many supportive services exist for the military family, including family resource centers, childcare programs, and informal networks among military families (Blaisure, Saathoff-Wells, Pereira, MacDermid-Wadsworth, & Dombro, 2012). However, not all service members and families use these services for several reasons, which can include being unaware of the services’ existence or having misconceptions about the services offered. Deployment, especially multiple deployments, can cause stress and confusion within the family, with postdeployment reintegration being a particularly challenging time for families (Skomorovsky et al., 2017). For example, incidents of family violence are more likely to occur during reintegration (for review, see Bakhurst, Loew, McGuire, Halford, & Markman, 2017). In fact, human services and mental health professionals should be aware of the significant rates of intimate partner violence within military families and the need for specialized intervention. Research suggests that intimate partner violence perpetration among veterans is almost three times greater than civilian rates and the violence within military families is often more frequent and severe than in civilian families (Klostermann, Mignone, Kelley, Musson, & Bohall, 2012; Tasso, Whitmarsh, & Ordway, 2016). However, most often families are supportive and serve as protective factors that help the military members transition back into civilian life; yet even in these instances, there can be a cost or burnout that occurs, so family members also need to make sure to care for themselves (Cederbaum et al., 2017; Skomorovsky et al., 2017). When appropriate, family assessments should be included in care plans to ensure that the needs of both the veteran or military personnel and his or her family are met.

views (Carter & Renshaw, 2016). This is another reason that it is important for clinicians to be sensitive to which war and warzone the veteran was deployed in because their experiences may differ. For example, Vietnam war veterans were not positively welcomed home or given adequate mental health services following their return. In fact, there was often a negative connotation to being a military member deployed in Vietnam. This experience likely affects the Vietnam veteran’s view of mental health treatment, which may differ from the view of OEF/OIF/OND veterans, for whom mental health has been made a priority. Recognizing these differences is important, and if a clinician is not sure about the experience of the veteran, it is important to ask and gather more information.

Along these lines, clinicians should be careful to not underestimate the psychological or emotional distress that military personnel and veterans might be experiencing, even if they do not report or evidence a trauma reaction or meet full criteria for a psychiatric diagnosis. As previously noted, nontraumatic stress can nonetheless contribute to depressive symptomatology among military personnel for up to a year following their return from deployment. Furthermore, subthreshold psychiatric conditions can contribute to increased functional impairment, physical health conditions, and even increased suicide risk (El-Gabalawy, Blaney, Tsai, Sumner, & Pietrzak, 2018). Additionally, both psychiatric diagnoses and subthreshold conditions can negatively affect family relationships and create a caregiver burden within the family (e.g., Dobry & Sher, 2018; Skomorovsky, Martynove, Lee, & Dursun, 2017). Early, effective individual or family interventions for clients with subthreshold conditions can therefore lead to improved functioning among military personnel and veterans and their families.

Programs that respond to family stressors throughout the deployment cycle, including reintegration preparation, have therefore been developed for military families. Cumulative deployments during a child’s life are associated with increased childhood depression and externalizing behaviors (Lester et al., 2016), which in turn can increase parental distress. Perhaps not surprisingly, the greatest brunt of the burden associated with mental health problems typically falls on those who are most intimate with the service member or veteran: namely, his or her spouse or partner. In the United States, 2 million children had a parent deployed in either OIF or OEF. Research data show that although most children cope with the stress of having a parent deployed, it can have an adverse effect on children of all ages. Studies indicate that for children separated from a parent on deployment, there was an 11% increase in healthcare provider visits related to mental health and behavioral issues. Family reintegration after the deployed parent returns can also be stressful and challenging for children. It has been found that children of veterans who have PTSD are at higher risk for anxiety and depression, and they can also acquire PTSD symptoms of their own in reaction to the veteran’s PTSD behaviors (Ohye, Rauch, & Bostic, n.d.). Social workers, psychologists, marriage and family therapists, and counselors may play an important role in supporting students whose parents are in the military, and ideally they should be aware of the children in their care who have a parent, and in some cases both parents, who are deployed. These children may present with somatic complaints related to stress and should be encouraged children to talk about their anxiety and worry (Military Kids Connect, 2016).

Spouses are especially vulnerable to experiencing negative consequences of the service member’s mental health problems (Dekel, Levin, & Solomon, 2015), although a spouse’s perceptions seem to be especially important. For example, a wife’s emotional distress increases as her veteran husband’s symptoms increase. Wives’ marital satisfaction is also associated with her veteran husband’s symptom severity. At times, spouses

take on a caregiver role and help accommodate the symptoms of their partners. This action initially seems adaptive; however, this dynamic can have a negative impact on both individuals' mental health. Additionally, a wife's marital satisfaction decreases as her veteran husband's symptoms become more extreme, and this dissatisfaction is often mediated by communication (Bakhurst et al., 2017). For example, a military veteran's wife may have positive interactions and communication with her husband, which would increase relationship satisfaction. However, it is common that the spouse and the military member do not communicate in a positive manner. It could be that the wife wants to avoid discussion because of some of the symptoms of PTSD or that the husband withdraws. This lack of communication decreases overall marriage satisfaction. To date, little is known about the dynamics of gay and lesbian couples or husbands of military wives.

Marital satisfaction can also affect the psychological well-being of the veteran upon return from deployment, although this is influenced by a couple's communication patterns such that the marriage can serve as either a buffer against or as a risk factor for psychological distress. While deployed, couples typically communicate using one of two primary methods. They can use "delayed" methods such as sending letters, care packages, and emails, in which one partner communicates at a time and must wait for a response from the other. They can also use "interactive" methods such as phone calls, online video chats, and instant messaging, in which partners communicate in "real time." In general, more frequent communication of both types is associated with less psychological distress for service members after returning from deployment. Delayed communication methods differentially influence psychological distress, however.

Case example: Discussing trauma-focused therapy during family/couples' session

After ongoing conflicts between Staff Sergeant (Ssgt.) O'Malley and his wife, Mrs. Izzy O'Malley, they decided to go to couples' counseling. The therapist, after reviewing the intake forms, notices elevated symptoms of PTSD in Ssgt. O'Malley and decides to have his wife fill out the same symptoms measures. As predicted, Ssgt. O'Malley and Mrs. O'Malley are both elevated in PTSD symptoms. The therapist decides to discuss these results and present treatment options to help reduce the PTSD symptoms and work on the relationship goals.

Therapist: "After reviewing the forms I had you fill out, it looks like your symptoms are consistent with PTSD..."

SSgt. O'Malley: "Yeah, I've heard that before, but what does that have to do with me fighting with Izzy all the time?"

Mrs. O'Malley: "I try not to make him mad, but it's like stepping on eggshells all the time, and anything can set him off."

Therapist: "Those are really important details to keep in mind. Mrs. O'Malley, it also looks like you are experiencing a lot of anxiety symptoms that are similar to Ssgt. O'Malley's symptoms as well."

Mrs. O'Malley: "Yeah, being around him all of the time has really made me feel anxious; I've started worrying about checking the doors at night and making sure the house is safe. He freaks me out sometimes, and I just can't control it anymore."

Therapist: "It is very common for that to happen. When someone has PTSD, it can really have an impact on the relationship of a couple. What's important is that we have treatments that can help both of you and ultimately help the relationship."

SSgt. O'Malley: "Right, I've heard that before."

Therapist: "There are a couple of options, and I want tell you both about them and see which way you'd like to go."

SSgt. & Mrs. O'Malley: "OK."

Therapist: "First, there are two main trauma-focused individual therapies that can help reduce PTSD. The first

Among couples with high marital satisfaction, more frequent communication via delayed methods is associated with less severe PTSD symptoms when the veteran returns home; among couples with low marital satisfaction, more frequent communication via delayed methods is associated with more severe PTSD symptoms (Carter & Renshaw, 2016). Therefore, for some couples (i.e., those with low marital satisfaction), less frequent communication while a service member is deployed might contribute to improved mental health for the veteran, which could in turn contribute to improved mental health within the family.

Innovative interventions have been developed to address the unique needs of military and veteran families. Emotionally focused couples' therapy has been adapted for use with military couples (Weissman, Batten, et al., 2017). Examples of these programs include Families Overcoming Under Stress (FOCUS), which is a resilience-building program for military families with children, and Operation Healthy Reunions, which emphasizes education and support for families entering postdeployment (Lester et al., 2016). FOCUS has been shown to decrease parental anxiety and depressive symptoms as well as reduced symptoms in the children of these individuals. There has also been increased focus on couple's therapy for military members who have PTSD, given the impact PTSD has on intimate relationships. For example, Cognitive-Behavioral Conjoint Therapy for PTSD (CBCT for PTSD) has been shown to reduce PTSD symptoms in the individual with PTSD and provide coping strategies and psychoeducation to improve the spouse's relationship satisfaction as well as how she/he think about the relationships (MacDonald et al., 2016).

is called cognitive processing therapy, or CPT. CPT is a 12-session therapy that helps you learn about PTSD and then identify thoughts and feelings related to the trauma. Once you can identify those thoughts that are getting you "stuck," or stuck points, you will learn skills to help you challenge those stuck points and change the way you think. The second therapy would be prolonged exposure therapy, or PE. PE is done in 8 to 15 sessions that focus on reducing the avoidance by having you talk through the trauma with a therapist in a technique called imaginal exposure. At each session you would talk through the trauma with the therapist, and your therapist would help you process the trauma during each session. Both CPT and PE have some homework to help you make even more gains outside the therapy room. Most importantly, both of these therapies focus on reducing PTSD symptoms, which in turn will help the relationship. These are both individual therapies for Ssgt. O'Malley, and while he is in those, we could find a therapist to help you, Mrs. O'Malley, with your symptoms as well. What do you think of that?

SSgt. O'Malley: "I'm not sure that's what I want to do right now, I just want to focus on not fighting with my wife."

Mrs. O'Malley: "I'm not sure about all of this."

Therapist: "Another option is for us to work on cognitive-behavioral conjoint therapy for PTSD. This is a 15-session protocol that you work on as a couple with me, and we focus on reducing PTSD and anxiety symptoms for both of you at the same time. This treatment has been shown to reduce PTSD symptoms and works on a healthier relationship for couples.

We will not only work on problems that come up in your relationship, but we will also teach each of you skills to help you with those negative thoughts that lead you to feeling bad. Just like the other therapy options, there will be homework to work on outside of therapy that may be tough but will help in the long run. What are your thoughts on that?"

SSgt. O'Malley: "That one sounds good, what do you think?"

Mrs. O'Malley: "Yes, that sounds better to me. I think that would help us both."

In this clinical example, the therapist incorporates psychoeducation on several options for treatment when she notices the veteran has symptoms of PTSD that are negatively affecting him and his wife. By providing psychoeducation about how PTSD can affect a partner and a relationship, it helps normalize the experience of the couple and provide hope

POSTTRAUMATIC STRESS DISORDER

PTSD is a complex syndrome that may occur after exposure to one or more traumatic events. PTSD involves a characteristic set of symptoms that includes re-experiencing the traumatic event, avoiding stimuli associated with the traumatic event, having negative changes in mood or cognitions associated with or worsening after the traumatic event, and experiencing increased reactivity and arousal. Individuals experiencing PTSD may also have other psychiatric disorders that are frequently comorbid with PTSD. Comorbidities include depression, anxiety, obsessive-compulsive disorder and related disorders, and substance use disorders, as well as somatic complaints and physical illnesses (Dayan, Rauchs, & Guillery-Girard, 2017; Wynn & Benedek, 2017).

PTSD is estimated to occur in approximately 15% of military personnel and veterans who have been deployed to either Iraq or Afghanistan (Substance Abuse and Mental Health Services Administration, 2012). Although PTSD among military personnel and veterans can be associated with a wide range of traumatic events (e.g., actual or threatened death, sexual assault, or serious injury), combat-related PTSD is the most common type among veterans and therefore of greatest concern. Numerous studies have confirmed that combat exposure is a significant predictor of PTSD (Hahn, Tirabassi, Simons, & Simons, 2015; Jakob, Lamp, Rauch, Smith, & Buchholz, 2017; Wanklyn et al., 2016; Watkins, Sudom, & Zamorski, 2016), with the likelihood of PTSD increasing as the intensity of combat exposure increases (Jakob et al., 2017). The diagnostic criteria for PTSD, based on the criteria identified in the fifth edition of the *Diagnostic and Statistical Manual (DSM-5)*; American Psychiatric Association [APA], 2013), are listed in Table 1. Many veterans receive health care outside of the VA system, and it is important during the initial interview to establish whether or not the client is a veteran. This step allows the provider to be cognizant of the possibility of the presence of PTSD. Simply asking the patient, "Have you been in the armed forces?" will elicit this information. However, studies show that about 56% of healthcare clinicians do not inquire whether the patient has a history of service in any branch of the military (American Psychiatric Nurses Association, 2014).

When diagnosing PTSD in military personnel and veterans, mistakes and errors can easily be made. Clinicians should therefore keep in mind the following important issues about diagnosing PTSD in general, as well as some caveats that may be unique to military personnel and veterans:

- 1. Exposure to combat:** As noted previously in this course, deployment does not always involve exposure to combat. Just because a service member or veteran has been deployed (even to a combat zone such as Iraq or Afghanistan) does not necessarily mean that he or she has experienced or witnessed a life-threatening situation that would constitute a trauma. Clinicians must be careful not to incorrectly diagnose PTSD in a military or veteran client simply because he or she is reporting a deployment-related concern. It is also important to assess for noncombat related traumas that may have occurred before or during the individual's service time (e.g., childhood trauma, MST) that are other risk factors for PTSD.
- 2. Reaction to traumatic exposure:** Service members or veterans who have been exposed to combat do not always

that there are treatments to help. When the therapist presents options, the couple is able to have power and control over their treatment. It is important that the clinician understand all of the treatments presented to provide this information even if the therapist does not provide the treatments. A referral resource list should be generated for patients as needed to guide them to a provider who is trained in these treatments. The clinician should also verify a diagnosis of PTSD or refer for a full diagnostic assessment if a gold-standard assessment has not been done.

experience that exposure as traumatic. Experiencing or witnessing a life-threatening event in and of itself is not sufficient for a PTSD diagnosis; there must also be a pronounced emotional and behavioral reaction to the event. Said another way, PTSD is driven not by the event itself, but rather by the individual's response and how that person construes the event. Clinicians must be careful not to incorrectly diagnose PTSD based on the assumption that all combat must intrinsically be experienced as traumatic by the service member or veteran.

Table 1: Posttraumatic Stress Disorder Diagnostic Criteria
A. Experiencing or witnessing traumatic event(s), learning that one or more traumatic events have been experienced by a close family member or friend, or repeated and extreme exposure to details of traumatic events that causes intense emotional distress for an individual and may include some of the following symptoms: <ul style="list-style-type: none">1. Re-experiencing the traumatic event through intrusive thoughts, memories, nightmares, dissociative reactions, physiological reactions, or fear when exposed to reminders of event.2. Avoidance of reminders of the event, including people, places, objects, feelings, or thoughts associated with it.3. Disturbances in mood and cognitions due to the trauma experience including memory and concentration problems; extreme negative cognitions about oneself, others, and the world; distorted thoughts about the trauma event(s) that result in blame of self or others; disturbed emotional states (i.e., guilt, shame, horror, anger); feeling detached from others; lack of interest in significant activities; and the inability to experience pleasant emotions.4. Marked symptoms of anxiety or increased arousal that lead to sleep difficulties, hypervigilance, restlessness, or irritability.5. This experience causes significant distress, impacting the individual's ability to function as effectively as before they were exposed to the traumatic event.
B. Duration of these symptoms is more than 1 month.
Note. Adapted from American Psychiatric Association. (2013). <i>Diagnostic and statistical manual of psychiatric disorders (5th ed.)</i> . Washington, DC: Author.

- 3. Moral injury:** Among military personnel and veterans, moral injury is a common contributor to PTSD. Moral injury entails "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). Recent research has shown that moral injury and PTSD are separate constructs that share some symptoms but have unique signs as well (Bryan et al., 2017). Guilt and shame are common emotional consequences of moral injury and are frequently reported by combat veterans. Military personnel and veterans do not necessarily have to be directly engaged in combat itself to experience moral injury. For instance, noncombatant military personnel (e.g., medical personnel, chaplains, staff in mortuary affairs) are frequently exposed to the consequences of combat, including corpses, severe in-jury, stench of decaying bodies, and so on. Similarly, military leaders who

“made the call” that resulted in the severe injury, death, or other negative consequences to their subordinates might suffer from moral injury. The combination of moral injury and PTSD is linked to higher rates of suicidal thoughts and behaviors (Bryan et al., 2017). Clinicians must be careful not to miss PTSD among veterans who were noncombatants or who were not directly engaged in combat.

- 4. Fear of reporting:** Many service members and veterans do not report (or deny experiences of) fear, helplessness, or horror after a combat-related traumatic event because they feel that acknowledging such an event may be seen as a weakness. This situation is acknowledged in *DSM-5*, where the requirement that the individual experience fear, helplessness, or horror in response to the traumatic event has been removed. When describing their reaction to a combat-related trauma (e.g., the death of a friend), many veterans will report an absence of emotions and frequently make statements such as, “I did what I was trained to do” or “My training just kicked in.” In contrast to fear, hopelessness, and horror, many military personnel and veterans might instead talk about feelings of guilt and shame in response to combat-related events, as noted previously. Clinicians must be careful not to miss PTSD because a service member or veteran denies experiencing an emotion at the time of the event. Oftentimes, veterans will express these emotions as they continue through therapy.

- 5. Multiple events:** Service members and combat veterans might experience multiple or repeated traumatic events while deployed. Treatments for PTSD appear to be effective for service members and veterans who experience multiple combat-related traumas. Clinicians must be careful not to abandon or avoid using empirically supported treatments for PTSD because they mistakenly believe they will not be effective with those who experience multiple combat-related traumas.
- 6. History of trauma:** Service members and combat veterans can acquire PTSD from noncombat-related traumatic events (e.g., sexual assault, childhood abuse, etc.). For example, women comprise the fastest growing segment of the military (15% of all active-duty military), with increasing access to combat-specific jobs. Prevalence rates estimate that approximately 40% of women in the military report MST (Barth et al., 2016). Military women with combat exposure are approximately 40% more likely to report MST than those who did not have combat exposure. Clinicians must be careful not to overlook the possibility of PTSD resulting from noncombat or nonmilitary events, which can be identified during a thorough assessment of trauma. Approaching patients with empathy and concern, validating their experiences, and ensuring privacy during an encounter can establish trust and open a dialogue to explore past traumas.

TREATMENTS FOR COMBAT-RELATED POSTTRAUMATIC STRESS DISORDER

A good deal is known about how to effectively treat PTSD. Although many treatment approaches and interventions have been developed and proposed for PTSD, a recent update to the *VA/DoD Clinical Practice Guideline* (VA/DoD, 2017) assessed the evidence supporting various PTSD treatments. This evidence indicated that a large proportion of the individuals diagnosed with the disorder can be treated to the point of recovery or remission with cognitive and exposure-based psychotherapies. The current *VA/DoD Clinical Practice Guidelines* (VA/DoD, 2017) recommends several cognitive, behavioral, and exposure-based therapies. Three therapies have the strongest empirical support for these treatments across a large number of randomized clinical trials – PE, CPT, and eye movement and desensitization and reprocessing (EMDR). These psychotherapies are recommended as a first-line defense over other pharmacological and non-pharmacological interventions. If these trauma-focused psychotherapies are not available or the individual chooses not to engage in them, the *VA/DoD Clinical Practice Guideline* also notes that selective serotonin reuptake inhibitors (SSRIs) or serotonin/norepinephrine reuptake inhibitors (SNRIs), two classes of antidepressants, might be useful for managing the symptoms of PTSD.

Several recent clinical trials for combat-related PTSD have been conducted with both active-duty personnel and veterans. Both CPT and PE have been shown to be especially efficacious for reducing PTSD symptoms with results suggesting a 50% reduction of severity symptoms on average after treatment (Acierno et al., 2017; Morland et al., 2014; Rauch et al., 2015; Resick et al., 2015; Resick, Monson, & Chard, 2017). It is estimated that 53% of individuals who participate in CPT or PE

Prolonged exposure therapy

Prolonged exposure therapy (PE) is based on emotional processing theory (Foa, Steketee, & Rothbaum, 1989; Lang, 1977). According to this theory, in the presence of a life-threatening or dangerous event, an individual experiences a natural fear response that includes attempts to escape or avoid the source of danger. Concurrent with this normal survival response, a fear network develops in the individual's memory that subsequently activates the same escape and avoidance behavior in response to stimuli associated with the original dangerous event, such as memories, thoughts, and environmental cues. In essence, when something reminds the

will no longer meet criteria for the disorder following completion of treatment (National Center for PTSD, 2017). Long-term follow-up studies conducted in nonmilitary samples suggest the benefits of these treatments are long-lasting (i.e., 10 years posttreatment; Resick, Williams, Suvak, Monson, & Gradus, 2012). Additionally, recent studies are also reporting that CPT and PE are associated with reduction in suicidal ideations for military personnel (Bryan et al., 2015; Resick, Wachen, et al., 2017; VA/DoD, 2017). Overall, there is excellent support for using these treatments with returning veterans.

EMDR is also recommended as a first-line treatment for PTSD according to the *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (VA/DoD, 2017). EMDR is defined as a “trauma-focused psychotherapy” and includes components of customary exposure therapy. However, the use of bilateral stimulation is unique to EMDR. During EMDR treatment, the patient sustains what is described as a “dual focus of attention” – maintaining awareness of the traumatic event while continuing to focus on current external stimuli (Psychological Health Center of Excellence, 2017). EMDR began to be used with veterans after a study conducted in 1989 with Vietnam veterans found that its use significantly decreased the symptoms of PTSD. How EMDR works is not yet clearly understood, but one possible explanation is that EMDR activates memory-processing systems in the brain that are normally triggered during rapid eye movement sleep but are impaired in patients with PTSD. Triggering these memory-processing systems during EMDR therapy allows for the processing of memories of traumatic events (Hase, Balmaceda, Ostacoli, Liebermann, & Hoffman, 2017).

individual of the original dangerous situation, the memories, thoughts, and emotions that were stored in the fear network become conscious and the individual responds as if the original dangerous event were occurring again, even though it is not. The fear network and escape/avoidance response eventually generalize across different situations and contexts and increasingly become the individual's established way of responding to events that are not life-threatening.

After establishing the presence of a PTSD diagnosis (or significant subthreshold symptoms) and any comorbidities via a thorough assessment, the clinician may implement PE if not

otherwise contraindicated. Contraindications for PE are active psychosis and substance use that needs medical management. PE targets the sequelae of PTSD that particularly relate to avoidance symptoms. According to PE, recovery from PTSD requires emotional processing of the traumatic event. Emotional processing is proposed to be the central mechanism of change for trauma recovery and is facilitated within PE through repeated exposure to memories of the traumatic event(s) and feared situations in life, such that the avoidance of traumatic reminders and triggers is no longer necessary. Repetitive exposure to feared situations and memories enables the individual to increase their capacity to tolerate his or her fear, which gradually declines in intensity. As fear decreases, individuals will experience a change in their thoughts and beliefs about the traumatic event, which reduces the generalization of the fear response across situations. Clinicians should be aware that there is no time limit or cutoff point to begin PE. They should discuss this treatment option with patients exhibiting signs and symptoms of combat-related PTSD, even if their military deployment was not recent.

Treatment overview

PE is structured into ten 90-minute individual therapy sessions, with sessions typically occurring one or two times per week, although 60-minute sessions are commonly used by practicing clinicians. Recent research has shown initial support for using 60-minute session for PE with 20 minutes being dedicated to the imaginal exposure (Nacasch et al., 2015). All PE sessions are audio-recorded so that patients can listen to the sessions between appointments as a method of facilitating and reinforcing further exposure. Sessions can be recorded using digital recorders that can subsequently be transferred to the patient's smartphone or other electronic device. For patients who own a smartphone, an even simpler solution is to record the entire session directly onto the phone using a built-in app. Using either of these technologies, patients can then listen to the session recordings with earphones, which can be much more discreet. Additionally, a PE-specific phone app has been developed: "PE Coach 2." This app has a built-in recording function, has trackers for the homework assignments for each session, and patients can fill out symptom report measures in the app. The app is not meant to be a stand-alone treatment and is meant as a tool to augment treatment.

PE comprises several core interventions and training exercises ("homework") to be practiced between sessions. Within the military, training exercises are routinely used to facilitate knowledge acquisition and skills mastery across a wide range of military-relevant activities. Use of the term *training exercise* to describe between-session assignments, in contrast to the more widely-used term *homework*, can therefore increase the cultural relevance of mental health treatment for military personnel and veterans. Training exercises are provided at the conclusion of every session to facilitate more rapid recovery; these training exercises are then reviewed as the first item of business at each subsequent appointment.

A ten-session format introduces the patient to various treatment components as described below.

Session 1: Introduction to PE and breathing retraining

- In the first session of PE, the therapist provides a general overview of the treatment and the emotional processing model of PTSD and then explains the rationale for PE's structure and components.
- **Trauma interview:** The initial interview focuses on the index trauma: the event that contributed most directly or proximally to the patient's distress and functional impairment. As is often the case with military and veteran patients, multiple traumatic events may have occurred. In these cases, the therapist can focus on the "worst" or "most upsetting" of the multiple traumatic events. During the trauma interview, the therapist seeks to obtain information about the circumstances leading up to and surrounding the trauma;

for instance, the sights, sounds, and smells associated with the event, and the thoughts and emotions experienced by the individual at the time of the trauma. In many ways, the trauma interview serves as a first therapeutic exposure to the traumatic experience.

- **Breathing retraining:** The therapist educates the patient on the utility of breathing exercises to reduce autonomic arousal and allows the patient to practice in-session to ensure he or she can successfully and effectively utilize the skill. For example, the therapist will train a patient on a breathing exercise where the patient inhales while counting to four, exhales while counting to six, and holds while counting to four. This process is repeated to help slow the breathing and reduce the anxiety related to short and shallow breathing.
- **Training exercises:** The therapist directs the patient to review the rationale for treatment, listen to the session recording at least once, and practice breathing exercises at least once per day before the next session.

Session 2: In vivo exposure

Psychoeducation on trauma reactions – The therapist provides education consistent with the emotional processing model on common emotional, cognitive, and behavioral reactions to traumas.

- **In vivo exposure:** The therapist introduces *in vivo* exposure, which is designed to undermine the escape and avoidance response that contributes directly to the person's functional impairment. For example, many veterans avoid crowded spaces because they feel trapped in these situations. As a result, they will refuse to go to large shopping centers, amusement parks, restaurants, or other such public areas with family or friends. Others avoid driving on highways because of intense anxiety or fear when driving under overpasses or seeing trash or other debris on the side of roads. Paradoxically, the veteran's attempts to avoid these distressing situations actually increase his or her emotional distress over time.

In vivo exposure should be approached gradually by beginning with easier tasks and systematically increasing their difficulty, as opposed to immediately engaging with the person's most feared situations. Within PE, therapists gradually introduce increasingly difficult exposure activities by developing a fear hierarchy with the patient. In the fear hierarchy, therapists and patients collaboratively generate a list of real-life situations that induce varying degrees of anxiety on a subjective scale called *subjective units of distress* (or "SUDs") ranging from 0 (no anxiety at all) to 100 (the most anxiety ever experienced). Events or situations that fall below a value of 30 on the SUDs scale are generally considered to be "mastered"; patients should therefore start *in vivo* exposure with situations that elicit a SUDs rating above 30. Patients and therapists debrief after each *in vivo* exposure. The therapist also helps ensure the fear hierarchy and *in vivo* exposures are able to be accomplished by the patient in order to facilitate the best outcomes. Corporal Connelly's fear hierarchy can be seen in Table 2.

Situation	Subjective Units of Distress
Driving on interstate in morning rush hour	100
Going to store on weekend afternoons	90
Driving under overpasses	80
Stopping at intersections	60
Driving on interstate mid-day	50
Going to store on weekday evening	40
Driving on residential roads	25
Driving on interstate at midnight	20
Going to store on weekday at midnight	10

Case example: Fear hierarchy

Corporal (Cpl.) Connelly reports extreme anxiety and fear when in crowded spaces or while driving. Careful questioning by the therapist uncovered different aspects and dimensions of crowded spaces and driving, resulting in a more refined understanding of the feared situations and development of Cpl. Connelly's fear hierarchy. For example, Cpl. Connelly actively changed her schedule to avoid certain places like going to the grocery store out of a fear it would be crowded. Cpl. Connelly's distress varies according to location and time of day (or week). Based on her fear hierarchy (see Table 2), Cpl. Connelly's first in vivo exposure activity would be to go to the store on a weekday evening since it was rated as above 30 on her SUDs scale but it was less likely to be particularly crowded than a weekend and seemed achievable after discussing it with her therapist. Together, Cpl. Connelly and her therapist agreed that she would stay in the store on a weekday evening until her SUDs reduced from a 40 to less than 30. It was not until several successful completions of this exposure that Cpl. Connelly moved up to the next most anxiety-producing situation on her fear hierarchy. Again, as she continues to work through her hierarchy, she does not move on until she is able to achieve a SUDs of less than 30 several successful times. This hierarchy is used throughout all of her sessions as training assignments outside of session. If the exposure was unsuccessful, Cpl. Connelly and her therapist would discuss what the barriers were and how to overcome these obstacles.

Session 3: Imaginal exposure

The therapist introduces and provides the rationale for imaginal exposure, which is perhaps the most recognizable intervention within PE. Imaginal exposure is designed to undermine the escape and avoidance response specific to memories identified in the individual's traumatic event(s) index. For example, a combat veteran might actively attempt to avoid or suppress thoughts, memories, or environmental reminders of a combat engagement in which a fellow service member was severely wounded in an explosion and subsequently died.

During imaginal exposure, the patient recounts the sequence of events that occurred during the trauma by describing the sights, sounds, smells, thoughts, emotions, and physical sensations that occurred. In early recounts, the therapist probes for all these sensorial experiences in order to ensure that the patient is providing a detailed description of the scenario and provide the best exposure intervention. Throughout the imaginal exposure, the clinician has the patient rate SUDs to see where the most difficult parts of the trauma occur and to track any reductions in the repeated telling of the trauma. In essence, the patient provides a play-by-play account of the event during which he or she is expected to become highly emotionally distressed and anxious. The patient is directed to continue recounting the details of the event for 45 to 60 minutes in a standard 90-minute session, which is typically sufficient for physiological arousal

Cognitive processing therapy

CPT is based on social-cognitive theory that focuses on how the individual constructs and copes with the traumatic event (Resick, Monson, & Chard, 2017). According to the social-cognitive model of PTSD, the individual's primary motivation after a traumatic experience is to regain a sense of mastery and control over his or her life that was lost during the trauma. Being largely influenced by cognitive theory, this model posits that the reason some trauma-exposed individuals develop PTSD and other trauma-exposed individuals do not can be explained by different types of cognitions and different emotional experiences. Specifically, there are three primary cognitive response styles that produce different trauma reactions: assimilation, accommodation, and overaccommodation:

- **Assimilation:** Occurs when the individual interprets the trauma based on pre-existing beliefs or attempts to alter

to naturally reduce. If his or her story finishes earlier, he or she should be directed to start over again from the beginning.

Following imaginal exposure, the therapist facilitates emotional processing through guided discussion and questioning (e.g., What was that like for you? What did you experience? What was hard and what was easy about remembering the event? How was this different from past memories of this event?).

Sessions 4 to 9: Imaginal exposure

Sessions 4 through 9 entail continued re-hearsal and further refinement of the skills and interventions already introduced within PE. The patient participates in 30 to 45 minutes of imaginal exposure during each session, followed by 15 minutes of guided emotional processing with the therapist.

At around the sixth session, the therapist actively works to increase the emotional intensity of the imaginal exposure by focusing on hot spots. Hot spots are those portions of the memory that are especially distressing for the individual, and are therefore typically central to full emotional processing. Common indicators or clues to hot spots include skipping over sections of the story, suddenly jumping forward in time, pausing or "stalling" in the middle of the story, and crying or becoming physically or behaviorally activated during certain portions. Additionally, the therapist likely has already identified the hot spots by indications from the patient's SUDs scale identifying the highest amount of distress during previous imaginal exposures. Therapists should be alert to identifying these hot spots within the trauma account so that emotional processing may be more directly facilitated by focusing particular attention on these sections of the memory. It is important to note that throughout all of these sessions, the patient is continuing to listen to the recorded audio session and work through the *in vivo* fear hierarchy as well.

Session 10: Termination

In the final session of PE, the therapist conducts imaginal exposure for 20 to 30 minutes, followed by 15 minutes of guided emotional processing. In this final session, however, the therapist additionally asks the patient to reflect on how the experience of imaginal exposure has changed over the course of the entire treatment.

Effectiveness

PE is arguably one of the most researched and well-understood psychotherapy protocols. A recent review of the treatment literature by the DoD and VA (2017) supports the effectiveness of PE therapy for PTSD, with recovery rates (i.e., no longer meeting criteria for PTSD) generally ranging from 60% to 95% among civilians (Foa et al., 1999; Rothbaum, Astin, & Marsteller, 2005). Remarkably, these gains are extremely robust over time, with recent data indicating that 82.5% of patients with PTSD no longer meet criteria for the disorder when assessed five to ten years after receiving PE (Resick, Williams, Suvak, Monson, & Gradus, 2012). A growing body of literature is showing similar results with military veterans, and the National Center for PTSD (2017) estimates that approximately 53% of veterans will not meet criteria for PTSD following PE.

incoming information to match his or her pre-existing beliefs or assumptions.

- **Accommodation:** Occurs when the individual adjusts his or her beliefs enough to incorporate new information from the trauma that might not align with these beliefs.
- **Over-accommodation:** Occurs when the individual alters or changes his or her beliefs to an extreme in response to the trauma in order to feel safer and in control.

Both assimilation and overaccommodation can lead to traumatic reactions, whereas accommodation leads to a more resilient response. Social-cognitive theory also differentiates between primary and secondary emotional experiences. *Primary emotions* arise directly from the traumatic event itself and typically involve "basic" emotions such as fear, anger, and sadness. *Secondary emotions* are "manufactured" emotions, such as guilt and

shame, that arise from faulty interpretations of the traumatic event. To demonstrate each cognitive response style and primary versus secondary emotions, consider the following case and the three responses to trauma:

While deployed to Afghanistan, Sgt. Rivera was preparing to leave on a routine convoy patrol comprising five vehicles. At the last minute, he exchanged places with another Soldier assigned to a different vehicle so that he could sit next to the squad leader to discuss an upcoming mission. While driving to the next location, an improvised explosive device (IED) that was buried underground suddenly detonated underneath the vehicle that Sgt. Rivera would have been in had he not switched vehicles. The explosion killed the Soldier with whom he had switched places.

- **Assimilation response:** *Sgt. Rivera has always believed in the “just world hypothesis,” in which good things happen to good people and bad things happen to bad people. Because of the circumstances of the Soldier’s death in this incident, Sgt. Rivera believes that the Soldier’s death is his fault and also begins to wonder if the deceased Soldier somehow deserved this fate. Sgt. Rivera now states that this incident confirms that he himself is a terrible, horrible, unforgivable person who is being punished for his mistakes. He feels guilty and believes he directly caused the death.*
- **Accommodation response:** *Although Sgt. Rivera has always believed that good things happen to good people and bad things happen to bad people, after this experience he now also really understands that sometimes bad things happen to good people. After this event, he feels sad about this Soldier’s death and angry at the insurgents who detonated the explosive.*
- **Over-accommodation response:** *Although Sgt. Rivera has always believed that good things happen to good people and bad things happen to bad people, when this Soldier was killed, Sgt. Rivera reported he now really believes that life is completely unpredictable. He believes that people cannot count on anything good ever happening and that no one is ever truly held accountable for their bad acts. Sgt. Rivera reports generally feeling indifferent or numb.*

PTSD is conceptualized in CPT as a failure of normal recovery because of maladaptive beliefs that stall or interfere with healing, referred to as “stuck points” (Resick, Monson, & Chard, 2017). Emotional expression is believed to be a critical component of recovery within CPT. Whereas emotional expression is viewed in PE as a means to becoming desensitized to anxiety and fear, CPT views emotional expression as necessary to allow individuals to become “unstuck” by changing their beliefs and assumptions about the traumatic event. Once these faulty beliefs and maladaptive cognitive styles are modified, secondary emotions (e.g., guilt, shame) and associated re-experiencing symptoms will decrease in intensity and frequency. The goal of CPT is therefore to help individuals replace maladaptive assimilations and over-accommodations with more adaptive and balanced accommodations. Of the two maladaptive response patterns, assimilations are generally viewed to be more pernicious because they tend to be more self-oriented and reflect cognitive rigidity (i.e., refusing to abandon beliefs in the face of contradictory evidence). It is therefore recommended that clinicians target assimilations first in CPT.

Treatment overview

CPT is structured into 60-minute individual therapy sessions, with sessions typically occurring weekly for 12 weeks. CPT comprises several commonly used cognitive interventions and training exercises to be practiced between sessions. Training exercises are provided at the conclusion of every session to facilitate more rapid recovery; these training exercises are then reviewed as the first item of business at each subsequent appointment. Importantly, although the original version of CPT had a trauma narrative (i.e., a highly detailed verbal or written chronological

account of the traumatic experience) in it, the current version of CPT does not include a trauma narrative, because previous studies have shown no benefit from having the trauma narrative (for overview see: Resick, Monson, et al., 2017).

Session 1: Impact statement

The therapist provides a general overview of the treatment and the social-cognitive model of PTSD, with particular emphasis on explaining the two primary sources of stuck points: assimilations and over-accommodations. Depression and trauma symptoms are explained, and the rationale for CPT’s structure and components are provided.

- **Review of traumatic event:** The patient is asked to briefly describe the circumstances surrounding the traumatic event(s), although he or she is not necessarily probed for detailed, chronological accounts.
- **Impact statement:** The impact statement is introduced and explained to the patient. The impact statement is a written assignment in which the patient is asked to describe why the traumatic event occurred and how the event has affected the patient’s beliefs about his or herself, others, and the world in terms of beliefs about safety, trust, power/control, esteem, and intimacy. The patient writes his or her impact statement as an initial homework assignment between sessions. It is reiterated to the patient that a trauma narrative or detailed account of the trauma is not part of this training exercise. In fact, if a patient provides a trauma narrative rather than an impact statement, the therapist and patient will work together to create an impact statement during the second session.

Session 2: ABC worksheets

Review impact statement – At the beginning of the second session, the therapist directs the patient to read his or her impact statement out loud. Some individuals will be reluctant to read their impact statement, or will ask the therapist to read it silently. However, it is important for a clinician to have the patient read his or her impact statement out loud, regardless of the patient’s reluctance or perceived sense of readiness, because this facilitates greater emotional expression and exposure to the distressing emotions. While the patient is reading the impact statement out loud, the therapist takes notes of potential stuck points, with a particular emphasis on assimilations (i.e., holding on to beliefs despite contradictory evidence). The meaning of the traumatic event is then discussed.

The therapist uses ABC worksheets (see Table 3) to teach the patient how events, thoughts, and emotions are interconnected and how to critically evaluate these beliefs and develop more balanced perspectives. The therapist can use recent incidents in the individual’s life to demonstrate how to complete the worksheet and should also complete a worksheet focused on the traumatic event. The therapist then begins to train the patient how to critically evaluate his or her beliefs. For more examples of all the worksheets described, please see the Resources section.

Table 3: Sample Worksheet

A ANTECEDENTS <i>What happened?</i>	B BELIEFS <i>What do I tell myself?</i>	C CONSEQUENCES <i>What emotion do I feel?</i>
Seeing vehicles at the motor pool reminds him of the IED blast and his friend’s death.	It’s my fault the Soldier is dead.	Guilt. Anger. Sadness.
CHALLENGING QUESTIONS: <ul style="list-style-type: none"> ● <i>Is the belief above in box “B” helpful?</i> <ul style="list-style-type: none"> ○ No, because it just makes me feel worse. ● <i>What is something else I can tell myself in the future when in a similar situation?</i> <ul style="list-style-type: none"> ○ Sometimes bad things happen that I cannot control. 		
IED = improvised explosive device.		

The following uses the above case example to demonstrate the use of ABC worksheets in session 2.

Sgt. Rivera reports his index trauma, the event that is most distressing and thought to be the cause of his PTSD symptoms, was watching his friend die in an IED blast. When filling out the worksheet, he puts this down as the activating event. He reports feeling guilty, ashamed, and anger at himself because "It's my fault I should have saved him." The therapist directs Sgt. Rivera to write down the activating event (i.e., the trauma of the IED blast and his friend's death), associated beliefs (i.e., "it's my fault, I should have saved him"), and emotional consequences of this belief (i.e., guilt, shame, anger). Sgt. Rivera indicates he now understands how this specific belief is related to his feelings of guilt, shame, and anger. When asked if his belief is helpful, Sgt. Rivera acknowledges that it is not, although he notes he wishes there was something he could have done. The therapist then asks him what he could tell himself instead, and together they develop the thought that the situation was out of his control. Sgt. Rivera did not have power over the IED blast nor could he do anything about it. He writes on his worksheet "Sometimes bad things happen that I cannot control."

Session 3: ABC worksheets

The patient is again asked to briefly describe the circumstances surrounding the traumatic event(s), although he or she is not necessarily probed for detailed, chronological accounts. In this second review, the therapist focuses specifically on acceptance or blame issues for the identified beliefs (B), and uses Socratic questioning to target stuck points. For example, therapists might ask questions such as:

- *If this thought is true, what would it mean about you?*
- *What is the evidence that supports this idea? What is the evidence against this idea?*
- *Is there another possible explanation for this?*

These questions start to reveal common themes around the stuck points the patient is presenting, and they also start to target cognitive flexibility, a skill that the rest of treatment will work to enhance.

Session 4: Challenging questions worksheets

The therapist uses a Challenging Questions worksheet to teach the patient how to critically evaluate his or her beliefs and engage in a Socratic dialogue. The patient is directed to select a maladaptive belief/stuck point and to then answer the questions as they relate to the belief. Questions from a Challenging Questions worksheet might include:

- *Is your belief based on habit or based on facts?*
- *Are you thinking in all-or-none terms?*
- *Is the source of information reliable?*
- *Are you focused on irrelevant factors?*

Session 5: Patterns of problematic thinking worksheets

The therapist uses a Patterns of Problematic Thinking worksheet to teach the patient how to label his or her problematic thinking (also commonly referred to as "thinking errors" or "cognitive distortions") into categories such as jumping to conclusions, minimizing, overgeneralizing, or mind reading. See Table 4 for a list of sample cognitive distortions that can be included on the worksheet.

Table 4: Sample Cognitive Distortions FOR Patterns of Problematic Thinking Worksheet

- Jumping to conclusions when the evidence is lacking or even contradictory.
- Exaggerating or minimizing a situation by blowing things way out of proportion or shrinking their importance inappropriately.
- Oversimplifying things as good/bad or right/wrong.
- Emotional reasoning by assuming there must be a reason because you have a feeling.

Session 6: Challenging beliefs worksheets

A Challenging Beliefs worksheet combines all of the previous worksheets into one "master worksheet." The therapist uses a Challenging Beliefs worksheet to teach the patient how to synthesize all of the cognitive strategies learned to date (i.e., ABC, Challenging Questions, and Patterns of Problematic Thinking worksheets).

Session 7: Safety module

The therapist focuses specifically on how the traumatic event has affected the patient's sense of safety and perceptions of danger and teaches how beliefs about safety that existed before the traumatic event may have influenced the patient's trauma response. Challenging Beliefs worksheets are then used on specific stuck points related to these concerns.

The following demonstrates topics discussed about Safety with Sgt. Rivera:

Sgt. Rivera tells his therapist "The world isn't safe." For example, he is worried to drive in a car now that he is stateside (i.e., back in the United States) as he believes something could happen to him or his family in his car. The therapist discusses how often an IED blast occurred in Sgt. Rivera's life while he was not deployed. Sgt. Rivera notes that it has never happened in his life, but it has happened before in the United States. They then discuss the likelihood of it happening in his life now. They agree that there is a low probability it would happen, which directly targets and provides evidence against the black and white thinking that the world is not safe. The therapist would then target additional situations and stuck points related to this theme of "the world is not safe" to help create a more balanced alternative thought.

Session 8: Trust module

The therapist focuses specifically on how the traumatic event has affected the patient's ability to trust the patient's own judgment, and the judgments, motivations, and actions of others, and teaches how pre-existing beliefs about trusting his or herself and others may have influenced his or her trauma response. Challenging Beliefs worksheets are then used on specific stuck points related to these concerns.

The following demonstrates topics discussed about Trust with Sgt. Rivera:

Sgt. Rivera reports strong thoughts that he "can't trust myself after the IED blast because I make bad decisions." The therapist follows up by asking Sgt. Rivera to describe what evidence he has that he always makes bad decisions. The discussion that follows leads Sgt. Rivera to noticing that he has made several good decisions in his life and that not every decision is bad nor leads to events like the IED blast. This change in thinking creates cognitive flexibility and allows Sgt. Rivera to realize even the decision to switch seats with his friend was not a bad decision. Sgt. Rivera's stuck point about not trusting himself has likely expanded beyond himself into not trusting others as well. The therapist would then discuss how there are different kinds of trust and it varies on each individual. For example, there are some friends he can trust to watch his dogs while he is away, but he may not be able to trust them to be on time to a movie. This does not make that person completely untrustworthy and demonstrates how individuals can be trusted at different levels.

Session 9: Power/control module

The therapist focuses specifically on how the traumatic event has affected the patient's ability to solve problems and face new challenges in life and teaches the patient how pre-existing beliefs about power and control may have influenced his or her trauma response. Challenging Beliefs worksheets are then used on specific stuck points related to these concerns.

Session 10: Self-esteem module

The therapist focuses specifically on how the traumatic event has affected the patient's self-perceptions and sense of worth and teaches the patient how pre-existing beliefs about his or her self-worth and confidence may have influenced his or her trauma response. Challenging Beliefs worksheets are then used on specific stuck points related to these concerns. The patient is also taught the importance of both giving and receiving compliments, as well as performing favors and other acts of kindness for others. In addition to completing Challenging Belief worksheets, the patient is giving a training exercise of giving compliments.

Session 11: Intimacy module

The therapist focuses specifically on how the traumatic event has affected the patient's ability to soothe and calm him or herself, and teaches the patient how pre-existing beliefs about close relationships with others may have influenced his or her response to traumatic experiences. Challenging Beliefs worksheets are then used on specific stuck points related to these concerns. The patient is also directed to write a second impact statement using the same instructions as in the first session.

Session 12: Termination

The patient is directed to read his or her second impact statement out loud and compare this impact statement to the one written at the beginning of treatment. The patient's progress through CPT is reviewed in detail, and strategies for the

Eye movement and desensitization and reprocessing

EMDR is a therapy that pairs cognitive and behavioral interventions (i.e., narration, visualization of trauma, cognitive restructuring) with bilateral eye stimulation (Shapiro, 1989a, 1989b, 2017). EMDR is based on the adaptive information processing model, which posits that when traumas and traumatic memories are not fully processed, the cognitive distortions that occurred during the trauma will be preserved and negatively affect the individual until they are processed. Similar to cognitive models of psychopathology, EMDR focuses on trauma memories – specifically on the emotions, thoughts and beliefs, and physical sensations that occurred during the traumatic event. Throughout EMDR treatment the focus stays on processing the trauma memories, not directly challenging or changing them. Initial theories suggested the bilateral eye movements accelerate memory processing; however, recent data suggest against this and instead support the idea of dual attention (Sack et al., 2016). *Dual attention*, which involves splitting attention between the trauma account and another task, has been shown to improve PTSD symptoms during treatment. These findings suggest that the pairing of exposure and cognitive interventions with a dual-attention task aids in reducing PTSD symptoms. Evidence suggests EMDR's effectiveness not only for PTSD but for a wider variety of anxiety and mood disorders (Valiente-Gomez et al., 2017).

Treatment overview

EMDR is an individual therapy that is often delivered twice per week in 50- to 90-minute sessions. EMDR follows an eight-phase process described below. Although part of EMDR is exposure to the trauma memories, EMDR differs from other exposure therapies in that the client does not need to recount the memory to the therapist. Instead, the client is asked to vividly recall the memory internally. Additionally, the exposure length is brief (e.g., typically less than a minute at a time) compared to other exposure-based interventions. Clients can process several traumas during EMDR, and each trauma is usually processed in one to three sessions. Once the traumas have been processed, the client and therapist evaluate the treatment to determine if EMDR should continue or if therapy should terminate.

Phase 1: History taking and treatment planning

In the initial phase of treatment, the clinician should do a full intake with a clinical history to determine an accurate diagnosis of PTSD. Additionally, the therapist should assess

continued application of learned skills are discussed to prevent relapse.

Effectiveness

CPT has strong empirical evidence supporting its effectiveness. The first clinical trials showed equal effectiveness to PE for female rape victims (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick, Nishith, Weaver, Astin, & Feuer, 2002). In recent meta-analyses, CPT has been shown to have the highest effect sizes compared with other trauma-focused treatments (Haagen, Smid, Knipscheer, & Kleber, 2015; Watts et al., 2013). The *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (2017) recommends CPT as a first-line treatment for PTSD.

Similarly to PE, recovery rates are extremely robust over time, with recent data indicating that 78% of patients with PTSD no longer meet criteria for the disorder when assessed 5 to 10 years after receiving CPT (Resick et al., 2012). CPT has been provided in a group format and has shown to be more effective than treatment as usual, or nontrauma-focused treatment; however, group CPT is not as effective as individual CPT, and individual CPT is recommended if possible (Resick, Wachen, et al., 2017). Research is continuing to be conducted with military veterans. Several randomized clinical trials have shown CPT to be effective, with estimates of 53% of veterans not meeting criteria for PTSD after treatment (National Center for PTSD, 2017).

for specific symptoms, behaviors, and impairment that need to be addressed. These should be discussed with the client, and measurable treatment goals should be developed collaboratively. Safety factors and strengths are assessed at this time to help prepare the client and therapists for the EMDR exposures. Finally, the therapists should also identify the specific traumas that will be reprocessed during the treatment.

Phase 2: Preparing the client

In the second phase, the therapist explains the treatment to the client and answers any questions related to the process so the client has a clear understanding of EMDR. Included in the preparation is introducing and practicing the eye movements. Therapists may introduce relaxation techniques and other strategies to help the client have a sense of power and control during treatment. Additionally, the client and therapist discuss the role avoidance plays in maintaining PTSD symptoms in order to identify how this may be addressed in treatment.

Phase 3: Assessment

During the assessment phase, the clinician works with the client to identify memories that should be targeted in treatment. When discussing these memories, the clinician often probes for the client to identify an image, thoughts, emotions, and physiological responses that are related to the memory. Often negative beliefs that cross-cut memories are identified. These can be used as targets for treatment, and the clinician and client may identify more realistic thoughts that could be used as replacement thoughts. It is also important to identify which thoughts are related to the different reactions (i.e., emotions, behavior, physiology).

Phase 4: Desensitization

The desensitization phase focuses on brief exposures (30 to 60 seconds) to the memory while engaging in the eye movement back and forth to create a dual attention paradigm. The therapist assesses SUDs during the exposure to determine when the current memory is no longer distressing. Following each brief thought exposure, the therapist and client discuss the experience. Often there are additional negative thoughts that occur during this process, and they can be identified and added to the memories that will be processed in future sessions.

Phase 5: Installation

The installation phase focuses on strengthening the positive thoughts the client and therapist have developed together to replace the negative thoughts. The therapist and client reframe and revise cognitions until they are realistic and believable. Therapists often use standardized measures to examine the strength of the new cognition.

Phase 6: Body scan

The sixth phase of EMDR is the use of a body scan after the new positive thought has been installed. The client focuses on the memory that previously was related to the negative thought. Then, the client is asked to perform a body scan in order to detect any residual tension and pain in the body that stems from the memory. If pain is identified, the client and therapist examine and residual negative thoughts related to the memory and process them with the standardized eye movements.

Phase 7: Closure

The next phase is closure and is used to end each session. If processing of a memory is complete, the client will have returned to a neutral state and the session can end. If the client has not returned to a neutral state, the therapists and client work together to reduce the emotional response and provide skills to help contain the thoughts and feelings until the next session where processing can continue.

Phase 8: Re-evaluation

Although re-evaluation is the last phase, it occurs at the next session. The therapist and client evaluate if the changes from the previous session are maintained, and if not, continue to

reprocess the memory. Additional memories may have been identified after processing the original memory, and these memories should be processed as well. This process continues until the client and therapist agree that the memories causing the symptoms are no longer distressing.

Effectiveness

In the *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*, researchers recently reviewed the evidence on EMDR and noted that EMDR has strong evidence for the reduction of PTSD symptoms (VA/DoD, 2017). With the overlap of cognitive and behavioral techniques in EMDR, results are similar to those of other evidence-based trauma-focused treatments (Steenkamp, Litz, Hoge, & Marmar, 2015). Many EMDR trials have focused on non-military samples; however, several smaller trials that have replicated these results. There has been some controversy surrounding whether or not the actual eye movements are a key component (for review see: Lee & Cuijpers, 2013, 2014). Some research suggests that the cognitive and behavioral components of EMDR are essential, whereas the eye movements are not key mechanisms in the treatment outcomes. Other data suggest that the eye movements are helpful as they create a dual-attention paradigm that decreases the vividness of the memories and allows for faster processing. Ongoing research is focusing on the mechanisms of EMDR from multiple perspectives (e.g., neuroimaging, self-report, neuropsychological assessment) in order to better understand how EMDR works.

PSYCHOTROPIC MEDICATIONS

References will be made throughout this section to various medications used to treat the mental health concerns described in the course. Pharmacotherapy treatments are frequently evaluated, changed, or discontinued, and new medications are introduced. To obtain the most current information available, readers are encouraged to regularly check product information provided by the manufacturer of each drug and available from sources such as the U.S. Food and Drug Administration (FDA) at <http://www.fda.gov>.

Effectiveness

PTSD has four distinct but overlapping symptom clusters: re-experiencing symptoms, avoidance symptoms, negative cognitions and mood symptoms, and hyperarousal symptoms. Because of the multifaceted presentation of PTSD, several medications that cut across different drug classes are often used to treat individuals diagnosed with PTSD:

- **Antidepressants:** Antidepressants, especially the SSRIs, are the most commonly prescribed drug class for PTSD. Two SSRIs, sertraline (Zoloft, Lustral) and paroxetine (Paxil, Pexeva), have FDA approval for PTSD and have received an A level evidence designation by the VA and the DoD (2010). For combat-related PTSD, SSRIs are used to reduce symptoms of all four PTSD clusters. Additionally, recent recommendations by the DoD and VA suggest that antidepressants in the form of SNRIs are also recommended for treatment of PTSD symptoms.
- **Alpha-adrenergic blockers:** Alpha-adrenergic blockers are typically used to treat blood pressure because they relax the blood vessels so that blood can flow more easily through the body. One particular alpha-adrenergic blocker, prazosin (Minipress), is commonly used to reduce sleep disturbance and nightmares among veterans with combat-related PTSD.
- **Anticonvulsants:** Anticonvulsants are typically used for seizure disorders and bipolar disorder because these drugs are believed to suppress the rapid, excessive firing of neurons that trigger seizures and mood swings. One particular anticonvulsant, valproate, is commonly used to manage irritability associated with combat-related PTSD.
- **Atypical antipsychotics:** Atypical antipsychotics are typically used to treat symptoms of psychosis (e.g., hallucinations).

Two particular antipsychotics, risperidone (Risperdal) and olanzapine (Zyprexa; Zydys), are frequently used for combat-related PTSD due to the drugs' effects on insomnia, irritability, and associated psychotic symptoms. However, the *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (VA/DoD, 2017) "recommends" that Risperdal not be used in the treatment of PTSD and "suggests" that other atypical antipsychotics should also not be used in the treatment of PTSD. Studies to date indicate that the harmful effects of these medications in the treatment of PTSD outweigh their benefits (VA/National Center for PTSD, 2017).

- **Benzodiazepines:** Benzodiazepines are typically used to treat acute anxiety symptoms because of their rapid action and sedating effects. For combat-related PTSD, benzodiazepines are used to manage symptoms of insomnia, panic, anxiety, and irritability. Some data suggest that benzodiazepines can be used as an avoidance strategy (Guina, Rossetter, DeRhodes, Nahhas, & Welton, 2015). It is important to consult with the prescriber when a clinician may suspect the use of prescription or nonprescription drugs for avoidance or self-medication. For example, if a clinician notices a patient is using benzodiazepines to reduce anxiety and symptoms across various situations, regardless of whether the patient would likely be able to manage the situation without drugs, the clinician should discuss this use with the patient and prescriber. Additionally, if the patient is using benzodiazepines to alleviate symptoms while doing therapy homework, this is likely an indication the benzodiazepines are being used in a nonhelpful manner. In fact, recent research has led the VA and DoD to recommend against using benzodiazepines in the treatment of PTSD (2017). The negative effects of benzodiazepines are most likely because they inadvertently reinforce and maintain avoidance of fear and anxiety, which are the core features of the disorder. Benzodiazepines are therefore contraindicated for combat-related PTSD.

Research continues to be lacking, and there have been far fewer clinical trials testing the effectiveness of psychotropic medications on PTSD than there have been psychotherapy trials.

The smaller number of medication trials is a result of general design and methodology problems that significantly limit the conclusions that can be drawn from these studies (Krystal et al., 2017). Another very important limitation of many medication trials is the absence of structured PTSD interviews. Because many of the medication trials to date only measure PTSD symptom severity but do not administer diagnostic interviews, it is not possible to determine if a medication contributes to remission of PTSD even if overall symptoms have improved. These limitations make it challenging to know whether a given medication is effective and for whom. In other words, most medication trials currently available cannot determine whether an individual has fully recovered from PTSD.

The newest clinical guidelines from VA/DoD note there is moderate quality of evidence for sertraline, paroxetine, fluoxetine, and venlafaxine. However, recent discussion on the effectiveness of these medications has led experts to call for more research to understand the mechanisms and potentially search for new pharmacological interventions (Krystal et al., 2017). Unfortunately, although small to moderate symptom improvement appears to be associated with SSRI treatment, remission rates have not routinely been reported in medication trials, thereby making comparisons to psychotherapy trials impossible. Many experts agree that the medications help with some symptoms but are not able to get at the actual underlying cause of PTSD.

DEPRESSION

Depression is estimated to occur in approximately 14% to 22% of military personnel and veterans who have deployed to Iraq or Afghanistan, with lifetime prevalence rates in these individuals estimated up to 42% (Brancu et al., 2017; VA, 2013). The diagnostic criteria for major depressive disorder, as described in the *DSM-5*, are listed in Table 5. Major depression should not be ruled out when depressive symptoms present after a significant loss; instead, the clinician needs to distinguish between the characteristic symptoms of bereavement and those of major depressive disorder (APA, 2013). This factor is important to consider when working with veterans and military personnel who have faced significant and multiple losses.

Table 5: Major Depressive Disorder Diagnostic Criteria
<div>1. The presence of five or more of the following during the same 2-week period. At least one of the symptoms is either a depressed mood or diminished interest or pleasure (anhedonia):<ul style="list-style-type: none">Depressed mood most of the day, nearly every day.Diminished interest or pleasure in all or most activities.Significant unintentional weight loss or gain.Sleep disturbances.Agitation or psychomotor retardation noticed by others.Fatigue or loss of energy.Feelings of worthlessness or excessive guilt.Diminished ability to think, concentrate, or make decisions.Recurring thoughts of death or suicide.</div> <div>2. This experience has led to a change from previous functioning.</div> <div>Note. Adapted from American Psychiatric Association. (2013). <i>Diagnostic and statistical manual of psychiatric disorders</i> (5th ed.). Washington, DC: Author.</div>

Among military personnel and veterans, depression and PTSD frequently co-occur, with data indicating that approximately half of military personnel with PTSD also have probable depression (Rytwinski, Scur, Feeny, & Youngstrom, 2013). Veterans with comorbid depression and PTSD make more frequent primary care and mental healthcare visits than veterans with only depression or PTSD, most likely because of more severe symptoms and lower levels of functioning, including significantly

Cognitive therapy

The cognitive theory of depression was initially developed by Aaron Beck (1967) and has subsequently been refined over the course of 45 years based on decades of research and clinical practice. Beck's most notable refinement to his cognitive theory of depression was in 2014, when he discussed the general cognitive model with the concept of the depressive mode (Beck & Haigh, 2014). According to Beck, the depressive mode is the structural or organizational unit that contains core schemas, underlying assumptions, and automatic thoughts associated with the depressive emotional state. In the presence of a triggering event (whether internal or external in nature), underlying vulnerabilities for depression become activated and manifest in terms of

higher levels of suicide risk (Bryan, Clemans, Hernandez, & Rudd, 2013; Mckinney, Hirsch, & Britton, 2017; Ramsawh et al., 2014). When working with military personnel and veterans with depression, clinicians should therefore routinely assess for other co-occurring conditions, especially PTSD. The Patient Health Questionnaire-9 (PHQ-9) is the most widely used assessment tool for depression in both primary care and behavioral health settings and can be completed by the patient alone or with the clinician. Clinicians can also assess for the symptoms of depression: low mood, loss of interest or enjoyment in past activities, insomnia, guilt or hopelessness, lethargy and fatigue, poor concentration, and thoughts of self-harm. Early recognition and treatment can relieve depression before symptoms impair daily functioning.

Treatments for depression

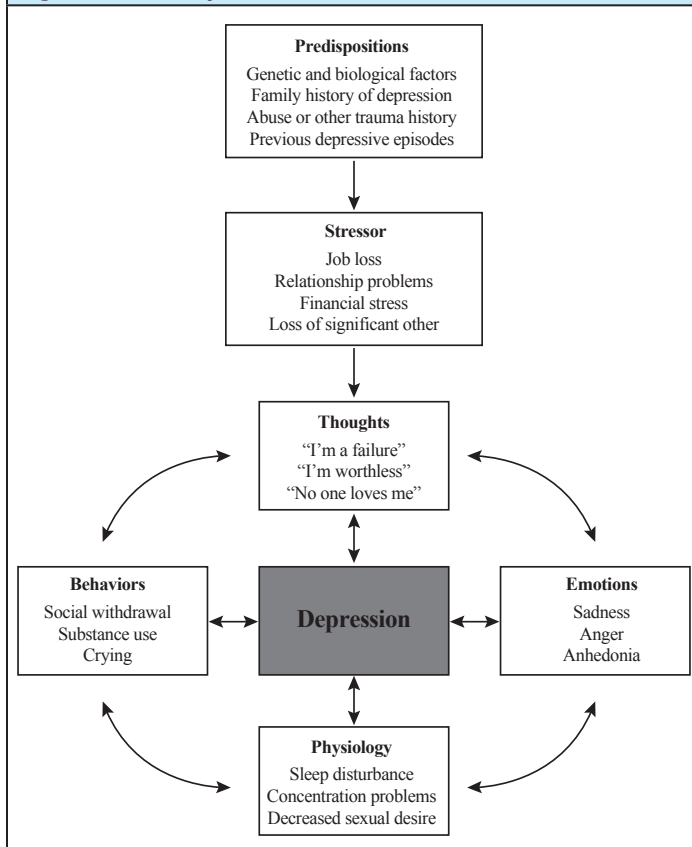
Determining the presence of comorbid PTSD is an important first step for treating depressed military and veteran patients. For individuals with comorbid depression and PTSD, clinicians should use either PE or CPT, described previously in this course, because both of these treatments have been found to effectively reduce the incidence and severity of comorbid depression for up to 10 years after both treatments (Resick et al., 2012). Accurately identifying comorbid PTSD is also critical for successful treatment outcomes because patients who received treatments that do not directly target trauma symptoms (especially avoidance and re-experiencing symptoms) are unlikely to improve.

For depressed individuals without comorbid PTSD (i.e., "pure" major depressive disorder), several effective treatment options exist. Cognitive behavioral psychotherapy (CBT), interpersonal psychotherapy (IPT), antidepressant medications, or combined antidepressants and psychotherapy are all considered first-line defenses for depression. Considerable research exists to support the efficacy of each treatment, with approximately comparable outcomes for each and some evidence of superior outcomes with combined psychotherapy (either CBT or IPT) with antidepressants (e.g., Guidi, Tomba, & Fava, 2015; Hollon et al., 2014). Because CBT is consistent with the interventions described previously for PTSD, it will be discussed in detail in this course. However, IPT is an equally effective therapy, and a brief overview is provided.

cognitions, emotions, physiological arousal, and behaviors (see Figure 1).

Central to the cognitive model of depression is the role of maladaptive thoughts and beliefs that contribute to and sustain the depressive episode over time, the most notable of which is the "cognitive triad": Depressed individuals typically have a negative view of themselves, of their environment, and of the future (Beck & Haigh, 2014). Because of these negative beliefs, depressed individuals tend to withdraw from social situations and stop engaging in meaningful activities, which further reinforces their depressive state.

Figure 1: The Depressive Mode



In cognitive therapy, the patient with depression is taught how to “deactivate” this depressive mode by identifying his or her negative beliefs and critically appraising these beliefs by considering a more rational or balanced perspective. Socratic questioning is the core cognitive intervention used by the therapist for challenging depressive thoughts and beliefs, with long-term recovery and relapse prevention occurring as a result of the patient’s ability to challenge these negative beliefs. Early in treatment, the therapist also assists the patient in developing plans for resuming pleasurable or meaningful activities in life, which can subsequently be used to challenge depressive beliefs. Additionally, because thoughts, feelings, behaviors, and physiological responses interact, a therapist may also teach patients ways to manage strong physiological responses (e.g., through relaxation, breathing, etc.). This decrease in physiological response will allow the patient to be able to challenge distorted beliefs. Through the repeated challenging and evaluation of depressive beliefs, the individual gradually adopts more balanced and reasonable perceptions of his or herself, the world, and others, which contribute to decreased symptomatology and reduced risk of relapse.

Treatment overview

Although cognitive therapy does not necessarily have a prescribed number of sessions, it is generally structured into 12 to 20 individual therapy sessions each 60-minutes long, with sessions typically occurring one or two times per week. Cognitive therapy comprises several core interventions and training exercises to be practiced between sessions. Unlike the manualized therapies for PTSD, cognitive therapy does not have a prescribed session-by-session sequence of interventions. Instead, it provides a “menu” of prescribed interventions that are designated for each treatment phase. Based on the patient’s current phase in treatment and particular clinical needs, the therapist selects interventions for administration. Interventions are practiced in-session and then assigned for between-session practice. Cognitive therapy for depression is not a one-size-fits-all treatment. The interventions chosen, even within each phase

of treatment, are done in a manner that matches the patient’s underlying vulnerabilities and skill deficits. The therapist must have a strong conceptualization of the individual to be able to create an effective treatment plan. All of this treatment depends on having a strong therapeutic alliance and collaborative empiricism so the patient and the therapist are each bringing in expertise – the patient is an expert on her/his life, and the therapist is an expert at modifying maladaptive thinking. Together, their expertise allows the patient and the therapist to work toward the therapeutic goals successfully, and each are responsible for sharing the work during therapy.

Phase 1: Symptom reduction

The first phase of cognitive therapy focuses on overcoming hopelessness, identifying problems, setting priorities, teaching the cognitive model of depression, and making rapid progress on the primary problem. The therapist uses a number of cognitive and behavioral strategies to accomplish this early symptom relief. Cognitive strategies are no different from those used in CPT, described previously: ABC worksheets, Challenging Questions worksheets, Patterns of Problematic Thinking worksheets, and Challenging Beliefs worksheets. In cognitive therapy for depression, however, the therapist and patient will focus on depressive thoughts and beliefs instead of trauma-related thoughts and beliefs. The initial goal of using these interventions is to illustrate how thoughts, behaviors, feelings, and physiology interact using examples from the patient’s own life. These examples can be used to illustrate how when one of the four previously stated domains is activated, the others become activated as well. Once a patient can identify these thoughts and feelings, the therapist and patient work together to start challenging them to increase cognitive flexibility and provide the patient with skills to be aware and challenge these thoughts when they occur outside of the therapist’s office.

Behavioral strategies include activity scheduling and behavioral activation plans to increase the patient’s engagement in pleasurable and personally meaningful activities. These activities function to increase the patient’s social supports, as well as his or her positive emotional states. Behavioral activation plans must be specific and easily achievable in order to maximize the likelihood of patient success (e.g., “go for a 30-minute walk on Monday, Wednesday, and Friday after dinner around the neighborhood”). Overly vague or nonspecific plans (e.g., “increase exercise”) are unlikely to be successful. Similarly, therapists should help patients to foresee and problem solve potential barriers to successful achievement of the plan. Often times behavioral strategies may be used first for severely depressed individuals in order to get them more activated. All behavioral strategies should be developed collaboratively, and the goals should be easily achieved given the patient’s barriers and mental health symptoms. These behavioral strategies often directly test some patients underlying assumptions, or self-worth contingencies or “rules” that apply across a wide range of situations, causing a direct change in their cognitions.

The following is a case example illustrating behavioral activation planning:

Technical Sergeant (TSgt.) Martin returned from an Air Force deployment about one month ago. TSgt. Martin and her husband have been having ongoing relationship difficulties since her return, and her husband decided to move out of their house. This split has caused an increase in depressive symptoms for TSgt. Martin. She used to have a very active social life and enjoyed going out on weekends. TSgt. Martin has withdrawn from her friends, has a hard time getting out of bed, and stays at home all the time if she isn’t at work. She used to exercise five days a week and now only exercises once a week at work. The therapist and TSgt. Martin discuss how increasing her exercise might help her feel better, and TSgt. Martin states, “I know, but I tried to go every day like I used to and I just couldn’t do it. Another reason I’m just a failure.” Her therapist suggests that instead of trying to go every day that maybe she should start with an easier goal of

going two times a week. TSgt. Martin believes that is possible and agrees to try going twice over the next week. The therapist works with TSgt. Martin to develop an even more specific and measurable plan. This plan includes a set day, time, and place – Monday and Thursday morning at 6:00 a.m. running around the neighborhood before work. Together they troubleshoot barriers such as what happens if the weather is bad and running outside isn't possible? TSgt. Martin develops two options – she could change the day that she runs to another day at the same time, or she could exercise inside using one of her exercise DVDs. Together they also create a detailed checklist of items that she will need to have ready for running in the morning including her running shoes, socks, and running clothes. TSgt. Martin initially thinks this list is not useful but later admits, "this will help me get everything ready the night before, and it will make it easier to get going in the morning."

Phase 2: Schema focus and relapse prevention

Once the severity of the patient's depression has been reduced, treatment transitions to focusing on preventing a relapse. In this second phase of treatment, the patient assumes increased responsibility for identifying and solving problems in his or her life, and the therapist becomes increasingly more of an advisor or consultant. Conceptually, this is when the patient has learned the skills needed to challenge negative and maladaptive cognitions, and instead of the therapist teaching new skills, the therapist helps hone the skills learned and apply them more broadly. The therapist continues to use the same cognitive and behavioral strategies in this second phase of treatment, but in contrast to the first phase of treatment, which emphasizes specific thoughts about particular problems, the second phase emphasizes core schemas about self and life that underlie many of the patient's problems. Schemas are thought of as strongly

Interpersonal therapy

IPT is another first-line defense and is an effective, evidence-based psychotherapy for clients with major depression (for review, see Cuijpers, Donker, Weissman, Ravitz, & Cristea, 2016). This therapeutic approach focuses on current stressors, interpersonal difficulties, and depressive symptoms. The underlying premise of IPT is that depressive symptoms are caused by a biological disease. However, negative life events compromise interpersonal functioning, which in turn exacerbates depressive symptoms and often triggers more negative life events. IPT focuses on interrupting the cyclic pattern of dysfunction caused by negative life events, psychosocial stressors, and symptoms of depression (Bernecker, Coyne, Constantino, & Ravitz, 2017; Ravitz et al., 2015).

There are two overarching principles for IPT. First, depression is a medical illness that causes a predictable set of symptoms that can be understood and managed and is not the fault of or defect of the patient. Second, the current episode of depression is linked to a current life event, and a practical link is drawn between the patient's mood and the life event that triggered the onset of depression (Ravitz et al., 2015). Therefore, IPT treats depression only within the context of interpersonal functioning, as opposed to other forms of psychotherapy that focus on a client's psychological symptoms. According to the IPT model, once the individual is able to manage the current problem, interpersonal functioning will stabilize, and the individual's depression should improve. IPT is usually used in combination with psychopharmacology, which treats the biological aspect of depression. IPT's therapeutic approach has these characteristics:

- Is time-limited and focuses on one or two problem areas.
- Is targeted towards diagnosis, symptoms, and the interaction of symptoms and interpersonal functioning.
- Focuses on the here-and-now (as opposed to childhood or behavioral issues).
- Focuses on interpersonal problems.
- Focuses on the interrelationship between mood and current life events.

held beliefs about the self, others, and the world. Often, they are formed early in life and are the lens from which the patient interprets life events and reacts to them, thereby contributing to long-term vulnerability for depression. Schemas tend to be more difficult to change than the automatic thoughts targeted in the first phase of treatment, as they are more identity-based and therefore more central to the patient's sense of self (e.g., "I'm a failure") than automatic thoughts, which are more closely tied to external life events (e.g., "I messed up"). During this phase of treatment, however, the patient and therapist have built up significant amounts of evidence against the schemas through their work on automatic thoughts.

Effectiveness

Cognitive therapy has been extensively re-searched and is considered to be an extremely effective treatment for depression (Cristea et al., 2017). Recent reviews suggest that recovery rates among civilians are around 50% to 60% and that CBT is effective for all levels of severity of depression and is long-lasting (i.e., over 2 years posttreatment; for review, see Hollon & Beck, 2013; McMain, Newman, Segal, & DeRubeis, 2015). Seminal research has shown that CBT for depression produces recovery rates of 50% for up to 1 year after the end of treatment, as compared with approximately 25% for those treated with antidepressants alone (e.g., DeRubeis et al., 2005; Dimidjian et al., 2006). CBT is also effective for a wide range of psychopathology, and several issues can be targeted throughout a course of treatment. Individuals who complete CBT are provided with ways to reappraise situations that may previously be interpreted negatively. These skills transfer across new stressors that occur, likely prevent the relapse into depression, and, overall, help individuals manage stressful situations in a more adaptive manner (Beck & Haigh, 2014; Hollon & Beck, 2013).

- Emphasizes patients' expression of feelings and learning to manage negative affects.
- Is adaptable for a wide variety of populations and causes of depression. (Frank, Ritchey, & Levenson, 2014; Weissman, Markowitz, & Klerman, 2017)

IPT is similar to CBT in its use of role-playing, skill building, and action planning to reduce depressive symptoms, but it differs from CBT in that IPT does not use formal homework assignments. Instead, IPT is less structured and focuses on expressing feelings, particularly negative ones, and learning to manage and regulate them. Another difference between CBT and IPT is that CBT focuses on distorted cognitions and associated behaviors, whereas IPT focuses on depression as a medical illness that can interfere with the development of positive interpersonal relationships. Although IPT recognizes the effects of childhood experiences, IPT does not incorporate childhood experiences into the therapy's focus on present functioning. Instead, IPT interventions aim to address the role of depression symptoms in current psychosocial functioning. This approach includes illuminating patients' understanding of anxiety and depression, along with the current role disputes (see the next sections) surrounding interpersonal relationships. Addressing ways that patients may adapt their current relationships to support their better mental health is a fundamental element of the therapy (Weissman, Markowitz, & Klerman, 2017).

According to the IPT approach, three treatment phases occur over approximately 12 sessions (Weissman, Markowitz, et al., 2017). The initial session is a review of the presenting problems and symptoms, along with the ways these symptoms related to interpersonal relationships. During this initial phase of treatment, the patient identifies a major problem area of interpersonal difficulty from four major areas of interpersonal difficulty all of which are primary contributors to mental health problems among military personnel and veterans. Weissman, Markowitz, et al., (2017) list the four major areas of interpersonal difficulty:

- Grief.
- Role disputes.
- Role transitions.
- Interpersonal deficits.

The second phase of IPT therapy addresses the major problem area of interpersonal difficulty, and the IPT therapist will use different techniques and interventions, depending on the area of interpersonal difficulty being addressed. When *grief* poses interpersonal difficulty, the IPT therapist might encourage service members or veterans who have lost a friend or colleague to express their grief and mourn their loss. As clients proceed through the bereavement process, the IPT therapist will help them develop new social networks and establish new social relationships, whether with family members, other service members, or veterans in order to build up their social relationships after this loss. *Role disputes* are an area of interpersonal difficulty involving conflict with a significant other. Role disputes can be common in military families, especially following service members' return from deployment. Another common source of interpersonal difficulty for service members is their relationships with supervisors or military leaders, who may be perceived as uncaring and/or overly demanding. In these situations, the IPT therapist encourages clients to express their feelings of frustration and anger in session and then work towards either a reconciliation or acceptance that the dispute is at an impasse. Oftentimes the therapists will focus on first identifying the reason for the dispute, make a plan to help solve the dispute, and provide skills (e.g., communication

Antidepressant medication

The three types of antidepressant medications that work directly with neurotransmitters are SSRIs, SNRIs, and monoamine oxidase inhibitors (MAOIs). The most commonly prescribed first-line defense antidepressants are SSRIs (National Institute of Mental Health, 2016; VA/DoD, 2016), due in large part to their relative safety, low side effect profile, and low cost. SSRI medications include fluoxetine (Prozac), citalopram (Celexa), sertraline (Zoloft), paroxetine (Paxil), and escitalopram (Lexapro). Medications in the SNRI category include venlafaxine (Effexor) and duloxetine (Cymbalta). The most common side effects associated with SSRIs and SNRIs are nausea and vomiting, sleep problems, weight gain, diarrhea, and sexual problems (National Institute of Mental Health, 2016). MAOIs, such as Nardil, Marplan, and Parnate, are older antidepressants but may work well for some clients. Tricyclic antidepressants, a separate class of medications that includes imipramine (Tofranil), amitriptyline (Elavil), doxepin (Silenor), and clomipramine (Anafranil), are rarely used in doses for depression owing to their side effects, but are frequently used in lower doses for sleep, pain, and headache or migraine that are often comorbid with depression and PTSD. Another commonly used antidepressant medication is bupropion (Wellbutrin), sometimes referred to as an "atypical antidepressant" because it works on the norepinephrine and dopamine systems. Mirtazapine (Remeron) is another "atypical antidepressant" that affects serotonin and norepinephrine and is frequently used to aid sleep in depressed patients.

Antidepressant nonadherence is a common treatment barrier, although it is not limited to military personnel and veterans.

skills) to implement the plan. *Role transitions* occur when a service member's military status or responsibilities change, such as when a service member transitions from active duty to veteran status, when a service member is promoted and assumes new responsibilities, or when a service member returns from deployment. In these situations, the IPT therapist assists clients to redefine and develop new coping skills to facilitate the role transition as well as express the emotions (e.g., anger, guilt, loss) associated with the transition. *Interpersonal deficits* may be present for clients who lack social skills. These clients may experience increased isolation, which can exacerbate depression and heighten the risk for suicide. The interventions for interpersonal deficits are often modeled from the client's relationship with the therapist and focus on understanding how to form new relationships, because individuals who identify interpersonal deficits as their major problem area likely do not have lasting supportive relationships in their current network.

The third phase focuses on termination and discusses maintenance sessions. Here the therapist and client focus on how the client feels about ending treatment. A complete review of the skills and strategies learned in therapy is done, including how they could be implemented in the future. The therapist helps the client recognize the competence gained in these areas and validates the work done in therapy. Additionally, a discussion occurs about warning signs that the problem is coming back and when the client should return for a booster or maintenance session with the therapist. Once these objectives are completed, the client and the therapist mutually agree to terminate therapy.

More than 50% of individuals report nonadherence to antidepressant medication treatment as recommended (Alekhya et al., 2015; Ho, Chong, Chaiyakunapruk, Tangisuran, & Jacob, 2016). Although psychological intervention can be used to target adherence, it is not common. A major factor contributing to early discontinuation of medication is side effects, with the risk for discontinuation increasing as side effects become more severe or intense, and when side effects begin within the first 2 weeks of antidepressant initiation (Mitchell, 2017). However, patient education can significantly improve adherence rates when several important messages are communicated. Specifically, patients are much less likely to prematurely discontinue antidepressant therapy when they are (1) educated that antidepressants must be taken consistently for 2 to 4 weeks for a noticeable effect; (2) given specific instructions for resolving questions about medication (e.g., how to communicate with the prescriber); and (3) directed to take their medication daily, to take their medication even if they are feeling better, and not to discontinue their medication without first talking with their prescriber.

In short, patient adherence to a full course of antidepressant therapy is low, with many discontinuing treatments before an adequate therapeutic effect is likely to be experienced. Although antidepressant adherence rates among military and veteran populations have not been explicitly investigated, there is no evidence to suggest that trends among this group would differ from those seen in the larger population.

COMORBID SUICIDAL THOUGHTS AND BEHAVIORS

Suicide rates among military service members has increased from 2005 to 2009 and surpassed the rates of demographically comparable civilians for the first time (Kang et al., 2015). Suicide has become the second leading cause of death among military personnel, second to only accidents (Armed Forces Health Surveillance Center, 2014; Franklin et al., 2017). Suicide attempts, defined as self-enacted, potentially injurious behaviors with nonfatal outcomes for which there was explicit or implicit evidence of intent to die (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007), also appear to be increasing in frequency among military personnel, although estimates are less reliable

than those for suicide deaths (Ramchand, Acosta, Burns, Jaycox, & Pernin, 2011).

When considering suicide-related behaviors (also referred to as *self-directed violence* by the Centers for Disease Control and Prevention, 2015), it is important to first discuss terminology. Terminology has been a major factor in limiting the professional understanding of *self-directed violence* (Klonsky, May, & Saffer, 2016). An abundance of terms has been used to describe various forms of self-directed violence (e.g., suicide attempt, parasuicide, self-harm, suicide gesture, self-mutilation, self-injury, etc.), with little evidence of standardization across studies and

clinical settings. To enhance effective communication among clinicians and between clinicians and their patients, the following standardized terms have been proposed for use (Klonsky et al., 2016; Silverman et al., 2007):

- **Nonsuicidal morbid ideation:** Thoughts in which death is a desired outcome, but there is no evidence of self-infliction or suicidal intent. Oftentimes, this desire is expressed as a wish to die without self-infliction.
- **Suicidal ideation:** Thoughts in which self-inflicted death is a desired outcome, and which may or may not include a plan, but do not involve an explicit attempt.
- **Suicide plan:** A proposed method of carrying out a design that will lead to a potentially self-injurious outcome.
- **Nonsuicidal self-injury (also referred to as nonsuicidal self-directed violence):** A self-inflicted, potentially injurious behavior for which there is evidence that the person did not intend to kill himself or herself (i.e., had no intent to die). Self-harm may result in no injuries, nonfatal injuries, or death.
- **Suicide attempt:** A nonfatal, self-inflicted, potentially injurious behavior with a nonfatal outcome with an intent to die as a result of the behavior even if the behavior does not result in injury. Suicide attempts that result in death are classified as suicide.
- **Suicide:** A self-inflicted death for which there is explicit or implicit intent to die as a result of the behavior.

See the Resources section for additional information about this classification of terms and a clinical tool to assist clinicians in differentiating between these behaviors.

Treatments for suicide risk

A mounting body of evidence supports the efficacy of certain suicide-focused psychotherapies for effectively reducing suicidal behaviors. Several seminal systematic reviews (e.g., Comtois & Linehan, 2006; Mann et al., 2005; Rudd, Joiner, Trotter, Williams, & Cordero, 2009) have noted that dialectical behavior therapy and CBT in particular have shown benefits for reducing repetition of suicidal behavior after treatment. Based on these reviews and meta-analysis, Rudd and colleagues (2009)

Brief cognitive behavior therapy

BCBT for suicide risk is based on suicidal mode theory (Rudd, 2006). According to this model of suicidal behavior (see Figure 2), each individual has a baseline risk for suicide that is affected by his or her unique combination of predisposing factors (e.g., genetic or biological factors, psychiatric illness, trauma). The presence of triggering events activates a network of cognitive, behavioral, physical, and emotional systems, which the individual experiences as an acute suicidal crisis. Suicidal crises subsequently resolve when the various systems of the suicidal mode are deactivated, at which point the individual returns to his or her baseline risk level.

The primary motivation for suicidal behaviors is to relieve emotional pain. In a clinical sample of military personnel who had attempted suicide, 100% reported this motivation (specifically, “to stop bad feelings”) as a reason for their attempts (Bryan, Rudd, & Wertenberger, 2013). Emotion regulation skills training to effectively and safely reduce emotional pain is therefore considered to be essential in BCBT for reducing suicide risk. Once patients have been stabilized, BCBT focuses on the cognitive domain of the suicidal mode. Many suicidal individuals have particularly negative, identity-based beliefs (e.g., “I’m a terrible person,” “I’m a burden on others,” or “I can’t take this anymore”) that confer long-term risk for suicide attempts above and beyond emotional distress (Bryan & Rudd, in press). Undermining this “suicidal belief system” is believed to adjust the patient’s baseline vulnerability for suicide risk over time.

Treatment overview

BCBT is structured into three separate phases that span twelve 60-minute sessions, with sessions typically occurring once per week. Many clinicians find it helpful to conduct a 90-minute first session so they have a bit more time to accomplish all of

have described several common “ingredients” for effective psychotherapies:

- Effective treatments are based on clearly articulated, well-defined, and easily understandable theoretical models that make it easy for patients to understand why they are suicidal and why prescribed interventions are helpful.
- Effective treatments are manual based or protocol driven. They emphasize clinician fidelity to the protocol by determining in advance what problems should be targeted in which order, and by placing suicide risk as the primary focus of treatment.
- Effective treatments directly target patient nonadherence.
- Effective treatments stress skills training in the areas of emotion regulation and problem-solving, teach patients what to do and how to do it, and practice these skills to ensure learning and mastery.
- Effective treatments prioritize patient responsibility and self-management over external sources of support.
- Effective treatments provide easy access to treatment and crisis services.

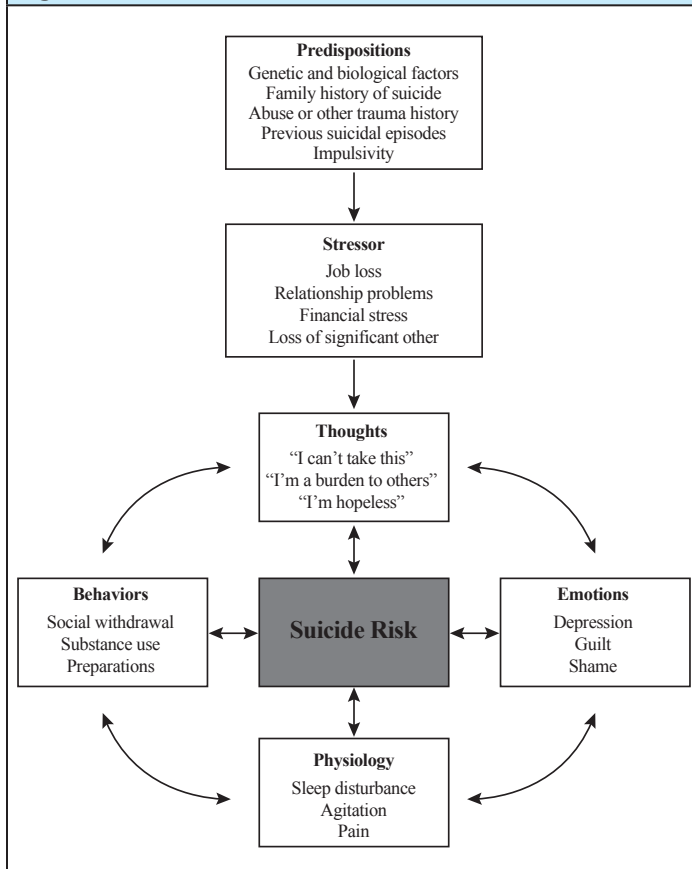
In contrast to these effective suicide-focused outpatient psychotherapies, the efficacy of psychopharmacology as a stand-alone treatment for suicide risk has not been supported (National Action Alliance for Suicide Prevention [NAASP], 2012). Similarly, there is limited evidence to support the widespread use of inpatient psychiatric hospitalization, although it is often considered a “gold-standard” intervention by the NAASP.

Given the previously mentioned research, to be most effective at reducing suicidal behaviors, treatments need to focus specifically on suicidal behaviors. Previous psychotherapy studies have focused on suicidal thoughts and behaviors as secondary outcomes. A second issue is that the majority of treatment studies for suicide risk have been conducted in civilian populations until recently. Both of these issues have been addressed in the development and testing of both brief cognitive behavioral therapy (BCBT) for suicide risk and crisis response planning (CRP).

the necessary tasks. Frequency of appointments can also be accelerated to two sessions per week to speed up progress through treatment. Phase I of BCBT, typically five sessions in length, focuses on emotion regulation skills training. Phase II, typically five sessions in length, focuses on cognitive restructuring of the suicidal belief system. Phase III, typically only two sessions in length, focuses on the relapse prevention task. BCBT uses a competency-based approach to treatment progress and completion (Rudd, Bryan, Wertenberger et al., 2015), in which advancement through treatment is dependent upon the patient’s demonstrated skill competency. As such, patients do not transition to Phase II until they have demonstrated they can effectively use the emotion regulation skills learned in Phase I, and patients do not transition to Phase III until they have demonstrated the ability to effectively challenge and adaptively respond to their suicidal beliefs in Phase II. Finally, patients do not “graduate” or complete treatment until they can effectively accomplish the relapse prevention task in Phase III.

Patients are taught emotion regulation and cognitive restructuring skills in session and are then instructed to practice the skills in between sessions as training exercises. At the conclusion of each session, patients are also directed to identify a “lesson learned” during each session and to write this observation down in a small notebook (called a “treatment log” or “smart book”) that is given to them by the therapist. Throughout the treatment, patients refer back to their smart books to maintain a positive focus. This smart book also becomes a resource at the end of treatment because the patient has all of the lessons learned in one easily accessible resource.

Figure 2: The Suicidal Mode



When treating actively suicidal patients, therapists should focus on suicide risk as the primary problem and treatment goal, not the associated psychiatric condition. In other words, therapists would not alter their treatment approach for patients with a depressive disorder versus patients with an anxiety disorder. Likewise, BCBT is administered in the same way for patients with a personality disorder as it would be for a patient with no personality disorder. Results from clinical trials to date suggest that outcomes (i.e., suicide attempt rates) do not differ based on psychiatric disorders or number of comorbid conditions; BCBT should therefore be administered consistently regardless of psychiatric diagnosis.

Phase I: Introduction to BCBT and emotion regulation skills training

Unlike many other manualized therapies, BCBT does not have a prescribed session-by-session sequence of interventions. Instead, it provides a "menu" of prescribed interventions for each treatment phase. Based on their patient's current phase in treatment, therapists select interventions from the appropriate menus for implementation based on a solid conceptualization of the patient. Interventions are practiced in-session and then assigned for between-session practice. An overview and rationale of treatment is provided by the therapist in the first session of BCBT. Other Phase I interventions include the following:

- **Narrative assessment:** Following the explanation of the treatment during the first session, the initial interview focuses on the most recent suicide attempt or suicidal crisis (for patients who have not made a suicide attempt). During the narrative assessment, the therapist seeks to obtain information about the circumstances leading up to and surrounding the suicidal crisis in a chronological story-like fashion to help understand the sequence of events that led up to the crisis. Additionally, it is important for the therapist to gather information on details such as the location of the

event and the thoughts and emotions experienced by the individual at the time of the crisis.

- **Suicidal mode education:** Immediately following the suicidal episode interview, the therapist educates the patient about the suicidal mode and provides the patient with a smart book to draw a picture of the mode for future reference. By conducting the narrative assessment prior to introducing the suicidal mode, the therapist can then use examples from the crisis or suicide attempt to help illustrate and personalize the suicidal mode for the patient. The therapist also explains the rationale for keeping a smart book to take notes during treatment and to facilitate long-term recovery.
- **CRP:** The therapist assists the patient in developing a written list of steps to take during future emotional crises instead of engaging in suicidal behaviors. The CRP first identifies the patient's unique warning signs of an impending crisis, then outlines self-management or coping the patient can use by him or herself, then a list of reasons for living are generated specific to the patient, and then social supports the patient can contact to feel a sense of connectedness and help manage distress are listed. In the final step, the CRP provides details about how to contact mental health professionals and other crisis support services. The CRP was developed as a problem-solving tool to help manage acute crisis promoting self-management before professional, giving patient a sense of more power and control over the crisis situation.
- **Controlled breathing:** The therapist educates the patient on using breathing exercises to reduce autonomic arousal and allows the patient to practice in-session to ensure he or she can successfully and effectively utilize the skill.
- **Mindfulness exercises:** The therapist educates the patient on the utility of controlling his or her attention to reduce cognitive reactivity to stressful thoughts and emotions and allows the patient to practice in-session to ensure he or she can successfully and effectively utilize the skill.
- **Reasons for living list:** The therapist assists the patient in identifying a more extensive list of his or her personal reasons for living (or said another way, reasons for not killing him or herself). The patient is directed to imagine these reasons for living in detail and to write them down on an index card for regular review in between sessions.
- **Survival kit:** The therapist asks the patient to obtain a container of some kind (e.g., envelope, shoe box, tackle box) and then fill it with objects that elicit positive emotions and thoughts, such as trinkets from past trips, pictures of loved ones, inspirational quotes, etc. Patients are instructed to review the objects in the survival kit to remind themselves of positive experiences.
- **Stimulus control and sleep hygiene:** The therapist reviews basic guidelines for reducing sleep disturbances and develops a plan with the patient to change his or her sleep-related behaviors (e.g., limiting activities in bed to sleep and sex only; only getting in bed when sleepy).

Phase II: Cognitive restructuring

Similar to their approach in Phase I, therapists can select from a number of interventions to accomplish the primary goal of Phase II: undermining the suicidal belief system. The worksheets used to accomplish cognitive restructuring in BCBT are the same as those used in CPT. Because many suicidal service members and veterans are diagnosed with combat-related PTSD (approximately 40% of Soldiers in the BCBT clinical trial; Rudd et al., 2015), worksheets from CPT, which overlaps most closely with BCBT, were selected for the purpose of consistency across treatments.

Therapists use ABC worksheets to teach patients how events, thoughts, and emotions are interconnected and how to critically evaluate these beliefs and develop more balanced perspectives. Therapists can use recent incidents in the patient's life to demonstrate how to complete the worksheet and then help patients to complete a worksheet focused on the traumatic

event. Therapists then begin to train patients to critically evaluate their beliefs (see Table 3 for an example).

- **Challenging Questions worksheets:** Therapists use Challenging Questions worksheets to teach patients how to critically evaluate their beliefs and engage themselves in a Socratic dialogue. Patients are directed to select a maladaptive belief and then answer the questions as they relate to the belief (see Session 4 in the previous description of CPT for an example).
- **Patterns of Problematic Thinking:** Therapists use Patterns of Problematic Thinking worksheets to teach patients how to label their problematic thinking (also commonly referred to as “thinking errors” or “cognitive distortions”) into categories such as jumping to conclusions, minimizing, overgeneralizing, or mind reading (see Table 4 for an example).
- **Behavioral activation:** Therapists develop behavioral activation plans with patients to increase their engagement in pleasurable or personally meaningful activities, with the goal of increasing their social support and positive emotional states. Behavioral activation plans must be specific, measurable, and easily achievable in order to maximize the likelihood of patient success.
- **Coping cards:** Therapists use coping cards for teaching and reinforcing cognitive and behavioral skills for responding more adaptively to suicidal thoughts. Coping cards can be created using 3 × 5 index cards that the patient can carry with them in a pocket, purse, or backpack, or keep nearby in a desk drawer or on a refrigerator. On the front side of the coping card the patient writes the suicidal or maladaptive belief, and on the back side of the card the patient writes a positive response. Coping cards tend to be most effective after patients can effectively complete ABC worksheets and Challenging Questions worksheets.

Phase III: Relapse prevention

Phase III is comprised of only a single intervention: the relapse prevention task. The relapse prevention task serves as the final competency check for the patient. Although the relapse prevention task typically spans only two sessions, therapists can add additional sessions in order to continue repeating the task until the patient “passes the final exam.” Once the patient can

successfully complete the relapse prevention task, treatment is terminated.

Relapse prevention task – The therapist first explains the rationale for the relapse prevention task in detail and answers the patient’s questions about the intervention. The patient’s smart book is then reviewed, with an emphasis on all the skills the patient has learned. During the relapse prevention task, the patient recounts the sequence of events that occurred during the original suicide attempt or suicidal episode that prompted them to seek out treatment. In essence, he or she provides a “play-by-play” account of the event, but this time must imagine him or herself using a coping strategy or skill used in treatment to solve the crisis instead of attempting suicide. This imaginal rehearsal is repeated several times, but the patient must generate a different solution each time. Once the patient has successfully demonstrated the ability to problem solve his or her way out of the original crisis, the patient and therapist generate hypothetical future scenarios for the patient to successfully problem solve.

Effectiveness

Results from a randomized controlled trial of BCBT compared with treatment as usual indicated that BCBT reduced suicide attempts by 60% in a sample of active-duty soldiers after a 24-month follow-up (Rudd et al., 2015). This outcome is especially promising given that the high-risk sample of military personnel used as patients in this study had either previously attempted suicide or had suicidal plans with intent. Additionally, crisis response planning has been tested as a stand-alone treatment for the prevention of suicidal behaviors (Bryan et al., 2017). In a separate randomized controlled trial, CRP was tested as a one-session intervention for high-risk military personnel, and it was compared with treatment as usual (i.e., contract for safety). The CRP was shown to reduce suicide attempts by 76% and contribute to faster declines in suicidal ideation as compared with treatment as usual. Additionally, follow-up analyses show that the CRP helps immediately reduce negative affect and the reasons for living component increases positive affect (Bryan et al., 2017). Of note, the CRP decreased the likelihood of hospitalization as well. These studies provide compelling evidence for both BCBT and CRP’s effectiveness in reducing suicide attempts in military personnel.

COMORBID ALCOHOL USE DISORDERS

Recent reports note that 16% to 40% of service members indicated alcohol misuse (i.e., risky drinking to alcohol use disorder [AUD]), with estimates higher for younger veterans (Grossbard et al., 2017). Additionally, veterans are more likely than civilians to use alcohol (Teachman, Anderson, & Tedrow, 2015). Despite these high rates of alcohol misuse, few are referred to treatment (Fox, Meyer, & Vogt, 2015). Alcohol use is associated with a variety of physical and behavioral health issues, including increased risk for PTSD, aggression, and suicide (Watkins, Sippel, Pietrzak, Hoff, & Harpaz-Rotem, 2017). Given

the increased risk for AUD combined with PTSD, it is important for mental health providers to assess for these problems at the initial appointment and throughout treatment. AUD can negatively affect treatment outcomes, especially if the treatment does not address the patient’s reasons (i.e., functional use) for drinking alcohol. Common alcohol use assessment tools include the CAGE Questionnaire, the Alcohol Use Disorders Identification Test (AUDIT), and the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C). The *DSM-5* diagnostic criteria for AUD are listed in Table 6.

Table 6: Alcohol Use Disorder Diagnostic Criteria
<p>During the same 12-month period, two (or more) of the following symptoms have been present:</p> <ul style="list-style-type: none">● Craving alcohol.● Alcohol is taken in larger amounts or for longer duration than intended.● Persistent desire or unsuccessful attempts to cut down or stop substance use.● Excessive time is spent attempting to obtain and use alcohol, or to recover from use.● Recurring alcohol use results in a failure to fulfill responsibilities at work, school, or home.● Important social, recreational, or occupational activities are reduced.● Continued use despite knowledge of worsening or persistence of social, interpersonal, physical, or psychological problems caused or exacerbated by alcohol use.● Alcohol use in physically dangerous situations.● Alcohol tolerance as defined by the need for greater amounts of alcohol to achieve the desired effect or diminished effect with use of the same amount.● Alcohol withdrawal symptoms.
<p>Note. Adapted from American Psychiatric Association. (2013). <i>Diagnostic and statistical manual of psychiatric disorders</i> (5th ed.). Arlington, VA: American Psychiatric Association. Washington, DC: Author.</p>

Treatment

AUDs are the most common substance use disorders among military personnel and veterans (Department of the Army, 2012). Common questions for many clinicians are how to best treat comorbid substance use disorders and whether the substance use disorder or the comorbid psychiatric disorder (when one is present) should be treated first. To answer these questions, it is important to understand why an individual abuses substances in general and alcohol in particular. *DSM-5* (APA, 2013) states:

all drugs that are taken in excess have in common direct activation of the brain reward system ... they produce such an intense activation of the reward system that normal activities may be neglected. Instead of achieving reward-system activation through adaptive behaviors, drugs of abuse directly activate the reward pathways. (pg. 481).

Along these lines, the leading theory of substance use disorders is the “self-medication hypothesis” originally proposed by Khantzian and his colleagues (e.g., Khantzian, Mack, & Schatzberg, 1974). According to the self-medication hypothesis, individuals abuse substances, including alcohol, to avoid or suppress emotional distress. The avoidance function of alcohol abuse was subsequently proposed to be the common etiological factor accounting for the high comorbidity of AUDs with a range of psychiatric disorders, such as PTSD, depression, aggression, and suicide risk (McDevitt-Murphy, Fields, Monahan, & Bracken, 2015; Watkins et al., 2017). The self-medication hypothesis also explains that suicide risk is increased among individuals who abuse alcohol because alcohol use and suicide both function to reduce emotional distress.

Because alcohol abuse frequently serves to manage emotional distress, therapists will often find themselves treating patients with psychiatric disorders who have comorbid alcohol abuse. From a treatment perspective, in order to treat AUDs, patients must develop and use alternative emotion relief strategies that effectively replace alcohol use. Effectively treating comorbid AUDs can be critical because alcohol consumption for the purposes of avoidance and suppression maintains current psychiatric distress and promotes unhealthy emotion regulation (Radomski & Read, 2016). Targeting emotion regulation with specific attention to the use of alcohol as a maladaptive emotion-regulation strategy paired with learning adaptive emotion regulation strategies could therefore reduce long-term health-related complications.

For military and veteran patients with acute alcohol dependence, it is generally recommended that inpatient detoxification occur

before initiation of outpatient treatment for the comorbid psychiatric condition (e.g., Resick, Monson, et al., 2017). Substance use disorders can typically be effectively treated by directly targeting the primary psychiatric condition (e.g., PTSD) in cases where the alcohol abuse is a behavioral avoidance strategy and has not become a physiological dependency. For instance, alcohol consumption can serve as a method to avoid trauma-related memories and to suppress unwanted emotions among individuals with PTSD. For patients with comorbid PTSD and alcohol abuse, trauma-focused therapies (i.e., PE and CPT) have demonstrated excellent outcomes for comorbid AUDs (Resick, Monson, et al., 2017). Interestingly, patients experiencing comorbidity demonstrate improvements in substance abuse as trauma symptoms improve, but the reverse is not necessarily true (Kaczurkin, Asnaani, Alpert, & Foa, 2016). This idea supports the perspective that alcohol use functions to manage or “self-medicate” PTSD symptoms. It suggests that trauma-focused therapies contribute to global improvement across both PTSD and alcohol-related conditions.

Concurrent treatment of depression and substance abuse with CBT has also been found to contribute to superior outcomes across both depression and substance abuse as compared with treatments that focus on either condition alone (Haller et al., 2016). Alcohol use is associated with an increased likelihood of suicide attempts, and addressing these problems together likely improves the outcomes of reducing suicidal ideation and use of substances (Borges et al., 2017).

Few of these studies have been conducted with military or veteran samples. However, the best evidence currently available suggests that among patients who are not currently in an acute state of substance dependence, concurrent treatment of the comorbid psychiatric condition and substance use disorders in general, and AUDs in particular, contributes to improved outcomes when alcohol use is conceptualized as an emotional avoidance strategy that sustains the psychiatric condition. Among patients with a substance use disorder and who are currently stable, therapists should consider using PE or CPT for comorbid PTSD, CBT or IPT for comorbid depression, or BCBT for comorbid suicide risk.

For individuals with substance use disorders without comorbid psychiatric conditions (i.e., “pure” substance use disorders), motivational interviewing and CBT with contingency management have received considerable research support as effective interventions (for review see Pace et al., 2017).

COMORBID TRAUMATIC BRAIN INJURY

As compared with PTSD, depression, and suicide, there is more limited research on the prevalence of traumatic brain injury (TBI) among military personnel and veterans, primarily because of methodological constraints such as assessment difficulties, case definitions, and restrictions on the release of such information (Helmick et al., 2015). Furthermore, although the identification of penetrating brain injuries is relatively straightforward, identifying closed head injuries and blast-induced injuries is much more difficult. Current estimates suggest that around 10% to 20% of veterans of Iraq or Afghanistan have “probable” TBI, with the vast majority being classified as mild, and that comorbidities with PTSD and depression are common (Chapman & Diaz-Arrastia, 2014; Helmick et al., 2015).

In response to the limitations in the TBI epidemiology, case definitions have been significantly improved and standardized; Table 7 lists the current definition of TBI, and Table 8 lists the criteria for classifying severity of injury (VA/DoD, 2009). In short, a TBI is typically diagnosed in two steps. First, one must determine if the patient meets criteria for a TBI of any severity. As can be seen in Table 8, a TBI is diagnosed if an

individual reports or demonstrates any one of the five listed clinical signs immediately after the injury. If an individual meets this definitional criteria for TBI, the severity level is classified based on the results of structural imaging (typically a CT scan) and the duration of loss of consciousness (LOC), alteration of consciousness (AOC), or posttraumatic amnesia (PTA). When medical records are available, an individual’s Glasgow Coma Scale score, ideally obtained within the first 24 hours of injury, can also be used. To meet criteria for a mild TBI, individuals must fall within all of the five criteria ranges; otherwise, they are upgraded to a higher severity classification. In other words, an individual must have a normal structural imaging, LOC for less than 30 minutes, AOC for less than 24 hours, PTA for less than 1 day, and a Glasgow Coma Scale score between 13 and 15. If the individual falls outside of these maximum ranges in even a single area, the TBI should be upgraded to a higher classification.

The following two case examples illustrate moderate and mild TBI.

Case example 1: Moderate traumatic brain injury

Cpl. Green reported sustaining a head injury from a car accident that occurred during his deployment. He states, "I don't remember much of anything that happened that day. I remember going out in the convoy, and an enemy vehicle ambushed us, hitting our car. I remember hearing the noise from the collision, and the next thing I know I'm waking up in the hospital." Details after the accident are difficult for Cpl. Green to recall. Upon waking, he describes having ongoing headaches, blurred vision, and nausea. Cpl. Green noted ongoing balance problems that took several weeks to recover from. LOC was noted by informants and lasted about 2 to 3 hours.

Cpl. Jones meets criteria for a TBI because he experienced physiological disruption of brain function (LOC, PTA, neurological deficits) as a result of an external force (i.e., a car accident). Although imaging was done and results were considered normal, a LOC for more than 30 minutes exceeds the range for mild TBI, moving the condition to the category of moderate TBI. Other common military events that may lead to moderate TBI are explosions, such as IED blasts.

Case example 2: Mild traumatic brain injury

Petty Officer First Class (PO1) Simmons reports sustaining a head injury 2 months ago when he slipped on ice on his way to work, partially caught himself, and hit his head. His immediate reaction was feeling "a little out of it." He did not lose consciousness, and he reported having a "headache, being more tired than normal, and being pretty irritable" for a few days afterward. PO1 Simmons went to the doctor but was told he did not need any imaging or medical tests. He reported that the headache went away, and he still felt a little irritable for a few more days. However, after about a week, he reported no ongoing problems.

PO1 Simmons meets criteria for a TBI because he experienced physiological disruption of brain function (AOC, neurological deficits) as a result of an external force (i.e., hitting his head on the ground). Although no structural imaging was conducted, it can be inferred that results would have been normal. There was no LOC or PTA, and AOC was under 15 minutes in duration. PO1 Simmons is therefore classified as having a mild TBI.

Table 7: Definition of Traumatic Brain Injury

A traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:	
•	Any period of loss of, or a decreased level of, consciousness (LOC).
•	Any loss of memory for events immediately before or after the injury (PTA).
•	Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.; alteration of consciousness/mental state [AOC]).
•	Neurological deficits (weakness, loss of balance, change in vision, difficulty planning or performing a movement, weakness/paralysis, sensory loss, loss of speech, loss of ability to understand spoken or written communications, etc.) that may or may not be transient.
•	Intracranial lesion (bleeding in the brain).

Note. Adapted from Department of Veterans Affairs & Department of Defense. (2016). *VA/DoD clinical practice guideline for management of concussion/mild traumatic brain injury* (version 2.0). Washington, DC: Author. Retrieved from <https://www.healthquality.va.gov/guidelines/Rehab/mtbi/mTBICPGFullCPG50821816.pdf>

Table 8: Classification of Traumatic Brain Injury Severity

Definitional Criterion	Mild	Moderate	Severe
Structural imaging	Normal	Normal or abnormal	Normal or abnormal
Alteration of consciousness	A moment up to 24 hr	More than 24 hr	More than 24 hr
Posttraumatic amnesia	0 to 1 day	2 to 7 days	More than 7 days
Glasgow Coma Scale (best within 24 hours of injury)	13 to 15	9 to 12	Less than 9

Note. Adapted from Department of Veterans Affairs & Department of Defense. (2016). *VA/DoD clinical practice guideline for management of concussion/mild traumatic brain injury* (version 2.0). Washington, DC: Author. Retrieved from <https://www.healthquality.va.gov/guidelines/Rehab/mtbi/mTBICPGFullCPG50821816.pdf>

Treatment

As noted previously, mild traumatic brain injury (mTBI) is the most common grade of TBI among Iraq and Afghanistan veterans, and is therefore the type of TBI that is most likely to be encountered by therapists. Research suggests that the overwhelming majority of individuals who suffer an mTBI will fully recover to preinjury functioning in a reasonably short period of time (Chapman & Diaz-Arrastia, 2014; VA/DoD, 2009), although long-term outcomes of mTBI are still poorly understood, even among civilian populations for whom many more studies are available. Although data suggest that the majority of individuals recover physically from mTBI, there is often ongoing emotional distress that can continue after the injury has healed (Chapman & Diaz-Arrastia, 2014). Physical problems are often strongly influenced by co-occurring psychological symptoms. Chronic pain and headache severity is strongly associated with mTBI, depression, and PTSD (Seal et al., 2017). Furthermore, patient expectations seem to play an important role in recovery. The use of the term *traumatic brain injury*, for instance, might inaccurately foster a perception of permanent and severe damage, relative to the term *concussion*, which is widely used

in the sports and medical fields and often conveys the sense that the injury is generally transient. Patients and therapists might therefore benefit from use of the term *concussion* when discussing past mTBI(s). Family members may also misinterpret the behaviors of the military member who is affected by mTBI. For instance, family members may view the service member as "lazy" or "unmotivated" when, in fact, he or she is experiencing the symptoms of mTBI (Butler, Hurley, & Taber, 2011). Education and support of the family are therefore important, especially for those with more caregiver responsibilities.

Several studies have considered the co-occurrence and overlap of TBI with other psychiatric conditions, especially PTSD (e.g., Jackson et al., 2016), and research on the treatment of PTSD with comorbid TBI is promising. Several clinical trials have examined the impact of TBI on treatment outcomes and have shown that TBI does not negatively affect results of treatment (Resick, Monson, et al., 2017). In the most recently updated manual for CPT by Resick, Monson, and colleagues (2017), adaptations for worksheets for use with patients are provided. However, many of the previous studies did not use these

adapted worksheets. Thus, it is generally recommended that patients with comorbid psychiatric condition and mTBI undergo the standard, indicated treatment for the psychiatric condition

Conclusion

Mental health issues have been rising among military personnel and veterans over the past decade. Although combat exposure is one important contributor to this rise, military personnel also experience a wide range of nondeployment stressors and problems that contribute to or exacerbate emotional distress. The consequences of untreated emotional strain are many and include death by suicide. Understanding the military context and embracing military cultural norms is a critical first step for improving mental health services provided to military personnel and veterans.

Clinicians who familiarize themselves with and commit themselves to providing the most effective treatments for

Resources

Treatment manuals

- Department of Veterans Affairs & Department of Defense. (2009). *VA/DoD clinical practice guideline for management of concussion/mild traumatic brain injury*. Washington, DC: Author.
- Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy: A comprehensive manual*. New York, NY: Guilford Press. This manual has many examples of the worksheets used in cognitive processing therapy and is available online. Website: <https://cptforptsd.com>

Online training

- Prolonged exposure therapy and cognitive processing therapy
Uniformed Services University of the Health Sciences/Center for Deployment Psychology
Website: <https://deploymentpsych.org/training/online-courses>
- Military culture
Uniformed Services University of the Health Sciences/Center for Deployment Psychology
Website: <https://deploymentpsych.org/military-culture>

Training workshops

- Brief cognitive behavior therapy for suicide risk/Crisis response planning
National Center for Veterans Studies
Website: <http://www.veterans.utah.edu/training.html>

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(e.g., PE or CPT for PTSD, CBT for depression, BCBT for suicide risk).

PTSD, depression, and common comorbid conditions are best positioned to help service members and veterans in need.

Clinical research for effectively treating military personnel and veterans is still growing; however, there is sufficient evidence to suggest that the treatments that are most effective for civilians are also highly effective for military personnel and veterans (as shown by many of the studies applying these treatments to military personnel.)

Therapists are encouraged to seek out advanced training in the treatments covered in this course. In many cases, additional training is free or of minimal cost. Information on obtaining additional training can be found in the Resources section.

Other resources

- Military culture
National Center for Veterans Studies
Website: <http://www.veterans.utah.edu/training.html>
- Worksheets for use in cognitive processing therapy, brief cognitive behavior therapy, and cognitive therapy can be downloaded from CPTWeb.
Website: <https://cpt.musc.edu/introduction>

Military suicide research

- Military Suicide Research Consortium
Website: <https://msrc.fsu.edu>
- National Center for Veterans Studies
Website: <https://www.veterans.utah.edu>

Military mental health

- Military Health System
Website: <https://health.mil/>

Suicide behaviors

- Information about the standardization of terms relating to suicide behaviors, as well as a practical clinical tool that can be downloaded to assist clinicians in differentiating between these types of self-directed violence and terms, are available at the website of the Veteran Administration's VISN 19 Mental Illness Research, Education and Clinical Centers (MIRECC).
Website: <http://www.mirecc.va.gov/visn19/education/nomenclature.asp>

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POSTCOMBAT-RELATED DISORDERS: COUNSELING VETERANS AND MILITARY PERSONNEL, 2ND EDITION

Final Examination Questions

Select the best answer for each question and complete your test online at [EliteLearning.com/Book](https://www.elitelearning.com/Book)

- From a multicultural perspective, mental health stigma among military personnel and veterans is due in large part to:
 - Insufficient outreach efforts.
 - Ineffective psychological treatments.
 - Differences in the diagnostic criteria in military and civilian populations.
 - Differences between the values of the military culture and the mental health system.
- Researchers have suggested that improved access to and engagement in mental health services by military personnel and veterans could occur through:
 - Increasing investment in outreach events.
 - Integrating strengths-based views of mental health.
 - Promoting discussion-based forms of treatment.
 - Conceptualizing mental health issues as illnesses.
- What is the most common mental health diagnosis among military personnel deployed to Iraq or Afghanistan:
 - PTSD.
 - Depression.
 - Anxiety.
 - Suicidal Ideation.
- When working with military and veteran patients, clinicians should recognize that when deployed:
 - All military personnel experience trauma.
 - Combat is the only source of posttraumatic stress disorder (PTSD) on deployment.
 - Almost all military personnel are directly involved in combat.
 - Daily hassles can augment the negative effects of combat exposure.
- After return from deployment, more severe psychological symptoms and alcohol-related problems among veterans are correlated with a:
 - Weaker sense of civilian identity.
 - Civilian identity that includes working for the military.
 - Total rejection of their military/veteran identity.
 - Balanced sense of civilian and military/veteran identities.
- Research suggests that intimate partner violence perpetration among veterans is almost times greater than civilian rates:
 - 2 times.
 - 4 times.
 - 3 times.
 - 5 times.
- Military spouses have increased stress during deployment cycles, and when the military member returns home:
 - Military spouses return to lower levels of stress.
 - Only the military member/veteran has difficulties transitioning.
 - Military spouses often act as a caregiver and should be cautious of burnout.
 - Life quickly returns to a similar pattern as before the deployment.
- The prevalence of PTSD among Iraq and Afghanistan veterans is estimated to be approximately:
 - 5%.
 - 15%.
 - 25%.
 - 35%.

69. When working with military personnel and veterans, a clinician should:
 - a. Not ask about traumatic events.
 - b. Focus on combat experiences.
 - c. Do a thorough assessment of traumatic experiences.
 - d. Diagnose veterans who have had combat exposure with PTSD.
70. PE is structured into 90- minute individual therapy sessions:
 - a. Ten.
 - b. Two.
 - c. Four.
 - d. Eight.
71. The prolonged exposure therapy intervention known as *imaginal exposure* directs the client to:
 - a. Describe the sights, sounds, smells, thoughts, emotions, and physical sensations associated with the traumatic experience.
 - b. Retrain their breathing so that they may control autonomic arousal when experiencing anxiety provoking situations such as large crowds.
 - c. Identify warning signs of an impending crisis and develop a written list of steps to take during future emotional crises.
 - d. Increase their social supports, positive emotional states, and complex coping skills in times of crisis.
72. What are the three primary cognitive response styles that produce different trauma reactions?
 - a. Accommodation, Under- accommodation, and Stimulation.
 - b. Impact Statement, EMDR, and Cognitive Therapy.
 - c. Cognitive Therapy, Accommodation, and Interpersonal Therapy.
 - d. Assimilation, Accommodation, and Over- accommodation.
73. Occurs when the individual adjusts his or her beliefs enough to incorporate new information from the trauma that might not align with these beliefs:
 - a. Assimilation.
 - b. Accommodation.
 - c. Over- accommodation.
 - d. Cognitive Therapy.
74. Cognitive processing therapy focuses on the failure to recover from a traumatic event by:
 - a. Using imaginal exposure.
 - b. Directly challenging maladaptive thoughts.
 - c. Diaphragmatic breathing.
 - d. Using psychopharmacology and interpersonal relationship deficits.
75. Benzodiazepines have been shown to:
 - a. Improve symptoms of all mental illnesses.
 - b. Increase avoidance of combat-related PTSD symptoms.
 - c. Stabilize a veteran's mood.
 - d. Increase physiological symptoms of anxiety in most veterans.
76. For individuals with comorbid PTSD and depression, use of exposure-based therapies results in:
 - a. Improved PTSD but no change in depression.
 - b. No change in either PTSD or depression.
 - c. Improved depression but no change in PTSD.
 - d. Improved PTSD and depression.
77. For individuals with "pure" depression, which of the following therapies should be used as a first-line defense?
 - a. Prolonged exposure therapy.
 - b. Internal Family Systems therapy.
 - c. Interpersonal psychotherapy.
 - d. Crisis response planning.
78. In using cognitive therapy to treat depression, the therapist assists the patient in deactivating the depressive mode through identifying, evaluating, and challenging negative beliefs, and in establishing plans to:
 - a. Increase the person's engagement in meaningful activities.
 - b. Increase the person's use of medication.
 - c. Decrease the person's responsibilities at work.
 - d. Decrease the person's interactions with others.
79. Cognitive therapy for depression focuses on:
 - a. The underlying biological mechanisms of depression.
 - b. Interpersonal relationships.
 - c. How thoughts, feelings, and behaviors and emotions interact.
 - d. Exploring the past and not moving to the present until there is an inner calm.
80. The treatment that has shown benefits for reducing repetition of suicidal behaviors is:
 - a. Group cognitive processing therapy.
 - b. Individual cognitive behavioral therapy.
 - c. Inpatient psychiatric hospitalization.
 - d. Antidepressant medication.
81. Brief cognitive behavioral therapy has been shown to reduce suicide attempts because it:
 - a. Emphasizes accessing therapists as the first step in managing distress.
 - b. Encourages the use of psychopharmacology as a stand-alone treatment.
 - c. Places suicide risk as the primary focus of treatment.
 - d. Directs clinicians to focus on issues other than suicide risk.
82. As the first step in their crisis response plan clients are encouraged to:
 - a. Contact their therapist immediately when stressors occur.
 - b. Use self-management tools during stressful times.
 - c. Sign a no-harm contract.
 - d. Go to the closest emergency room.
83. The self-medication hypothesis explains that suicide risk is increased among individuals who abuse alcohol because:
 - a. Depression is improved by alcohol use.
 - b. Alcohol use and suicide both function to reduce emotional distress.
 - c. PTSD is associated with both alcohol use and suicide.
 - d. Alcohol use and suicide risk both require inpatient care.
84. The most common category of traumatic brain injury is:
 - a. Mild.
 - b. Moderate.
 - c. Severe.
 - d. Permanent.
85. While deployed, a veteran reports he was struck in the head by a brick following an explosion and lost consciousness for about an hour. After waking up, he was nauseous, complained of vertigo, and blurred vision. His doctor ordered a brain scan, and it returned normal. This veteran's severity level for traumatic brain injury should be ranked as:
 - a. A concussion.
 - b. Mild.
 - c. Moderate.
 - d. Severe.

Chapter 5: Self Injury in Adults and Adolescents, 2nd Edition

3 Contact Hours

Release Date: February 2, 2019

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Upon successful completion of this course, continuing education hours will be awarded as follows:

- **Social Workers and Psychologists: 2 Hours**
- **Professional Counselors: 3 Hours**

Faculty

Author: Edward A. Selby, PhD, is the director of clinical training and an associate professor in the clinical psychology program at Rutgers University in New Brunswick, New Jersey. Dr. Selby has extensive research and clinical experience in improving our understanding and treatment of self-injurious behavior. He has published 80 peer-reviewed publications and book chapters – many of which examine nonsuicidal self-injury and suicidal behavior – and serves on the editorial boards of the *Journal of Abnormal Psychology*, *Suicide and Life-Threatening Behavior*, and the *Journal of Clinical Child and Adolescent Psychology*. Much of his work is aimed at understanding the emotional experiences that precede the onset of self-injury, as well as the negative emotional and social consequences that result from such behavior. His recent work has also involved preliminary investigations of the newly proposed nonsuicidal self-injury disorder. Funding has been awarded for Dr. Selby's research by the National Institute of Mental Health, the Brain and Behavior Research Foundation, and the Association for Behavioral and Cognitive Therapies. Dr. Selby has been extensively trained in major treatments for self-injurious and suicidal behavior, including cognitive behavioral therapy, dialectical behavior

therapy, and mindfulness-based interventions. Dr. Selby's recent work involves developing new treatments for emotional and behavioral problems, including self-injury, using daily digital assessment with smartphones.

Edward A. Selby has no significant financial or other conflicts of interest pertaining to this course.

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Rhonda Goodman has no significant financial or other conflicts of interest pertaining to this course.

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The planner who worked on this continuing education activity have disclosed that they have no significant financial or other conflicts of interest pertaining to this course book.

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INTRODUCTION

Learning objectives

After completing this course, the learner will be able to:

- Define self-injury, including its prevalence and common presentations.
- Explain the historical classification of self-injury and its inclusion as a disorder for further investigation in *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5).
- Identify the developmental trajectories for self-injury in adolescents and adults.

- Identify factors that commonly contribute to the development of self-injury, the possible functions of self-injury, and the health consequences of self-injury.
- Describe approaches to assessing self-injurious thoughts, behaviors, and methods.
- Differentiate self-injury from other diagnoses and comorbidities.
- Explain the approaches to treating self-injury.

Course overview

Self-injury is a serious behavioral problem in which an individual purposefully inflicts damage to his or her body through methods such as cutting, scratching, burning, or other activities in the absence of suicidal intent. Research indicates high prevalence rates of self-injury, with between 13% and 45% of adolescents reporting having purposely self-injured at least once, and 4% to 28% of adult clinical populations reporting a lifetime occurrence of the behavior (Bentley, Nock, & Barlow, 2014; Plener et al., 2016). Common methods of self-injury include skin cutting, scratching to the point of drawing blood, head banging or hitting, burning, and inserting sharp objects into the skin, among other methods. This behavior can result in serious medical complications and is a known risk factor for later suicidal behavior. Yet despite the seriousness of this behavior, many clinicians are uncertain about self-injury's diagnostic implications or the best methods for treating it. The psychosocial determinants of self-injury are of considerable interest to clinicians, educators, and researchers because a better understanding of these factors may inform selection of appropriate treatment approaches. Furthermore, the *DSM-5* (American Psychiatric Association [APA], 2013) includes a new disorder, nonsuicidal self-injury disorder (NSSI disorder), for

future consideration as a validated *DSM* diagnosis. The inclusion of this disorder in *DSM-5* highlights the clinical and public health importance of a severe behavior that has until recently been understudied and overlooked in clinical settings.

The purpose of this intermediate-level course is to provide clinicians with the most up-to-date information on self-injury so they are better able to assess for the presence of the behavior and provide the best possible treatment. The course describes the various presentations of self-injury, presents a history of the diagnosis, and details developmental considerations, risk factors, and possible biopsychosocial functions of self-injury. Attention is then paid to assessing, diagnosing, and treating self-injury in a variety of settings, including mental health and school settings. The course is intended for human service and healthcare professionals, including social workers, mental health counselors, psychologists, and marriage and family therapists.

"Patient" is the standard term in primary care and hospital settings, and "client" is the preferred term in most behavioral health and outpatient settings. These terms are used interchangeably in this course.

SELF-INJURY DEFINITIONS, PRESENTATIONS, AND PREVALENCE

Self-injury is defined as the direct and deliberate destruction of bodily tissue in the absence of lethal intent or suicidal ideation (Bentley et al., 2014; Hooley & Franklin, 2018); it is a behavior that can involve a wide variety of methods, including cutting, scratching, burning, or hitting oneself. This behavior is done with purposeful intent to inflict either harm or pain upon the individual's own body, often for a variety of motivations. It is important to emphasize that *self-injurious behavior* refers to self-harming behavior that is not motivated by suicidal desire or intent (which would be more appropriately called a suicide gesture or attempt; Nock, 2010). In contrast, a suicide attempt consists of enacting a potentially lethal self-injurious behavior with the purposeful intent of ending one's life (Nock, 2010). Because of the frequent confusion with suicidal behavior, self-injurious behavior that exhibits no suicidal intent is often referred to as nonsuicidal self-injury (NSSI). There are also other common terms for self-injury, including *deliberate self-harm*, *self-mutilation*, or *parasuicidal behavior*, all of which are different names referring to the behavior of NSSI. These terms, however, tend to be vague, outdated, and less frequently used. In this course, NSSI will be referred to simply as self-injury.

In addition to differentiating self-injury from suicidal behavior, it is also important to differentiate self-injury from other behaviors that are often considered indirect forms of self-harm (Nock, 2010). Common examples of indirect self-harming behavior that people often confuse with direct self-injury include using substances, eating poorly, smoking, reckless driving, anorexia, neglecting hygiene, or even quitting a job. These behaviors are not considered self-injury because, although they can be harmful to a person's health and well-being, they are not engaged in with the purpose of intentionally causing bodily destruction. Similarly, self-injurious behaviors such as head banging or hitting oneself, which are often found in pervasive developmental disorders such as autism spectrum disorders or intellectual disabilities, are not considered self-injury in the current context, because the purpose of such behavior in individuals with developmental delays is difficult to ascertain. Thus, in the present context, self-injury applies to adolescents and adults who are developmentally appropriate and cognitively developed.

Although prevalence estimates for self-injury vary widely by the study and population examined, epidemiological research consistently indicates high prevalence rates of self-injury. A review by Bentley, Nock, and Barlow (2014) indicated that prevalence rates of self-injury fall between 13% and 45% among adolescents in the general population and between 40% and 60% among adolescents receiving mental health treatment in

some form. Among adults, prevalence rates range from 4% to 28% in the general population, and among adults receiving some type of mental health treatment, they range from 19% to 25% (Bentley et al., 2014; Klonsky, 2011; Nock, 2010). Often, the highest rates of self-injury are found among high school-aged adolescents (Nock, 2010), and the second highest rates are found in college-aged young adults (Taliaferro & Muehlenkamp, 2015). These high prevalence rates of self-injury are alarming, given that the behavior is associated with numerous deleterious consequences. Despite the high frequency of self-injury, however, the majority of adolescents and young adults that self-injure appear to do so only a few times (Klonsky, 2011). However, in samples in which the participants are receiving mental health treatment, the majority of persons who self-injure engage in the behavior much more frequently, with some studies reporting more than 1,000 instances of self-injurious behavior (Andover & Gibb, 2010).

The most common method of self-injury is skin cutting (70% to 90% of persons who self-injure), followed by head banging or hitting (21% to 44%), and then burning (15% to 35%; Bentley et al., 2014; Klonsky, 2007). As stated earlier, cutting is the most common form of self-injury. It is typically implemented with a sharp object such as a razor or knife, and cuts are frequently made on the arms or legs. However, cutting can also include inflicting injuries to other parts of the body, such as the stomach or, in some instances, the genitals (Bentley et al., 2014; Nock, 2010). Other forms of self-injury can include scratching to the point of drawing blood, pinching, hair pulling, inserting objects such as sharp pins under the skin, and even breaking one's bones purposefully (Gratz, 2001; Hawton, Saunders, & O'Connor, 2012). Finally, there are some behaviors that can be considered forms of self-injury in some individuals, but can be difficult to classify because they overlap with normative behavior or other conditions.

Examples of these behaviors include skin picking (a behavior typically identified as a symptom of excoriation), hair pulling (identified as a symptom of trichotillomania), picking at wounds, and biting the lip. In cases in which these latter behaviors are the only potentially self-injurious behaviors present, it may be important to perform additional assessment to ensure that a behavior is not inappropriately being considered as self-injurious. Thus, self-injury can take a variety of forms with a differing level of severity. However, it is also important to clarify that most individuals who engage in self-injury employ multiple methods (Nock et al., 2006; Nock, 2010). A list of common presentations and methods of self-injury can be found in Table 1.

The age at which self-injury typically begins is between 12 and 14 years (Hawton et al., 2012; Nock, 2009); however, because self-injury in younger populations is difficult to study, it is unclear to what extent children younger than age 12 engage in self-injury. In addition, there are instances in which the behavior starts later in adolescence or in young adulthood (Hawton et al., 2012) and, less commonly, in adulthood (Klonsky, 2011), and the vast majority of those who self-injure once go on to self-injure a number of additional times (Klonsky, 2011).

Regarding the demographic features of those who self-injure, girls and women tend to be at higher risk for self-injury (Andover, Morris, Wren, & Bruzese, 2012; Bresin & Schoenleber, 2015). Some research suggests that self-injury is not only more common among females than males, but also more stable and less likely to remit among females, at least during adolescence (Bresin & Schoenleber, 2015; Moran et al., 2012; Zetterqvist, Lundh, Dahlström, & Svedin, 2013). Research examining the effects of race on self-injury has been inconsistent and is limited by a dearth of non-Caucasian samples (Jacobson, Muehlenkamp, Miller, & Turner, 2008; Muehlenkamp & Gutierrez, 2004). However, self-injury has been reported among various ethnic and racial groups and occurs at all family income levels (Klonsky, 2011).

HISTORY AND DIAGNOSTIC STATUS OF SELF-INJURY

Over the past two decades, the understanding of self-injury has increased dramatically. In fact, based on accumulating evidence, self-injury has increasingly been conceptualized as a distinct behavioral pattern that may warrant its own diagnostic label, leading to the inclusion of self-injury as a disorder in need of further investigation in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*; APA, 2013). However, in order to appreciate the progress that has been made in understanding self-injury, it is important to examine how self-injury has historically been viewed within the context of the *DSM*.

Until recently, self-injury had been included in the *DSM-III* (APA, 1980) and *DSM-IV/DSM-IV-TR* (APA, 2000) only as one criterion of borderline personality disorder (BPD). However, clinical descriptions of self-injury have existed for several decades, even if a full appreciation of this behavior has emerged only recently. For example, Pao (1969) was one of the first to call for recognition of self-injury as a disorder, as well as the first to distinguish between suicidal and nonsuicidal self-injury. Pao examined clinical admissions to a psychiatric hospital and found that more than 7% of patients purposefully engaged in cutting themselves. Although a number of these individuals reported suicidal intent, many appeared to make repetitive, superficial, delicate, and carefully placed incisions without suicidal intent. A few years later, Rosenthal and colleagues (1972) published a report on the potential for a "wrist-cutting syndrome." This syndrome was characterized by nonlethal self-injury without suicidal intent that was primarily present in young women and that often arose as a response to difficulties with emotional experience and states of depersonalization.

The inclusion of self-injury in *DSM-III* (APA, 1980) as a criterion for BPD was in part the result of an increasing understanding of the connection between self-injury and BPD. Gunderson and Singer (1975) provided one of the earliest and most comprehensive conceptualizations of BPD, including "self-mutilation" as an example of the underlying difficulties with impulsive and self-destructive behavior in the disorder. However, in *DSM-III* (APA, 1980) self-injurious behavior was removed from the general impulsivity criterion and instead combined with suicidal behavior as an independent criterion.

In 1983, Pattison and Kahan continued to extend the understanding of self-injury when they examined a small literature of case studies and identified a recurrent pattern of deliberate, low-lethality self-injury that frequently presented in late adolescence and persisted over many years. Although they

Table 1: Presentation and Methods of Self-Injury

- Cutting with a razor.
- Burning with a cigarette.
- Severe scratching.
- Punching self.
- Head banging.
- Burning (e.g., with a cigarette lighter, match, or other item).
- Carving words or pictures into skin.
- Biting.
- Sticking pins, needles, staples, or other objects into skin.
- Cutting with glass.
- Picking at wounds or preventing them from healing (rule out excoriation).
- Pulling hair (rule out trichotillomania).
- Other methods – usually rare (swallowing objects, breaking bone, dripping acid on skin, rubbing bleach on skin).

proposed inclusion criteria for a potential self-injury syndrome for the *DSM-IV*, these criteria failed to make their way into the publication. Favazza and Rosenthal (1993) similarly examined the scientific literature and classified three primary forms of self-injury:

- Infrequent self-injurious behavior that often results in major tissue damage and is frequently associated with psychosis and substance use.
- Stereotypic self-injurious behavior that is frequently associated with developmental disorders.
- Frequent moderate self-injurious behavior that is associated with a variety of mental disorders and commonly takes the form of skin cutting, burning, and scratching.

Pattison and Kahan (1983) recommended that this final form of self-injury be classified as a distinct Axis I disorder, under the impulse control disorders section of the *DSM-IV*. Muehlenkamp (2005) again examined the literature, found substantial evidence that self-injury was a prevalent problem, and also proposed the creation of a self-injury syndrome in the next iteration of the *DSM*.

This growing body of research and the multiple calls for inclusion of a self-injury disorder were finally recognized during the preparation of *DSM-5*, when the Childhood and Mood Disorders workgroups generated a proposal for the inclusion of self-injury disorder in the next revision (Shaffer & Jacobson, 2009). Although this proposed disorder was not included as a formal diagnosis in *DSM-5*, the criteria proposed by Shaffer and Jacobson (2009) were eventually modified and adopted in the *DSM-5* section for disorders needing further investigation (APA, 2013).

The absence of self-injury from the *DSM* until recently has not fully impeded the study of self-injury, however. Since its first description decades ago, a substantial literature and understanding of the behavior have developed. For example, findings from a study by Glenn and Klonsky (2013) also confirm that self-injury has clinical significance beyond its association with BPD. The authors examined the association between self-injury disorder and clinical impairment, and whether this association remained significant after controlling for a BPD diagnosis. Results indicated that self-injury predicted suicidal ideation and the presence of suicide attempts in the past month, as well as emotion dysregulation and loneliness, above and beyond BPD. These findings indicate that self-injury has clinical significance beyond its association with BPD and that self-injury predicts impairment in behavioral, emotional, and interpersonal

domains. Furthermore, In-Albon and colleagues (2013) provided evidence that 80% of adolescents who met criteria for self-injury disorder did not meet criteria for BPD, and adolescents with self-injury disorder had a higher level of impairment (e.g., elevated rates of internalizing and externalizing symptoms, more difficulties with emotion regulation, and lower functioning) than adolescents with other mental disorders. These findings provide evidence challenging the assumption that self-injury is unlikely to

occur outside of a BPD diagnosis and highlight the importance of assessing and treating self-injury even in those without a BPD diagnosis (Selby, Kranzler, Fehling, & Panza, 2015). More research is likely to further establish the utility of a self-injury disorder diagnosis, in addition to improving our understanding of self-injury and how best to treat such behavior (Selby et al., 2015).

DEVELOPMENTAL TRAJECTORIES FOR SELF-INJURY

One reason that self-injury has been a particularly difficult behavior to study is that it is a behavior that spans adolescence and adulthood. The highest prevalence rates of self-injury are found in adolescents and high school-aged individuals (Bentley et al., 2014), and self-injury most commonly has its onset during early adolescence, typically considered ages 11 to 14 years (Ferrara, Terrinoni, & Williams, 2012); however, self-injury is relatively common in adulthood and can potentially have its onset in adulthood (Klonsky, 2011; Plener et al., 2016). Further complicating an already complex behavior, self-injury rates have increased in frequency over the past few decades (Hooley & Franklin, 2018), possibly due to increased stress facing adolescents, possible social promotion of the behavior through online and social media, and increased identification of self-injury in clinical settings as the knowledge base about the behavior has grown.

Thus, any discussion of self-injury needs to recognize that, although it is a behavior that affects many adults, the majority of persons who self-injure begin the behavior in early adolescence. Accordingly, it is important to consider the developmental factors associated with self-injury.

One of the first important issues to consider with self-injury in adolescents is that it is a very common behavior, particularly among adolescents in high school (Plener et al., 2016). Despite being a common behavior, self-injury is still problematic and associated with multiple harmful outcomes that should not be dismissed (Bentley et al., 2014; Nock, 2010). Any individual, particularly an adolescent, who self-injures should be further assessed to determine the extent and severity of the behavior, and provided treatment if necessary.

Another important developmental issue to consider with self-injury is that for many adolescents the behavior lacks stability (Moran et al., 2012; Plener et al., 2016; Wichstrom, 2009). What this means is that if a group of adolescents who self-injure were reassessed at a later time, say 1 to 2 years later, most of them would have ceased engaging in self-injury during that time period. Along these lines, a majority of persons who are identified as self-injuring during adolescence cease the behavior, even without intervention, as they transition into adulthood. For example, Plener, Schumacher, Munz, and Groschwitz (2015) conducted a metaanalytic study of the course of NSSI. Overall, NSSI was found to increase throughout adolescence, but the prevalence of those who self-injured decreased into young adulthood. This was consistent with a previous study which indicated that 2.4% of participants reported self-injury at an initial assessment, and among this group only 9.9% of the participants at baseline also reported self-injury during follow-up 5 years later (Wichstrom, 2009). This finding suggests that self-injury may naturally remit for many adolescents. However, for approximately 10% of adolescents who self-injure, the behavior continues even 5 years later and potentially beyond

that. Moran and colleagues (2012) also conducted a longitudinal study of the natural course of self-injury among a large sample of adolescents, following them from age 14 to age 29. Results from this study indicated that there was a significant reduction in the proportion of individuals reporting self-injury during late adolescence and young adulthood, with 7.4% of all participants reporting self-injury in adolescence but not in young adulthood, and only 0.8% of all participants reporting self-injury in adolescence that continued into young adulthood.

However, reports of any self-injurious behaviors during adolescence were strongly associated with subsequent self-injurious behaviors in the young adult phase, for girls in particular. Accordingly, these studies suggest that, although self-injury may in fact be a transient behavior for a subset of adolescents, self-injury is also a stable behavior that persists into adulthood for a significant proportion of adolescents. Although it is important to understand that self-injury is common among adolescents and young adults, self-injury is also known to lead to severe psychological, interpersonal, medical, and fatal consequences (Rockett & Caine, 2015; Turner, Cobb, Gratz, & Chapman, 2016). Although the presence of self-injurious behavior in any individual is linked with a number of harmful outcomes and should be thoroughly assessed and treated, the majority of individuals who self-injure will cease the behavior as adulthood progresses. That being said, many people who begin to self-injure as adolescents persist well into adulthood. This makes clinical assessment and treatment of any individual who self-injures a necessary and important clinical response to the behavior.

Another particularly salient issue when dealing with adolescents and young adults who self-injure is the emergence over the past two decades of websites promoting self-injurious behavior that have propagated widely (Lewis & Seko, 2016). Although much of the research on the role of the Internet and social media on promoting self-injury is still in the early stages, preliminary findings suggest that many adolescents are attracted to self-injury websites in the hope of finding social support that is absent from their existing social connections (Lewis & Seko, 2016). Many who self-injure also post pictures of their injuries on social media outlets, such as Instagram, and often receive supportive comments from others (Brown et al., 2018). Even if users are receiving some support and encouragement to seek treatment, self-injury content on websites and social media is particularly problematic because they normalize and promote self-injury (Cha et al., 2016) or even introduce self-injury to adolescents who have yet to engage in it. They may also decrease the site visitor's desire to seek help. Thus, it would be beneficial for any clinician or family member working with a self-injuring adolescent to determine how much, if any, of his or her behavior is tied to Internet or social media activity.

DISCOVERY AND DISCLOSURE OF YOUTH SELF-INJURY

In recent years societal awareness of self-injurious behavior as an important developmental issue has drastically increased, relative to a generation ago. That being said, awareness and knowledge of self-injury is still underdeveloped in many health, clinical, and educational settings. Likewise, the general public remains relatively unaware of the prevalence and danger of self-injury. This is particularly problematic, as self-injury is a particularly provocative and inherently upsetting behavior to most who face

it. Indeed, it is common for parents of youth to react with shock, surprise, or anger when self-injury is discovered or disclosed (Walsh, 2014). Such responses are also common for parents of young adults. It is also common for parents to feel either guilty or dismissive of the youth's self-injurious behavior, which may increase the importance of incorporating family involvement in the youth's treatment.

When self-injury is disclosed to or discovered by a clinician or parent, there are a few important considerations of which they should be aware. First, despite potential feelings of shock at observing or learning about the behavior, the most important response is a sense of calmness or even curiosity. This is because an overly emotional response by a parent, caregiver, or educator (e.g., of fear, anger) may escalate the situation or prevent future disclosure. Calmness is necessary, though it might feel inappropriate, because a calm and level head is needed to ensure: (1) that the injury is not life-threatening and is properly dressed, (2) that the youth feels that trust can be established, (3) that additional stigmatizing or criticizing remarks are not made, which may then serve to instigate additional self-injurious behavior, and (4) that a proper plan of intervention is initiated.

Treatment approaches will be discussed shortly, but there are a few key issues to consider upon discovery or disclosure of self-injury. First, even if an injury appears severe, the severity of the wound can be misleading based on the amount of blood present. At times, even small, superficial wounds will bleed heavily if made to skin tissue with high vascular content, making the wound appear worse than it actually might be. Thus, care should be taken to stop any bleeding and gently clean the wound before determining if further medical intervention is necessary. Second, self-injurious behavior can occur in the context of a suicide attempt, so additional, calm follow-up questions should be used to determine if the self-injury was related to suicidal thoughts or a suicide plan, and additional suicide risk assessment and intervention may be needed. Third, the youth should have an opportunity to explain why self-injury has occurred, without receiving criticism or judgment. This should be followed with a firm insistence that even if the causes of self-injury are understandable, additional emotional support and intervention are still necessary. Finally, keep in mind that many who self-injure discontinue or mature out of the behavior as they age, and further intervention may expedite this process and possibly prevent future behavior.

One final issue that can arise with youth disclosure of self-injury in clinical settings is a potential issue for needing to break youth patient confidentiality. It is common for youth in a treatment setting to disclose self-injury to their clinician or health provider, and to request that the provider not disclose the behavior to the youth's parents. This presents a particular dilemma for clinicians: There may be a need to disclose the behavior to parents in order to ensure the safety of the youth, but disclosing self-injurious behavior against the youth's wishes is likely to impede trust

or therapeutic alliance. Indeed, disclosure against the youth's wishes may break the youth's trust of the clinician completely.

If such a scenario arises, the provider or clinician should first determine what kind of confidentiality disclosure (if any) a youth's parents have made with the clinician – parents have a right to know the details of a youth's treatment and are privy to essential health information. However, in many youth treatment scenarios parents are willing waive this privilege upon being informed that it can impede treatment, especially if the patient is an adolescent and knows that parents can learn the details of therapeutic content. If the parents/guardian have not signed such a disclosure for their child, then the primary focus of the clinician is the health and safety of the youth, and the parents should be made aware of the youth's self-injurious behavior – even if self-injurious behavior is mild or trust is impeded. This will often be the case for school educators and health staff, who typically do not have a confidentiality agreement with a youth patient. Failure to make parents aware of self-injurious behavior could lead to the behavior going unnoticed or being ignored, and parents also have responsibility to address self-injurious behavior when it is brought to their attention, as failing to do so could be considered a situation of neglect.

On the other hand, when parents have waived their right to know about a youth's therapeutic discussions (often in the context of working with a youth counselor, school psychologist/counselor, or social worker), the decision process is somewhat more complex. In these scenarios, the first necessity is a thorough assessment of suicidal ideation and risk. In cases where suicidal ideation is absent and severity of self-injurious behavior is mild (e.g., scratching, pinching) risk is typically lower, and disclosure of such behavior to parents may damage therapeutic alliance. Likewise, in cases where self-injury is moderate (e.g., actual cuts, lacerations, puncturing, bleeding), but frequency is less than once per month and suicidal ideation is absent, the clinician may be justified in waiting to disclose behavior until, with close monitoring, the youth deteriorates further and suicidal ideation appears or frequency of self-injury increases. In any other situation, however, where self-injury is moderate or severe and frequent, or suicidal ideation is present in conjunction with self-injurious behavior (even mild), then the clinician should make the youth's parents aware and work to facilitate the safety of the youth. Further information on how to approach the assessment and disclosure of self-injury in youth settings can be found in the following handout created by the Cornell Research Program on Self-Injury and Recovery: <http://www.selfinjury.bctr.cornell.edu/documents/schools.pdf>.

Case vignette 1

Benjamin was an African American adolescent and high school junior who was actively engaged in school athletics. In particular, he was a sprinter on the track team and was particularly competitive in state-level competitions. By all measures, Benjamin was a well-adjusted, well-liked, and academically proficient student, and he did not appear to have any particular mental health symptoms at the time, such as depression or anxiety. However, Benjamin engaged in unobserved self-injurious behavior on a regular basis. In particular, if Benjamin performed inadequately during a sprint, during either training or overt competition, he would respond with intense anger. Importantly, inadequate performance was defined by Benjamin as failing to meet his own high standards and was not a function of peer or adult criticism. Accordingly, in scenarios of rage at having underperformed, Benjamin would excuse himself from social surroundings, typically to an area of obscured visibility or a restroom, and he would then proceed to kick himself in the legs, raking and driving his track spikes into his calf muscles. Track spikes are very sharp and occasionally lead to injuries during competition, especially if contact with another runner is involved. In Benjamin's case, such self-injury led to a reduction in his anger, primarily due to feelings of having deserved punishment for poor performance. In most cases, Benjamin's

leg injuries went unnoticed as he was typically able to stop the bleeding prior to returning to the field, or any visible injuries were (apparently) misattributed to contact with another runner.

Benjamin's self-injurious behavior continued unnoticed into his senior year and remained restricted to athletic activities. However, on one occasion during track season his behavior was observed by coaching staff. Coaching staff was understandably confused and concerned about Benjamin's behavior and confronted him about it. He lied to them about the behavior's frequency, saying it had happened only a few times, and he characterized the behavior as "no big deal." Though his coaching staff was worried about this provocative behavior, given Benjamin's high level of functioning and absence of other major mental health symptoms (at least from the perspective of high school athletics staff), they agreed not to inform school health authorities or Benjamin's parents.

No one else was aware of Benjamin's self-injurious behavior until his second year of college. At this time he presented at his university-based counseling center for stress and anxiety about school, and during his discussion with his clinician he disclosed his self-injurious behavior, which had continued to occur in the context of college-level athletics. It was only in the context of working with a mental health professional that Benjamin came

to fully appreciate his self-injurious behavior as being connected to a more fundamental difficulty coping with his high standards for performance. Although Benjamin's case was moderate in contrast to many severe self-injury cases, it's noteworthy on two counts: (1) his case illustrates the type of self-injury where the behavior is rightfully concerning, but escapes notice by others long enough that the individual discontinues the behavior

at some point as a young adult; and (2) it also displays the importance of early intervention and careful attention and assessment by education and clinical professionals working with youth. Had Benjamin's coaching staff pursued further evaluation of the behavior or disclosed it to his parents, he may have received intervention earlier, which may have prevented further distress and need for intervention at a later point in life.

RISK FACTORS FOR SELF-INJURY

There is no single, required risk factor for the development of self-injury. Instead, there are a number of risk factors that predispose individuals to self-injury, and the more of these risk factors an individual has, the more likely it is that self-injury will be a problem. Risk factors for self-injury can be roughly divided into three primary types: biological, psychological, and social. Many of these risk factors interact with each other in a dynamic, synergistic fashion to lead to the development of self-injury (Hooley & Franklin, 2018; Selby, Kranzler, Panza, & Fehling, 2014), such that biological vulnerabilities can be compounded by problematic family or peer environments, and then further compounded by other cognitive or social risk factors. The risk factors to be discussed are outlined in Table 2.

Biological factors

A growing body of research has revealed that there are important biological precursors to the development of self-injury. For example, it has been estimated that genetic factors account for 37% of the cause for self-injury in men, and 59% in women, which means that familial and genetic factors likely contribute much to the development of self-injury, especially for women (Maciejewski et al., 2014). Specific genetic contributions to self-injury are unknown, and genetic risk often applies to multiple forms of psychopathology and is often nonspecific to a particular outcome such as self-injury. In line with this notion, no studies have consistently identified a specific gene related to self-injury, although there is increasing evidence that genes

Psychological factors

To date, numerous psychological risk factors for self-injury have been identified. One of the biggest predictors of the development of self-injury is the presence of preexisting psychopathology, including depression, anxiety disorders, conduct disorder, BPD, eating disorders, and substance use disorders (Cucchi et al., 2016; Hawton et al., 2012; Nock, 2010). The development of a diagnosis of depression or a negative thinking style has been found to predict onset of self-injury (Hankin & Abela, 2011), as does having a low global sense of self-worth (Aggarwal, Patton, Reavley, Sreenivasan, & Berk, 2017). Similarly, having elevated levels of anxiety and anxiety disorders is another risk factor for self-injury (Aggarwal et al., 2017). It is thought that many of these disorders set the stage for eventual development of self-injury because many involve elevated stress levels and the potential for distressing emotions, which may then lead to the use of self-injury as a coping strategy (Bentley et al., 2014; Voon et al., 2014).

Another risk factor for self-injury involves poor or underdeveloped coping skills when responding to stressful situations (Voon et al., 2014). For example, people who self-injure have been demonstrated to respond to frustrating tasks with elevated physiological arousal and difficulties tolerating the experience of distressing emotions (Nock & Mendes, 2008). It is thought that, because those who self-injure have not had the opportunity to learn healthy and effective coping skills, they may engage in self-injury as a method of coping with upsetting thoughts and emotions (Selby, Franklin, Carson-Wong, & Rizvi, 2013).

In addition to difficulties regarding coping with stress, there are also important cognitive vulnerabilities for self-injury. Presence of a negative thinking style increases risk for self-injury (Aggarwal et al., 2017). Another cognitive risk factor that has been associated

Table 2: Risk Factors and Associated Features of Self-Injury	
<ul style="list-style-type: none">• Genetics.• Female sex.• Maternal depression.• History of physical or sexual abuse.• Maternal borderline personality disorder.• Major depressive disorder.• Anxiety disorder.• Eating disorder.• Alcohol or other substance use disorder.	<ul style="list-style-type: none">• Disordered body image.• Low global sense of self-worth.• Poor coping skills.• Rumination.• Thought suppression.• High conflict family environments.• Minority sexual orientation.• Peer rejection.• Bullying.

involved in serotonergic neurotransmission may be linked to self-injurious behavior (Turecki & Brent, 2016). Beyond genetics, there are other heritability factors that increase risk for self-injury. For example, it has been shown that an individual's mother having depression increases the likelihood of self-injury (Hankin & Abela, 2011). Furthermore, if an adolescent or adult's mother has difficulties with emotional reactivity, self-injurious behavior, or BPD, then that individual has elevated risk for self-injury (Turecki & Brent, 2016). Thus, as our genetic, physiological, and neurological research methods continue to improve, it is likely that additional biological risk factors for self-injury will be identified.

with self-injury is a process called "rumination" (Gardner, Dodsworth, & Selby, 2014; Hasking, Whitlock, Voon, & Rose, 2017; Nolen-Hoeksema, 1991), which refers to a tendency to think repetitively and persistently about upsetting situations and emotions, and to focus on the causes and consequences of such upsetting situations. It has been suggested that individuals who self-injure may do so as a way of providing physical distraction from rumination (Selby, Anestis, & Joiner, 2008; Selby, Nock, & Kranzler, 2014). Using experience sampling methods, in which participants record their emotional, cognitive, and behavioral experiences multiple times daily on a digital device, Selby and colleagues (2013) found that higher levels of rumination predicted an increased frequency of self-injury over the next 2 weeks in a sample of impulsive individuals. Similarly, in a sample of Chinese adolescents, rumination levels predicted a more chronic course of self-injury over time (Barrocas, Giletta, Hankin, Prinstein, & Abela, 2014).

Another problematic thinking style, highly related to rumination, which may be involved in self-injury is thought suppression (Hasking et al., 2017). Thought suppression refers to a deliberate attempt to reduce the frequency or intensity of unpleasant cognitions – in other words, trying not to think about something (Wenzlaff & Wegner, 2000). Meta-analytic studies suggest that purposeful attempts to suppress undesired thoughts may actually have a paradoxical rebound effect in which the frequency of the unwanted thought increases following efforts to suppress it (Wenzlaff & Wegner, 2000). Accordingly, attempts to suppress unwanted thoughts may increase the intensity of those thoughts, cause further rumination, and lead to increased emotional distress (Selby & Joiner, 2009). For example, there appears to be a strong link among thought suppression, rumination, and self-injury (Tuna & Bozo, 2014). Other research has indicated that thought suppression may play a role in self-

injury, where attempts to push negative thoughts away lead to increased intensity of those same thoughts and more likelihood of self-injury (Hasking et al., 2017). These maladaptive thought

Social and cultural factors

In addition to biological and psychological risk factors, a number of social and interpersonal risk factors for self-injury have been established. With regard to cultural differences, most self-injury research has taken place in Western countries, and self-injury is under-researched in non-western countries. However, the work that has been done has found that self-injury does occur in numerous non-western countries, including China, Japan, Hong Kong, Indonesia, Taiwan, and Turkey (Gholamrezaei, De Stefano, & Heath, 2017). These studies have generally found that the risk factors for self-injury in non-western regions are comparable to Western risk factors, but the prevalence of the behavior is variable, and method of injury varies somewhat between countries. For example, self-injury in Japan is frequently characterized by self-hitting behaviors, rather than the more prototypical Western behavior of cutting (Gholamrezaei et al., 2017). It is also unclear if the functions of self-injury are constant across cultures. It is obvious that more research on the cultural influences of self-injury is needed.

Within Western cultures there are important cultural and social experiences that are strong predictors of self-injurious behavior. For example, multiple studies have indicated that a history of physical or sexual abuse contributes to the later development of self-injury (Martin et al., 2016). Similarly, experience of neglectful family behavior has been linked to self-injury (Brunner et al., 2013). Although problematic family interactions can contribute to the development of self-injury, difficulties at school and interacting with peers can be just as problematic in its development. For example, bullying has been found to increase the odds of later self-injury among children and adolescents (Moore et al., 2017), and peer victimization has been linked across numerous studies to self-injurious behavior, especially when the child is younger (van Geel, Goemans, & Vedder,

patterns that have been found to be linked to self-injury may provide an important target for treatment of the behavior.

2015). Indeed, daily life experience of interpersonal conflict is associated with increased self-injurious behavior (Turner et al., 2016). Thus, it is important when assessing individuals who self-injure to determine the nature of their peer and family relationships, and to discern if there are any social factors that may be contributing to the individuals' behavior.

Sexual attraction to someone of the same sex has recently been identified as a risk factor for self-injury and is gaining support in study replications (Hawton et al., 2012; Mereish, O'Cleirigh, & Bradford, 2014). It is thought that same-sex attraction may lead to self-injury behaviors because of difficulties with increased stress, discrimination, stigma, and a potential negative sense of self (Mereish et al., 2014). In addition, adolescents and young adults who identify as gay, lesbian, or bisexual have elevated rates of self-injury and suicidal behavior (Jackman, Honig, & Bockting, 2016); therefore, minority sexual orientation status is considered a social risk factor for the development of these behaviors. Accordingly, the possible roles of an individual's sexuality and sexual identity in his or her self-injury should be examined during clinical assessment.

There is also increasing evidence that having a transgender identity is a major risk factor for self-injurious behavior. For example, Marshall and colleagues (2016) conducted a systematic review of studies and found that trans individuals have a higher prevalence of self-injurious behavior (both suicidal and nonsuicidal) than cis gender individuals. Furthermore, among trans individuals, trans men appeared to be at the highest risk for self-injurious behavior. Thus, patients presenting for gender identity concerns may be particularly important to assess for a history of self-injurious behavior.

FUNCTIONS OF SELF-INJURY

One of the challenges to understanding self-injury is that there are many motivations for such behavior, and at times people who self-injure can do so for more than one reason. These functions can include social motivations, management of internal emotional conflicts and suicidal ideation, or a way to feel positive sensations. Although the various functional motivations for self-injury will be discussed, the primary function that people report for engaging in self-injury is the reduction of emotional distress (Bentley et al., 2014; Klonsky, 2007). In fact, the primary reason of self-injuring – to escape from emotional pain – is one of the most perplexing functions of self-injury and is a function that many clinicians and families struggle to understand. Accordingly, recent advances in our understanding of why self-injury can help reduce emotional distress, even if in a harmful manner, will be discussed. A list of the various functions for self-injury is displayed in Table 3.

Social functions

Self-injury has long been regarded as serving social functions and has often been superficially considered as a way that the individual manipulates others or influences the surrounding environment (Bentley et al., 2014; Hooley & Franklin, 2018). Other theories have viewed self-injury as a response to negative interpersonal interactions, such as criticism from a loved one or other actions that invalidate the individual's emotions (Linehan, 1993; Selby & Joiner, 2009; Selby, Joiner, & Ribeiro, 2014).

Recent research indicates that, although social motivations do apply to self-injury in some instances, they are typically less commonly reported than other motivations (Bentley et al., 2014; Klonsky, 2011). For example, one of the first studies to examine the social functions of self-injury, Nock and Prinstein (2004) highlighted two social reinforcement motivations for the

Table 3: Functions and Health Consequences of Self-Injury

Common Functions	Health Consequences
<ul style="list-style-type: none"> • Social motivations. • Biological functions. • Anti-suicide function. • Self-punishment function. • Anti-dissociation function. • Feeling generation function. • Affect regulation function. 	<ul style="list-style-type: none"> • Treatment from emergency medical services. • Nerve damage. • Poor academic functioning. • Peer rejection. • Suicidal ideation. • Suicide attempt. • Death by suicide. • Accidental death.

behavior. The first social function they proposed, automatic positive reinforcement, refers to the use of self-injury as a method of obtaining desired social outcomes from others. Accordingly, an individual may self-injure in order to receive attention or care from another person who may not provide this attention otherwise. The second social function proposed by Nock and Prinstein (2004) is automatic negative reinforcement.

This refers to an individual's use of self-injury to avoid certain social outcomes or responsibilities. Social functions of self-injury have been supported by a number of additional studies (Bentley et al., 2014; Taylor et al., 2018). Even so, social motivations do not appear to represent the most commonly endorsed motivation for self-injury.

Although most social motivations for self-injury tend to involve attempts to receive positive reinforcement or care from others, there are some scenarios in which self-injury is motivated by the hope of receiving negative reinforcement. For example, self-injury has been documented to arise in correctional facilities – particularly in adolescent correctional settings – in individuals with no history of the behavior (Dixon-Gordon, Harrison, & Roesch, 2012; Gardner et al., 2014), with one motivation being that self-injury results in medical release to a less restrictive setting. Regardless of the motivation for the self-injury, this detained individual may receive medical or other attention as a result of the behavior. Others in the same facility may then replicate the behavior to get the same special treatment. For this reason, it may be beneficial for clinicians in these settings

to clarify the potential role of malingering for a self-injuring individual and to determine if self-injury is present for any other motivations than social reasons.

Although the social nature of NSSI is still being examined in research settings, interpersonal conflict is a well-established factor for self-injury (Turner et al., 2016). Even if self-injury is not engaged in with the explicit purpose of receiving an interpersonal response, interpersonal problems that arise with family, with friends, or at school or work commonly serve as initiators of self-injurious thoughts and behaviors. Thus, when working with a self-injuring patient, it is important to understand how social factors contribute to the self-injury of that specific patient.

BIOLOGICAL FUNCTIONS

Because self-injury involves the direct destruction of bodily tissue, it is not surprising that there are likely important biological responses to such behaviors. One of the most prominent biological functions of self-injury that have been theorized involves attempting to manipulate and regulate the release of endorphins (Bresin & Gordon, 2013; Worley, 2017). Endorphins are endogenous opioids that are released in response to tissue damage and have the function of natural painkillers while simultaneously inducing feelings of euphoria (Bresin & Gordon, 2013; Liu, 2017). The opioid hypothesis of self-injury suggests that the influences of endorphins may cause the mood-regulating effects of self-injury (Bresin & Gordon, 2013) when, by causing bodily tissue damage, the individual releases endorphins that not only dull the pain, but also lead to positive sensations. The support for the endorphin function of self-injury has been mixed, however, by empirical findings that naloxone (an opiate antagonist, which effectively blocks the effects of opiates such as endorphins) did not stop the emotional benefits of self-injury during a laboratory task that induced pain (Bresin & Gordon, 2013; Russ, Roth, Kakuma, Harrison, & Hull, 1994). This means that even when endorphins were blocked during self-injury,

study participants reported feeling emotional improvements as a function of self-injurious behavior. Furthermore, there are a number of other behaviors besides self-injury that have been found to release endorphins, making the reasons for selecting self-injury for this function less clear.

Even though the opioid hypothesis has met with mixed results, there still appears to be a physiological basis to self-injury that may be illuminated by animal models. For example, some research findings suggest that the dopamine neurotransmitter pathway may be involved in self-injury. Many drugs have been found to stimulate the dopamine system, and it is thought that this effect on the brain is what makes many substances addictive (Bresin & Gordon, 2013; Volkow, Fowler, Wang, Swanson, & Telang, 2007; Worley, 2017). This same reasoning has been applied to self-injury, in that self-injury may alter the dopamine system in such a way that self-injury becomes almost addictive (Bresin & Gordon, 2013; Nock, 2010). Although examining the interplay between dopamine and self-injury is challenging, more time and research will likely lead to a more precise understanding of the biological functions of self-injury.

Anti-suicide functions

Another theorized function of self-injury is the anti-suicide model. In this view, self-injury is thought of as a compromise to suicide and suicidal desire, and that through self-injury the individual is able to appease self-destructive and suicidal impulses and/or desires without actually dying (Klonsky, 2007; Selby, Joiner, & Ribeiro, 2014). Few studies have examined the anti-suicide function of self-injury using empirical methods, and only modest evidence exists to support this as a major function

of self-injury (Klonsky, 2007). However, participants in one study indicated that they self-injured “to prevent me from acting on suicidal feelings,” and in other studies participants reported engaging in self-injury to “stop suicidal ideation or attempts” or because “it stopped me from killing myself” (Selby, Joiner, & Ribeiro, 2014). Thus, clinicians occasionally may find that this is a motivation for self-injury, but that it typically is not a motivation for most individuals who self-injure.

Self-punishment functions

The self-punishment function of self-injury (Hooley & Franklin, 2018; Klonsky, 2007) proposes that self-injury provides a way for persons who self-injure to express anger or frustration against themselves and to inflict self-punishment for either real or perceived wrong-doing. Self-punishment appears to be a particularly common reason for self-injury (Klonsky, 2007). The use of self-injury as a way of punishing oneself is also consistent with research indicating that feelings of low self-worth serve as a risk factor for self-injury, as do childhood physical and sexual abuse (Aggarwal et al., 2017). Those who self-injure may think that they deserve to be derogated and punished because of

events that occurred in the past. Indeed, many who experienced childhood abuse self-injure as self-punishment; such individuals were often trained during childhood to think that they deserved abusive treatment, leading them to continue to see self-injury as deserved punishment even in adulthood (Hooley & Franklin, 2018). If a client reports self-injuring for self-punishment motivations, then it may be important for clinicians working with the individual to assess for an abuse history and address feelings, needs, or impulses to self-punish in general, as these feelings are likely contributing to multiple issues with mental health, including self-injury.

Anti-dissociation functions

The anti-dissociation function of self-injury suggests that those individuals who self-injure do so in response to states of dissociation or depersonalization (Klonsky, 2007; Selby, Joiner, & Ribeiro, 2014). Dissociation is an experience in which someone reports feeling as though he or she is outside of his or her body, feeling that everything is unreal, or feeling numbness or nothing at all. Dissociative states have been considered to be commonly associated with self-injurious behavior (Klonsky, 2007) and are an important symptom of BPD and post-traumatic stress disorder

(PTSD; APA, 2013). It has been suggested that dissociation is a response to extreme emotional states and that physical pain or the sight of blood may shock the person's system and inhibit the dissociative state (Klonsky, 2007; Selby & Joiner, 2009). Evidence supporting the anti-dissociation function of self-injury has primarily been mixed (Klonsky, 2007), however, and additional research is needed for a better understanding of how this function works.

Feeling generation functions

The feeling generation hypothesis is similar to the anti-dissociation hypothesis, except that rather than using self-injury as a method of inhibiting dissociation, self-injury is used as a way to generate positive feelings such as pleasant physical sensations, satisfaction, or excitement. The feeling generation function of self-injury applies broadly, in that the person's motivation is to generate any feeling at all. Many people report feeling "numb" prior to engaging in self-injury, and self-injuring helps them to feel "something" (Selby, Joiner, & Ribeiro, 2014). Recent research has determined that commonly reported reasons for engaging in self-injury involve feeling generation as well as automatic positive reinforcement (Bentley et al., 2014; Taylor et al., 2018), in which a person experiences a positive feeling from the behavior. One longitudinal study of self-injury over 6 months in a sample of high-risk adolescents recently hospitalized for self-injury or suicidal behavior indicated that attempts to feel positive emotion as a result of self-injury was one of the strongest predictors of self-injury over follow-up (Yen et al., 2015). Similarly, Selby, Nock, and Kranzler (2014) found that a major portion of self-injury episodes by a group of adolescents who self-injured were enacted in order to "feel

Affect regulation functions

Although numerous functions have been proposed for self-injury, the most common function for most who self-injure, supported by a bulk of empirical evidence, is affect regulation, or the reduction of negative or distressing emotions (Bentley et al., 2014; Kranzler et al., 2018; Selby, Joiner, & Ribeiro, 2014). Those who self-injure consistently report that this is the most common reason for self-injury. They often maintain that self-injury helps to distract negative affect or thoughts, which again differentiates self-injury from suicidal behavior, for which the most commonly reported reason is to make others better off (Selby, Joiner, & Ribeiro, 2014). Smartphone studies of emotional experiences have also found decreases in negative emotion following self-injury (Kranzler et al., 2018).

Further evidence for the affect-regulating effects of self-injury comes from a similar study with non-BPD individuals who engaged in self-injury. Nock and Prinstein (2004) examined the functional aspects of self-injury in a group of adolescents in an inpatient setting and found that one of the most common reasons for engaging in self-injury was to reduce negative emotional experience. Other studies have since replicated these findings (Kranzler et al., 2018; Selby, Joiner, & Ribeiro, 2014). Additional studies have indicated that self-reported reasons for engaging in self-injury involve tension release, decreasing feelings of rage, distraction from painful feelings, and to "control my mind when it is racing" (Bentley et al., 2014; Nock, 2010; Selby et al., 2018). However, because affect regulation is the most commonly reported motivation for self-injury, it has been extensively investigated. Different reasons for the affect regulating effects of self-injury have been proposed. In particular, two recent models that specifically attempt to understand this seemingly paradoxical function have emerged: the experiential avoidance model (Chapman, Gratz, & Brown, 2006) and the emotional cascade model (Selby et al., 2008).

The emotional avoidance model of self-injury suggests that repetitive use of self-injury can result in a conditioned behavioral response that serves to maintain and reinforce self-injury, primarily through negative reinforcement (Taylor et al., 2018). The term *experiential avoidance* refers to any behavior, including self-injury, that is used as a method of avoiding or escaping from an unwanted internal experience (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Such experiences may include thoughts, feelings, and bodily sensations that an individual finds uncomfortable and extremely unpleasant. Avoidance behaviors (e.g., self-injury) may then remove the unwanted internal experience. The reward for this behavior is the removal of an aversive stimulus, and this negative reinforcement may lead to an increase in frequency of the behavior.

something" or to "feel satisfaction." This was consistent with the results of a smartphone study of daily experiences and self-injury, which found that self-injury resulted in subsequent increases in positive emotion (Kranzler et al., 2018).

Recent psychophysiological research has examined the potential for a "pain-offset relief" phenomenon of self-injury, wherein completion of self-injury is followed by immediate feelings of relief (Hooley & Franklin, 2018). In fact, in experimental paradigms when pain is removed, those who self-injure demonstrate greater postauricular startle reactivity, an eye blink response that indicates increased feelings of positive emotion (Hooley & Franklin, 2018). These findings provide additional support for the feeling generation model of self-injury, in that a number of those who self-injure report feeling positive emotion, or demonstrate a positive emotional biological response, as a function of self-injury. Thus, the feeling generation function of self-injury has been gaining more research support in recent years and is likely to emerge as one of the most important functions of self-injury.

The experiential avoidance model posits that when individuals experience emotion dysregulation and negative affect, they respond by engaging in self-injury as a way of escaping the experience. The emotional avoidance model suggests that self-injury helps to avoid negative emotion through mechanisms such as biological changes, emotional distraction, and self-punishment. In the process of avoiding negative emotion, however, self-injury subsequently becomes rewarding, becoming a conditioned first response to any slight experience of negative emotion. This leads to more frequent use of self-injury as a first response to avoid any negative emotion. The emotional avoidance model of self-injury is supported by a number of studies and a large body of literature indicating that those who self-injure have poor skills for coping with stress and reduced distress tolerance (Bentley et al., 2014; Nock & Mendes, 2008).

A second affect regulation model of self-injury, called the *emotional cascade model*, has also been proposed (Selby et al., 2008; Selby & Joiner, 2009; Selby, Kranzler, Panza, et al., 2014; Selby et al., in press). Like the emotional avoidance model, the emotional cascade model suggests that self-injury is used to reduce emotional distress. However, the emotional cascade model attempts to answer the question of why self-injury is used to reduce emotional distress when there are other, less painful and intimidating ways to avoid emotional experience. For example, Klonsky (2007) questioned why some people would self-injure rather than take a cold shower. This is one of the questions that the emotional cascade model attempts to answer.

In the emotional cascade model, the cognitive risk factor for self-injury called *rumination*, or a *repetitive thinking style*, is engaged in by those who self-injure. Ruminating about an upsetting problem results in an extremely intense state of negative emotion, which ultimately leads to even more intense rumination. In this cycle, rumination and negative emotion progressively aggravate each other and lead to a particularly aversive cognitive and emotional state that is painful to experience, called an *emotional cascade*. Self-injury, then, is thought to serve as a potent physical distracter from rumination. The emotional cascade model suggests that, in order to distract from an emotional cascade, impulsive individuals will engage in a behavior that provides potent physical sensations on which to focus, such as pain or the sight of blood in self-injury. Indeed, pain appears to be experienced by most who self-injure (Selby et al., 2018), and this pain may have a function. By focusing on the physical sensations or pain of the behavior, the individual may be able to distract himself or herself from the rumination and negative emotion cycle, which may cause it to cease and lead to feelings of relief and reduced emotional distress.

To date, multiple studies have found evidence supporting emotional cascades in self-injury (Kranzler et al., 2018; Meaney, Hasking, & Reupert, 2016; Nicolai, Wielgus, & Mezulis, 2016; Selby, Anestis, Bender, & Joiner, 2009; Selby, Connell, & Joiner, 2010; Selby, Kranzler, Panza, et al., 2014; Selby, Kranzler, Panza, & Fehling, 2016; Selby et al., 2018; Tuna & Bozo, 2014). Furthermore, one study found that individuals who self-injure commonly report doing so in order to view the blood (Glenn & Klonsky, 2010), which may serve as a visual distraction from rumination. In another recent study, in which participants completed multiple assessments of emotions and thoughts on a

Case vignette 2

Leibenluft, Gardner, and Cowdry (1987) presented the case of Ms. C. (p. 320), who was a 34-year-old single lesbian. During outpatient treatment, she reported having vivid and intense fantasies about self-injury, which were often paired with feelings of anxious emotions and physical tenseness. Ms. C. described this emotional distress as "torment." Even though she knew that there were things she could or should do instead of self-injuring, she expressed constant struggle to enact healthy choices, such as contacting her clinician instead. Further, if any barrier to help seeking arose, such as the unavailability of her clinician, she would readily pursue self-injury, even though she knew the behavior was problematic. She described having self-injury impulses, and weakness resisting these impulses. In a particular instance, after attempting to seek help and finding her clinician unavailable, she proceeded to self-injure while at work.

She entered a restroom and made an incision in her side with a razor, with a superficial cut at first, and then cutting deeper

daily basis, emotional cascades at one momentary assessment predicted the occurrence of various dysregulated behaviors, including self-injury, at the subsequent momentary assessment a few hours later (Selby & Joiner, 2013), and intense fluctuations in rumination also predicted self-injury (Selby et al., 2013). Although important advances have been made in linking emotional cascades to self-injury, additional work needs to be done to clarify how people, particularly adolescents, come to learn about and use self-injury as a method of coping with intense emotional distress.

and deeper followed the initial incision. She described her experience with the self-injury as follows: "My body eased of the tension and I began to feel relieved of the torment. My body eased of the tension and I began to feel comforted. Right after I hurt myself, I felt physical pain, but my mind and body were much more at ease than before." However, even though Ms. C. experienced momentary emotional relief from her behavior, she indicated that she would soon begin to feel scared and anxious about what she had done (i.e., her self-injury). She worried what others would think if they were to discover her – would they be angry at her, or disappointed? She was particularly worried about how her clinician would react and that her clinician might cease providing services to her. This case demonstrates the importance of understanding the personal function that self-injury has for each case and that the emotional response to self-injury can be just as important to examine.

HEALTH OUTCOMES AND SUICIDAL BEHAVIOR

The high rate of self-injury among adolescents and young adults (Bentley et al., 2014; Plener et al., 2016) is alarming given that self-injury is associated with numerous deleterious consequences, including physical health consequences, psychological consequences, social consequences, and

Physical health outcomes

One of the reasons that self-injury is such a provocative and dangerous behavior is that it is associated with multiple, clearly negative health consequences. When adolescents and young adults self-injure, they typically inflict moderate to severe tissue damage in the process (Nock, 2010). Although self-injury is often superficial and heals without issue, in some cases it can result in emergency room visits, severe scarring, risk for contracting infectious diseases, nerve damage, and even accidental death (Cassels & Wilkinson, 2016; Cloutier, Martin, Kennedy, Nixon, & Muehlenkamp, 2010; Doshi, Boudreaux, Wang, Pelletier, & Camargo, 2005; Lewis, 2016). Thus, although some individuals may present with mild or minor self-injury, perhaps due to scratching or bruising due to banging, this does not mean that

Psychological and social health outcomes

An increased frequency of self-injury is associated with numerous problematic psychological and social outcomes (Rockett & Caine, 2015; Selby, Bender, Gordon, Nock, & Joiner, 2012). These consequences often include academic difficulties, rejection and stigmatization by peers, and increased risk of suicide (Pompili et al., 2015). Studies have found that those who self-injure commonly experience interpersonal problems with peers and family, and they report more problematic interpersonal relationships compared to those who do not (Turner et al., 2016). In addition to relationship problems, there is also evidence that adolescents who self-injure report significantly more problems with schoolwork (McMahon et al., 2010).

The most concerning psychological and behavioral consequence is that self-injury is highly associated with subsequent suicidal behavior and suicide attempts (Grandclerc, De Labrouhe,

educational consequences. Particularly severe among these consequences are permanent tissue damage, suicidal behavior, and impairments in social relationships. Please see Table 3 for the various consequences of self-injury.

the behavior should be dismissed. Indeed, for individuals who continue to self-injure, the behavior tends to increase in severity over time (Yen et al., 2015). Surprisingly, despite the clear physical tissue damage that can occur with self-injury, many who self-injure report feeling no pain, while others report specifically self-injuring in order to feel pain (Selby, Nock, & Kranzler, 2014; Selby et al., 2018). Thus, the role of pain in self-injury is not well understood, but the absence of pain during self-injury is often associated with more severe behavior and worse clinical outcomes (Nock et al., 2006; Nock, 2010). Finally, the presence of scarring from self-injury can also lead to inhibited recovery, as it is common for patients to have negative perceptions of their scars or fear social perceptions of those scars (Lewis, 2016).

Spodenkiewicz, Lachal, & Moro, 2016; Rockett & Caine, 2015; Selby, Bender, Gordon, et al., 2012). This observation is supported by consistently high rates of co-occurrence between self-injury and suicide attempts (Pompili et al., 2015), with self-injury often functioning as one of the strongest predictors of subsequent suicidal behavior (Grandclerc et al., 2016; Rockett & Caine, 2015). In fact, recent research has demonstrated that self-injury is as strong a predictor of a future suicide attempt as past suicide attempts (Guan, Fox, & Prinstein, 2012; Pompili et al., 2015). Similarly, 70% of adolescents who engage in self-injury reported a lifetime history of suicide attempts, and recent studies reveal a robust and strong association between self-injury and suicide attempts (Grandclerc et al., 2016). The strong association between self-injury and suicide makes suicide risk assessment of individuals who self-injure a particularly important issue.

ASSESSMENT

An important aspect of treating self-injury is conducting an appropriate assessment of the behavior. In assessing self-injury, according to Nock (2010), there are three primary goals: (1) to determine if a person has engaged in self-injury at present and/or in the past, (2) to determine the factors and functions that contribute to self-injury for that particular individual, and (3) to monitor the form and frequency of self-injury over time and as a response to treatment. Assessment is particularly crucial because there are numerous behaviors that can be mistakenly classified as self-injury, such as indirect self-injurious behavior (e.g., substance use, anorexia), and there are direct behaviors that are often ambiguous as to whether they are actually self-injury, such as skin picking and hair pulling. Furthermore, suicidal behaviors such as suicide gestures or attempts are often mistakenly classified as nonsuicidal self-injury. By using a standardized assessment, a clinician can make a better determination as to whether the behaviors under consideration are self-injury, as well as determine the severity of such behavior. Use of appropriate assessment techniques is also important for making distinctions between self-injurious behavior and closely related self-harm behaviors such as suicide attempts and suicide threats and gestures.

There are two primary approaches to the assessment of self-injury: self-report and clinical interview. Self-report methods

Self-report

For clinicians in need of quick assessments of self-injury, and who have little time for a detailed interview, it is recommended that the recently developed *Inventory of Statements About Self-Injury* (ISAS; Klonsky & Glenn, 2009) be used. The ISAS is a self-report measure of the frequency and functions of self-injury. The reliability and validity of the ISAS as a measure of self-injury frequency and functions has been demonstrated in multiple studies (Klonsky & Glenn, 2009; Victor, Styler, & Washburn, 2016). The first section of the ISAS assesses the lifetime frequency of 12 different methods of self-injury (i.e., banging/hitting self, biting, burning, carving, cutting, interfering with wound healing, needle-sticking, pinching, hair pulling, rubbing skin against rough surfaces, severe scratching, and swallowing chemicals). Total self-injury frequency scores can be calculated

Clinical interview

For clinicians wanting to obtain a thorough assessment of self-injury, along with highly relevant information on suicidal ideation and behavior, it is recommended that the *Self-Injurious Thoughts and Behaviors Interview* (SITBI; Nock et al., 2007) be used. The SITBI is a well-validated, structured clinical interview consisting of five modules that assess self-injury, suicidal ideation and plans, and suicidal behavior. A major focus of the interview is about the form, frequency, and severity of self-injury, as well as the frequency and intensity of urges about self-injury. Participants respond to open-ended questions about the frequency, methods, and severity of self-injury, and then they rate the various functions of self-injury as it applies to their behavior using a Likert scale ranging from 0 (never) to 4 (frequently). Options for the functions of self-injury include escaping aversive feelings, generating feelings, communication with others, or to avoid activities or others. Participants also rate the extent to which they feel pain during self-injury and to what extent their family, friends, or peers may have contributed to self-injurious behavior. Finally, participants also rate the likelihood that they will engage in self-injury in the future.

Therapeutic stance when assessing and discussing self-injury

Clients, family members, and the broader population often view suicidal behaviors and self-injury as highly stigmatized. Because of this perceived stigma, it is common for clients to be reluctant to disclose or feel uncomfortable discussing such behavior or to minimize its severity. For this reason, it is necessary to facilitate rapport and therapeutic alliance right from the start of the assessment and treatment process. Often,

have a number of advantages when assessing self-injury. These assessments can be administered quickly to many people, even those in busy settings who have not previously expressed potential problems with self-injury. However, they have drawbacks in that some individuals, particularly adolescents, may be reluctant to self-disclose self-injurious behavior for fear of family reactions to the behavior or potential stigma.

The best method for assessing self-injury involves the use of standardized in-person clinical interviews, with the interviewer asking the person set questions and following up with inquiries to clarify the person's response to those set questions. Standardized in-person clinical interviews provide the most accurate and consistent assessments of self-injury. However, the major drawbacks to this type of assessment – making this type of assessment less than ideal in a clinical setting – are that interviewers require extensive training and the interviews are time consuming. With either form of assessment, self-report or interview, it is important to establish information on the following aspects of self-injurious behavior: self-injurious thoughts, actual self-injurious behaviors, methods of self-injury, and motivations for self-injury. In addition to this information, it is also highly recommended that any self-injuring individuals being assessed be provided with a suicide risk assessment if any suicidal ideation is reported (Grandclerc et al., 2016).

by summing lifetime frequency of engaging in each of these methods of self-injury. The last section of the ISAS assesses different functions of self-injury, asking participants to rate from 0 to 2 the extent to which they are engaging in self-injury for a variety of different functions, such as “releasing emotional pressure that has built up inside of me,” “calming myself down,” “reducing anxiety, frustration, anger, or other overwhelming emotions,” “causing pain so I will stop feeling numb,” “doing something to generate excitement or exhilaration,” “trying to feel something (as opposed to nothing) even if it is physical pain,” and “making sure I am still alive when I don't feel real.” Ratings for these motivations can be summed to create a total score for the primary functions of self-injury, along with total frequency of self-injury.

The SITBI interview also assesses the dangerousness of self-injurious behaviors and if previous medical attention was required for the behavior. The SITBI also consists of segments about the frequency, intensity, and duration of suicidal ideation in the past week through the past year, occurrence of suicidal plans and gestures, and detailed information about previous suicide attempts. Each of the five modules begins with an initial screening question, and if that initial question is endorsed, then the full module is included in the interview. This allows for skipping sections that are not relevant to an interviewee, thus reducing the total length of the interview. A particular advantage of the SITBI is that it includes a thorough assessment of suicidal ideation and behavior, in addition to self-injury, a feature that is particularly useful given the high association between self-injury and suicidal behavior (Hawton et al., 2012). The SITBI interview is freely available from the developer's website (see the Resources section of this course) and comes in longer and shorter versions depending on assessment needs. With some time, preparation, and training, the interview can be integrated into a wide variety of clinical settings.

clients who self-injure have faced negative reactions, criticism, discomfort, or horror when the behavior was discovered by or disclosed to friends or family (Walsh, 2014). It is therefore important for clinicians to respond to the disclosure of self-injury with an understanding and supportive response; it is essential for the clinician to be nonjudgmental and caring and to avoid causing additional anxiety or embarrassment for the adolescent

or young adult. However, practitioners should not minimize or trivialize the behavior, nor should they allow themselves to show an exaggerated reaction to it, as either approach could encourage or increase urges for self-injury (Walsh, 2014). Instead, it is important that the clinician validates the client's emotional distress while at the same time avoids inadvertently appearing

to approve of the self-injurious behavior (Linehan, 1993). In general, a "low-key, dispassionate demeanor" by the clinician is recommended when discussing self-injury (Walsh, 2014). Such an approach should demonstrate genuine interest, curiosity, and respect for the client and the behavior, while remaining both neutral and calm.

CO-OCCURRING DIAGNOSES AND DIFFERENTIAL DIAGNOSIS

Although still specified primarily as a symptom of BPD in *DSM-5* (APA, 2013), self-injury is truly a transdiagnostic behavior that can present across a variety of diagnostic domains, ranging from mood disorders, to personality disorders, to eating disorders, among others. It is important to understand the disorders that commonly present along with self-injury, and it is equally important to be able to differentiate self-injury from other possible disorders. Among both adolescents and adults,

Depressive, anxiety, and substance use disorders

Major depressive disorder is a condition in which an individual is experiencing substantial and persistent depressed mood, lack of interest in enjoyable activities, changes in appetite and/or sleep, feelings of worthlessness, suicidal ideation, hopelessness, physical overactivity or lethargy, and difficulty concentrating. Major depression is thought to be a particularly salient problem for those who self-injure, as self-injury may be used at times to cope with feelings of sadness (Selby et al., 2013; Weintraub et al., 2017), which are frequently worse during a depressive episode. In addition to major depressive disorders, bipolar disorder is also commonly diagnosed among patients who self-injure (Weintraub et al., 2017).

Anxiety in general, as well as specific anxiety disorders, may also commonly co-occur among persons who self-injure for the same

Conduct problems

Self-injury can also present along with conduct and other behavioral problems (Nock, 2010), although most people who self-injure do not tend to have major conduct issues. Sometimes, people with diagnoses of conduct disorder or who have been remanded to detention centers for criminal activity will also engage in self-injury, either out of difficulties coping or, at times,

Eating disorders

Eating disorders, such as bulimia nervosa and anorexia nervosa, are commonly found in people who self-injure (Cucchi et al., 2016). Bulimia nervosa is a condition in which women, typically but not exclusively, engage in frequent episodes of binge-eating large amounts of food and then attempt to compensate for this calorie consumption with purging methods, such as vomiting, excessive exercise, laxative misuse, or misuse of enemas. Research has indicated that individuals diagnosed with bulimia often have problems with a number of impulsive behaviors, including self-injury (Gonçalves et al., 2016; Selby, Doyle, Crosby, et al., 2012). Anorexia nervosa, on the other hand, is a disorder characterized by excessively low weight and a refusal to maintain an appropriate weight (APA, 2013). Despite

Borderline personality disorder

The disorder with which self-injury is most commonly and traditionally associated is BPD, with approximately 50% of people who self-injure also meeting criteria for this diagnosis (Selby et al., 2015). BPD is a multifaceted disorder that involves extreme and rapidly shifting emotional responses, frequent interpersonal difficulties, fears of abandonment, a loosely developed sense of identity, suicidal and self-injurious behavior, feelings of emptiness, anger and aggression, and dissociative or paranoid behavior when stressed (APA, 2013). The primary reason that so many individuals who self-injure also meet criteria for a diagnosis of BPD is that one of the criteria for BPD refers specifically to self-injurious behavior. In fact, prior to *DSM-5*, self-injury was included in the *DSM* only as a symptom of BPD. However, many clinicians mistakenly make the assumption that the presence of self-injury indicates that BPD is present in some

common co-occurring disorders aside from BPD include: major depressive disorder (Hankin & Abela, 2011; Selby, Bender, Gordon, et al., 2012), anxiety symptoms and various anxiety disorders (Aggarwal et al., 2017; Kranzler et al., 2018), childhood conduct problems (Nock, 2010), eating disorders such as anorexia nervosa or bulimia nervosa (Cucchi et al., 2016), and alcohol or other substance use disorders (Brausch & Boon, 2015).

reason, in that self-injury is often used as a method of coping with anxious emotions, thoughts, and worry (Bentley et al., 2014; Selby, Bender, Gordon, et al., 2012). Relatedly, self-injury has been linked to poor sleep quality and nightmares (Liu, Chen, Bo, Fan, & Jia, 2017), which may further interface with depression or anxiety disorders.

It is also common to observe alcohol or other substance use disorders co-occurring with self-injurious behavior, likely because substances are often used for functions similar to those of self-injury, such as coping with distressing emotions or attempting to generate positive feelings (Brausch & Boon, 2015; Selby et al., 2015). Self-injury may occur in response to hallucinations and delusions brought about by substance use. This type of self-injury is differentiated in a subsequent section of the course.

as a potential method of obtaining social reinforcement (Gardner et al., 2014). Occasionally, though infrequently, individuals with severe conduct problems may engage in self-injury as an attempt to manipulate others around them, and in such cases the functions of self-injury should be carefully assessed before determining treatment approaches (Dixon-Gordon et al., 2012).

popular misconceptions, individuals with anorexia often engage in bingeing and purging behavior in addition to calorie restriction, and those who do so are referred to as having the binge-purge subtype of anorexia. Importantly, those with the binge-purge subtype of anorexia often have higher rates of self-injury (Gonçalves et al., 2016; Selby, Smith, Bulik, et al., 2010), making it particularly relevant when assessing self-injurious behavior. In eating disorder cases, it can be easy for clinicians to be so focused on the eating disorder symptoms that self-injurious behavior is neglected. Yet, given the deleterious consequences of self-injury, neglecting this behavior is likely to be problematic, especially when it presents along with an eating disorder.

form. Although there is some evidence behind this notion, with a major proportion of those with BPD reporting self-injury (Selby, Bender, Gordon, et al., 2012), this point neglects findings that many who self-injure have very few symptoms of BPD (Selby et al., 2015; Ward et al., 2013). In fact, the rate of self-injury in the population (with low-end estimates between 4% and 13%; Bentley et al., 2014) is much higher than the prevalence rate of BPD (1% to 6% of adults; ten Have et al., 2016). Glenn and Klonsky (2013) found that only 52% of adolescent inpatients who self-injured on a frequent basis also met criteria for BPD, whereas among adolescents who met criteria for BPD, 78% also regularly self-injured.

Understanding that some persons who self-injure may meet criteria for BPD and some may not is important because preliminary findings suggest that those with a co-occurring

diagnosis of BPD may be less responsive to treatment than those with only self-injury (Ward et al., 2013). In particular, a self-injuring patient who presents with BPD may be best helped with the psychological treatment dialectical behavior therapy (DBT; Linehan, 1993), which will be discussed in more detail shortly. The best method for establishing a differential diagnosis of self-injury with or without BPD is to use a clinical interview for the diagnosis of personality disorders, such as the Structured Clinical Interview for *DSM-IV* Personality Disorders (SCID-II; First, Spitzer, Gibbon, & Williams, 1997) for adults, or the Childhood Interview

Psychotic disorders and substance use

Self-injury can occur during psychotic episodes (Honings, Drukker, Groen, & van Os, 2016); however, this presentation is less common and is typically distinct from most typical episodes of self-injury. During psychosis, self-injury often occurs in response to hallucinations or delusions and can be extremely severe, including the infliction of severe damage to the genitals or amputation of limbs (Large, Babidge, Andrews, Storey, & Nielsens, 2009). This level of self-injury is far beyond the

Developmental and intellectual disabilities

Self-injury is quite frequent among children with pervasive developmental disorders, stereotypic movement disorder, or an autism spectrum disorder (Maddox, Trubanova, & White, 2017). Intellectual disability (formerly referred to as mental retardation in *DSM-IV*) is often associated with these disorders and self-injury, however, and self-injury in the context of developmental and intellectual disorders may be phenomenologically different from the most common forms of self-injury. For example, it is difficult to determine if the self-injury present in developmental disorders is consciously deliberate, if it arises from internal mechanisms or a complex interaction with environment or adult caretakers, or if suicidal intent (or absence thereof) can actually be determined. Furthermore, self-injury occurring in

Trichotillomania and excoriation disorder

Other relevant disorders may not be as easy to rule out. Trichotillomania and excoriations, for example, are two potentially challenging differential diagnoses. Trichotillomania involves repetitive, purposeful, and often painful pulling of hair from the body. The disorder affects approximately 1% of the population (APA, 2013), making it far less prevalent than most self-injurious behavior. Excoriation, on the other hand, is a new disorder to *DSM-5* and involves repetitive skin picking and wound picking. Although both hair pulling and skin picking can present in those who self-injure, there are important distinctions between these diagnoses and more traditional forms of self-injury. Trichotillomania is limited to hair pulling, while in contrast, self-injury is a broader construct that is inflicted upon many different body parts using multiple different methods (Selby et al., 2015). Furthermore, trichotillomania frequently occurs during periods of boredom, in addition to times of anxiety or stress

for Borderline Personality Disorders (CI-BPD; Selby & Yen, 2014; Zanarini, Frankenburg, Sickel, & Yong, 1996). Although including an assessment of BPD with a participant who self-injures might increase the length of the assessment, the information about presence or absence of symptoms will undoubtedly inform the course of treatment. Alternatively, if time for a thorough assessment is sparse, a self-report BPD inventory such as the McLean Screening Instrument for BPD could be used (Zanarini et al., 2003).

typically much less severe self-injury with which most of those who self-injure present. Self-injury can also take place during use of substances such as methamphetamine (Kratofil, Baberg, & Dimsdale, 1996). However, this behavior is also frequently severe and associated with hallucinations, unlike most self-injury. Furthermore, such substance-induced self-injury can be identified via substance screens in most cases.

developmental disorders appears to be qualitatively distinct, often characterized as repetitive and invariable, frequently occurring in the presence of other people attempting to intervene, and is characterized primarily by head-banging and self-biting (Rojahn, Matson, Lott, Esbensen, & Smalls, 2001), both of which are less common among developmentally normative individuals exhibiting self-injury. Thus, although self-injury may have similar emotion regulation functions in this group, it appears that when self-injury is present in conjunction with a pervasive developmental disability, the developmental disorder should be the primary diagnosis under consideration, rather than self-injury.

(Weidt et al., 2016), indicating potentially different functions for each behavior. Similarly, excoriation is often limited to a few areas of the body, the face in particular, and tends to be a more compulsive behavior that is difficult to resist (Arnold, Auchenbach, & McElroy, 2001). Given differences in clinical presentation and frequent use of more than one method of self-injury, it is unlikely that most cases of self-injury would be confused with either trichotillomania or excoriation. However, the presence of these behaviors could be problematic in cases in which self-injury is seemingly minor (e.g., light scratching) and only these other behaviors are more prevalent. It is important to use a standardized assessment of self-injurious behavior prior to clinically addressing self-injury in order to avoid inadvertently diagnosing someone with excoriation or trichotillomania with having primarily self-injury.

NONSUICIDAL SELF-INJURY DISORDER

With the publication of *DSM-5* (APA, 2013), nonsuicidal self-injury disorder was finally included as a disorder in need of further investigation. This was a major step toward recognizing the prevalence and perniciousness of self-injury and will likely lead to a better recognition of the behavior in various clinical settings. However, because NSSI disorder has not yet been fully validated and included in the primary body of the *DSM*, it is not yet a fully recognized disorder. Research on NSSI disorder has been escalating in the past few years, and it seems probable that NSSI disorder will be included as a fully validated disorder in a future version of the *DSM* (Selby, Bender, Gordon, et al., 2012; Selby et al., 2015; Zetterqvist, 2017).

The primary difference between an individual presenting with self-injurious behavior and a person who meets criteria for NSSI disorder has to do with the frequency, functions, and consequences of self-injurious behavior. Thus, even if an individual has self-injured a few times in the previous year, he or she still might not technically meet criteria for NSSI disorder

(Table 4). In order to meet criteria for NSSI disorder, an individual must have engaged in self-injury on at least 5 days over the past 12 months, there must be one functional expectation for the behavior, there must be at least one outcome experience of the behavior, and self-injury cannot be better accounted for by other conditions.

If a person in a clinical setting were to meet criteria for NSSI disorder, even though it is not yet a validated disorder, this diagnosis would still be useful for indicating the severity and problematic consequences of the self-injurious behavior. Individuals who meet criteria for NSSI disorder are less likely to remit from their self-injurious behavior, and they may experience more severe long-term consequences from the behavior (Andover, 2014; In-Albon et al., 2013; Zetterqvist, 2017). Finally of note, because NSSI disorder is still under research investigation, there is potential for the diagnostic criteria to change with a later version of the *DSM*, so it is important to keep the limitations of NSSI disorder in its current form in mind.

Table 4: Summary of DSM-5 Criteria For Nonsuicidal Self-Injury Disorder

- A. Over the previous 12 months, the individual has on 5 or more days engaged in self-injury that was severe enough to cause minor or moderate damage, but without suicidal intent.
- B. The individual engages in self-injury with one or more of the following expectations:
1. To obtain relief from a negative feeling or cognitive state.
 2. To resolve an interpersonal difficulty.
 3. To induce a positive feeling state.
- C. Self-injury is associated with at least one of the following:
1. Interpersonal difficulties or negative feelings or thoughts immediately precede engagement in self-injury.
 2. A period of preoccupation with self-injury precedes the self-injury.
 3. Self-injury urges or thoughts occur frequently even if not acted upon.
- D. The behavior is not socially sanctioned or restricted to picking a scab or nail biting.
- E. Self-injury causes significant distress or impairment in important areas of functioning.
- F. Self-injury does not occur exclusively in a state of psychosis, delirium, or intoxication and cannot be accounted for by another medical or psychological disorder.

Note. Adapted from Diagnostic and Statistical Manual of Mental Disorders (5th ed.), 2013, by the American Psychiatric Association.

TREATMENT OF SELF-INJURY

Because an improved understanding of self-injury has only emerged over the past two or three decades, treatments for this condition are still in the process of being developed. Accordingly, the evidence base for treating self-injury is not as well established as it is for other, related conditions such as BPD (Selby et al., 2015). However, there are a number of promising approaches that can be utilized for treating patients who self-

Pharmacological treatment

Unfortunately, to date there are no clear psychopharmacological treatments for self-injury. Although a number of potential medications have been studied, most studies have been either case studies or have used small sample case series to demonstrate only modest decreases in self-injury (Turner et al., 2016). Given that these are generally considered preliminary empirical approaches, there is no primary medication that is clearly indicated for reducing self-injury. Researchers are continuing to work on development and testing of medications for self-injury, however, and anticipate that drugs that affect the serotonergic and dopaminergic systems of the brain may yield the most promise (Turner et al., 2016). Although there is not

Psychological and behavioral treatments

A few treatments that have been designated specifically to target self-injury seem promising; however, these treatments have not yet developed a strong research base of support (Stanley, Fineran, & Brodsky, 2014). For adolescents and adults who self-injure and who also have a diagnosis of BPD, dialectical behavior therapy (DBT) is a strongly recommended, empirically supported option for treating self-injury (Cook & Gorraiz, 2016). Linehan (1993) originally developed DBT in order to help people with suicidal ideation and those who were diagnosed with BPD, a condition that frequently presents with self-injury. The primary focus of DBT is to help clients learn how to cope with and tolerate intense negative emotions, and to do so without engaging in harmful behaviors, such as self-injury. In DBT, individuals engage in weekly individual therapy sessions, as well as weekly group therapy sessions. There are four modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. During the mindfulness module, clients learn skills involving mindfulness meditation, which involves learning how to focus thoughts in a desired manner. This can involve focusing on internal physical sensations such as rhythmic breathing, or on external sensations such as what one is hearing or seeing. The purpose of mindfulness skills is to help clients when they feel overwhelmed with emotion. Rather than focusing on the emotional experience, clients can focus on other experiences, allowing them to reduce emotional intensity.

In the interpersonal effectiveness module, on the other hand, the client learns how to handle stressful interpersonal situations in new and helpful ways. Finally, in the modules addressing

injure (Turner, Austin, & Chapman, 2016), potentially using a combination of pharmacological methods, psychological and behavioral treatments, and involving family in the treatment process. There is also evidence that those who self-injure, without complicating diagnoses such as BPD, are often responsive to treatment and that their prognosis is generally good (Andover et al., 2017; Ward et al., 2013).

yet a specific medication for treating self-injury, in many cases those who present with self-injury are likely to have co-occurring diagnoses that may be treatable with medication. For example, major depression often presents along with self-injury (Selby et al., 2015), and although using a pharmacological approach to treat depression is unlikely to have a direct effect on self-injury, treating the co-occurring depression or anxiety may improve the mood of the individual, reducing the likelihood of upsetting emotions triggering self-injury. Thus, it is important to assess and potentially treat cooccurring diagnoses, as doing so may indirectly improve self-injury.

emotion regulation and distress tolerance, the client learns about ways to influence emotion through healthy eating and sleep behaviors, as well as coping strategies for dealing with distressing situations that might lead to self-injury. DBT has been found to more significantly reduce both self-injurious and suicidal behavior when compared with other treatment options (Turner et al., 2016). Importantly, even though the bulk of clinical studies of DBT have been conducted with adults, recent clinical trials have indicated that DBT is also effective for adolescents (Mehlum et al., 2014). However, it is unclear how effective DBT is at reducing Self-injurious behavior in individuals who self-injure and do not have a co-occurring BPD diagnosis. Another drawback to DBT is that in some parts of the country DBT services are not accessible, making it difficult to obtain group therapy services. Fortunately, important advances are being made on this end, such as the development of emotion regulation group therapy for self-injury (Gratz, Tull, & Levy, 2014), which has shown preliminary effectiveness and can be more readily implemented in areas that lack DBT services. Pilot studies have also examined smaller-scale treatments that appear to improve mindfulness and cognitive reappraisal among self-injurers (Bentley, Nock, Sauer-Zavala, Gorman, & Barlow, 2017) or interpersonal and emotional distress (Andover, Schatten, Morris, Holman, & Miller, 2017).

Another option, which can be used in treating either adults or adolescents, is cognitive behavioral therapy (CBT; Stanley et al., 2014). In this treatment modality, clinicians work with self-injuring individuals to identify self-injurious thoughts and maladaptive thought patterns; they also work on generating

new thought patterns and behavioral skill sets that can be used, instead of self-injury, to cope with upsetting events and emotions. During the course of CBT, it is also helpful to examine the circumstances, functional motivations, thoughts, emotions, interpersonal experiences, and behaviors that occurred prior to recent self-injury episodes. Although only a few studies have been conducted on the utility of treating self-injury with CBT, the preliminary evidence indicates that it is likely to be helpful for a number of individuals and may improve overall levels of functioning (Stanley et al., 2014; Ward et al., 2013). There is also preliminary evidence that those who self-injure but do not have a diagnosis of BPD may respond more to standard CBT than those with BPD (Ward et al., 2013).

Another recent adaptation of CBT involves manual-assisted CBT for self-injury (Davidson, Brown, James, Kirk, & Richardson, 2014; Stanley et al., 2014), in which self-directed completion of a treatment manual is paired with a reduced number of in-person treatment sessions. This therapy has the benefit of being a highly accessible, brief, and cost-effective intervention for self-injury

Family involvement

For clients who self-injure, having their family provide active support may potentially improve the success of treatment. Often, partners of individuals who self-injure require additional support, education, and planning to improve coping skills related to their partner's self-injury. For adolescents who self-injure, having their families providing active support may also potentially improve the success of treatment. Indeed, adolescents who present with self-injury frequently have parents who struggle with many of the same emotional and behavioral challenges (Barrocas, Holm-Denoma, & Hankin, 2014; Gromatsky et al., 2017), and intervening with parents can lead to improvements for the adolescent. Even in families without parental mental health concerns, the family can be a powerful advocate for helping an adolescent reduce self-injurious behavior.

Although family therapy has not yet been indicated as a primary treatment for self-injury, having families understand the factors that contribute to the person's self-injurious behaviors can help modify the family environment to make it more supportive. Furthermore, helping the family learn about the consequences

Case vignette 3

Katie presented to an outpatient program specializing in the treatment of women's psychological health. Her primary reasons for seeking treatment involved difficulties managing stress and recent suicidal ideation. Katie, a 26-year-old Hispanic female, was found to be physiologically fit and healthy during her most recent physical examination. She is a full-time mother who currently lives in the same home as her mother, brother, and her two children from two previous, discontinued romantic relationships. Katie had sought clinical services for mental health concerns when she was a teenager, and more recently she had received psychotropic medication prescriptions for bupropion (Wellbutrin), aripiprazole (Abilify), and clonazepam (Klonopin), which she reported to be taking as prescribed. She indicated that these medications were somewhat helpful to her. During a diagnostic interview, Katie met criteria for current major depression. Katie also reported a number of eating disorder symptoms, especially concerns about her body weight and shape, and bingeing and purging episodes that occurred approximately 2 to 3 times a week. Katie also used alcohol heavily, approximately twice per week, which caused increasing strain and conflict with her family, but no evidence of tolerance or withdrawal was reported. Diagnostic assessment (according to DSM-5 standards) indicated that Katie met criteria for current major depression, panic disorder, alcohol use disorder, and bulimia nervosa. She also met criteria for subthreshold BPD, endorsing four of the required five criteria. Katie reported that she has been experiencing elevated suicidal ideation over the previous weeks. However, she indicated that this ideation consisted primarily of thoughts about wanting to die that came into her mind 3 or 4 times a day, and that she had not

(Davidson et al., 2014). In this format, the treatment generally consists of as many as seven sessions with a treatment service provider, and is supplemented with self-directed readings that focus on providing patients with education about self-injury, emotion regulation, and coping skills, developing healthier thinking patterns, and preventing relapse. Although still in the preliminary stages of treatment development, manual-assisted CBT has shown some preliminary evidence of effectiveness. Compared to treatment as usual, manual-assisted CBT has been shown to reduce self-injury frequency and to increase the amount of time that passes between self-injury episodes (Davidson et al., 2014; Stanley et al., 2014). Thus, self-directed treatment programs paired with occasional guidance from a clinician appear to have growing potential for the treatment of self-injury. Although specific manual-assisted CBT materials are not yet commercially available for clinicians, the Resources section of this course lists a number of relevant treatment guides that could be utilized.

of self-injury, particularly suicidal behavior, can be helpful for improving monitoring of the self-injuring person's progress when away from medical settings. Finally, identifying interpersonal factors that contribute to self-injury can help the family work with the client to address problems in a healthy way, rather than through self-injury (Turner et al., 2016).

There is also growing evidence that providing basic education about self-injury using primary prevention programs will be beneficial to adolescents. Importantly, there do not appear to be any iatrogenic or harmful experiences resulting from such prevention programs, as might be feared when introducing adolescents to the topic of self-injury (Fazel et al., 2014). As prevention programs gain more empirical support, it may become beneficial to integrate such programs into settings with youth early in their adolescence, as the start of adolescence is when many individuals begin to self-injure. Prevention efforts might help forestall the onset of self-injury or encourage those who have already started to seek treatment.

developed any plans or preparations for suicidal behavior. She endorsed no intent to engage in suicidal behavior.

Regarding her self-injurious behavior, as assessed by the SITBI, Katie indicated that she engaged in self-injury approximately 2 to 3 times each week and had been self-injuring at this rate for approximately the past 18 months. She typically would cut herself using either a razor or a knife, and if she were without access to a sharp instrument, she would scratch to the point of drawing blood. She would also occasionally punch walls, hit herself, or pinch herself to the point of bruising. She initially started self-injuring when she was 14, in response to stressors at school, and has continued intermittently into adulthood, with a recent increase in frequency and severity of self-injury. She has never spoken to her family about her self-injurious behavior, but she suspected that they knew because of physical scars visible on her arms. Katie reported that most of the time when she self-injured, she did so because of upsetting thoughts about herself and mistakes that she'd made, both recently and in the past. She reported that self-injury was frequently on her mind, and that she often viewed self-injury as a "friend" that helped her cope with her difficult emotions and daily struggles at home and at work. Due to her cutting frequency and motivations, she also met criteria for nonsuicidal self-injury disorder (a condition for further study in DSM-5).

Katie was seen weekly for 16 weeks, during which time she was treated primarily with a DBT individual therapy approach, as DBT group therapy was not available. During these sessions, Katie discussed her emotional and cognitive reactions to stressors, and how these experiences contributed

to problematic behaviors, including her self-injury, alcohol use, and binge eating. She was provided psychoeducation on the negative consequences of these behaviors, and because she displayed both self-injurious behavior and suicidal ideation, her suicidal ideation was monitored on a weekly basis. Fortunately, her suicidal ideation steadily diminished as therapy progressed. Many of the sessions focused primarily on helping Katie learn new behavioral coping strategies and skills from DBT, including working on mindfulness exercises, developing interpersonal effectiveness skills, and learning about emotions and emotion regulation.

Approximately 9 weeks into treatment Katie had shown improvements in her suicidal ideation, and she was reporting feeling better and indicated improved functioning overall. However, her self-injurious behavior, alcohol use, and binge eating had remained essentially unchanged in terms of frequency. At this point, therapy alternated to a motivational approach for a few sessions, as Katie understood how to use new coping skills but still chose to self-injure instead of using the new skills on multiple occasions. Upon exploring this issue further, Katie indicated that she was having difficulty stopping self-injurious behavior in particular because she felt that it was an especially effective coping strategy for her. With more focus

on motivation for improving self-injurious behavior, particularly examining the consequences of self-injury relative to the benefits of the behavior, Katie came to admit that she was afraid to stop self-injury because she was afraid of what would happen if other skills failed to help her. Although she declined to commit to stopping self-injury completely, she eventually agreed to work on reducing the behavior in favor of using the DBT skills she had been learning.

When Katie decided to stop engaging in psychological treatment, primarily due to the challenges of fitting in treatment along with coordinating care for her children, she had made important improvements. Her previous suicidal ideation had been absent for the last 6 weeks of treatment, she reported feeling better overall and more capable of coping with distressing situations, she hadn't engaged in binge eating and purging for 3 weeks, and she indicated less conflict with her family. Although she hadn't completely ceased self-injurious behavior and was still using alcohol, she was self-injuring approximately once a week, usually with scratching, and only on days that she found to be particularly upsetting. She indicated that she would continue to work on her coping skills, with the eventual goal of stopping self-injury completely.

CHALLENGES WITH ASSESSMENT AND TREATMENT

There are two primary challenges that can arise with the treatment of self-injury: (1) reluctance on the part of the self-injuring individual to report such behavior, and (2) reluctance on the part of the person who self-injures to engage in treatment or unwillingness to decrease self-injurious behavior. Regarding the first issue, many who self-injure are hesitant to disclose their self-injury, not only to their families, but also to medical service providers (Hawton et al., 2012). Often, individuals who self-injure are afraid to disclose their behavior because they are concerned about potential stigmatization, hospitalization, or extreme responses by either family or professionals (Hawton et al., 2012), or are fearful of alienating themselves from their peers. Accordingly, family or professionals may never even notice many cases of self-injury. Indeed, it is likely that some cases of self-injury are missed simply because no one asks about it. Importantly, over the past decade, improvements have been made in assessment methods for self-injury, which will help in the identification of self-injury in many cases. With increased understanding of self-injury, it is more likely that families and professionals will inquire about the behavior, and with use of appropriate assessments there should be ample opportunity for the majority who self-injure to disclose their actions. However, there still may be some who are reluctant to admit to self-injury, even when directly asked. Researchers are working on better ways to identify self-injury, even in those who attempt to hide such behavior. One potential method, which is still in the preliminary stages of development and validation, is the use of computer programs that can distinguish between those who self-injure versus those who do not via presentation of self-injury images (Hooley & Franklin, 2018; Randall, Rowe, Dong, Nock, & Colman, 2013). Such a program would likely have utility in various clinical and educational settings, and ideally with more research it will be practical to implement such a program in those settings.

The second challenge that is frequently faced when attempting to identify or treat self-injury is that even when in treatment for self-injury, many persons who self-injure are reluctant to cease the behavior entirely. Research suggests that many persons who self-injure experience the behavior as egosyntonic, such that they do not perceive personal concern with the behavior and do not view it as problematic (Klonsky & Muehlenkamp, 2007).

Case vignette 4

Carla was a college freshman who presented to an outpatient psychological clinic for concerns regarding depression as well as anxiety about her schoolwork. When Carla completed her intake

There are also some who self-injure who feel that self-injury is a lifestyle choice that does not harm others and facilitates interpersonal connections (Adler & Adler, 2007; Lewis & Seko, 2016). Others may view self-injury as an effective solution to their emotional distress, rather than as a source of distress. Indeed, Zetterqvist and colleagues (2013) found that approximately one-quarter of adolescents who met criteria for self-injury disorder did not find their self-injury to be distressing. This issue can thus be a challenge in treatment, when clinicians are attempting to teach new methods of coping with stress but the patient is unwilling to implement new coping skills. In working to reduce self-injury, it may be useful for clinicians and patients to explore alternatives such as artistic or creative activities, recreational activities, or interpersonal/group activities that can be used in addition to or, ideally, in lieu of self-injury for self-expression, connecting, coping, and self-enrichment (Berger, Hasking, & Martin, 2017).

Although there is no clearly agreed upon method of reducing patient resistance or unwillingness to work on reducing self-injurious behavior, one potential way to increase motivation is to employ techniques from motivational interviewing, a psychotherapy used specifically to enhance the motivation for change (Emery, Heath, & Mills, 2016; Miller & Rollnick, 2002). This treatment approach involves taking a neutral stance regarding patients' need to change, rather than pushing them to change. Techniques involve open exploration of the pros and cons of self-injury, facilitating a sense of choice in patients (that it is their choice to continue using self-injury as a problematic coping method or to work toward developing better skills), and facilitating patients' sense of their ability to change if they choose to do so. The aim of motivational interviewing is to help the patient come to the conclusion that active change is necessary and desired, rather than for the therapist to demand that the patient change. Despite the promising potential of motivational interviewing in reducing self-injurious behavior, however, no studies have yet been done indicating how helpful this approach is to the reduction of self-injury. Nonetheless, it remains a reasonable, and potentially the best, treatment option for clinicians working with patients who are reluctant to cease self-injuring.

assessment with a graduate student trainee, she disclosed that she had been self-injuring regularly, three to four times a week, since she was 15 years old. This typically consisted of

primarily shallow cuts with a razor along her thighs and arms, and though bleeding was typical, the wounds never required medical attention. Carla stated that she had not been having any feelings of suicidal desire and had never attempted suicide in her life. She was experiencing moderate symptoms of anxiety, however, which she described as “panic,” but her description of panic was not consistent with typical panic disorder symptoms. In these self-described panic experiences, Carla would become upset because of an upcoming exam or class assignment, and this distress would become stronger and stronger over the course of hours. In many instances, Carla found self-injury as a helpful way for managing her anxiety, and she reported that she would start to feel better within moments of self-injuring.

When Carla’s case was assigned to a clinic psychologist, the clinician discussed her experience with depression symptoms as well as self-injury. She felt immense pressure to succeed academically and was having trouble meeting the expectations of both herself and her parents over the previous few months, which led to feelings of worthlessness and indecisiveness. When the clinician brought up the issue of her self-injury, Carla indicated that resolving the self-injury was not an essential treatment goal, and instead she wanted to focus on her depression and anxiety. The clinician expressed the seriousness of self-injury and made Carla aware of the severe risks of the behavior (e.g., serious medical injury, future suicidal behavior). Carla maintained that she wanted to focus on her other mental health symptoms, and the clinician agreed that potentially working on those symptoms might result in a synchronous reduction of self-injurious behavior along with depression and anxiety reduction.

Over the course of the next 4 months, the clinician provided CBT to help address Carla’s depression and anxiety, and carefully monitored her self-injurious behavior as well. Carla learned new ways to challenge her typical way of thinking and to examine evidence that supported or disproved her thought patterns. Carla demonstrated reasonable treatment adherence, missing approximately one session per month for what were frequently generic excuses given a day or two before the session. Her completion of homework was sporadic and decreased as therapy progressed. During this time, however, she demonstrated improvements in her depression symptoms and was in partial remission. However, her anxiety and “panic” remained present, and her self-injury frequency did not decline.

Conclusion

Self-injury can be a frightening and disturbing behavior to those who are unfamiliar with its functions. However, self-injury is much more common than once thought, with particularly high rates among adolescents. It is a transdiagnostic behavior, and can be found in people with mood, anxiety, eating, and personality disorders. Importantly, self-injury often has very serious negative consequences, ranging from physical consequences such as the need for emergency medical assistance to serious psychological consequences such as the development of suicidal ideation or attempting suicide. Fortunately, as the research on self-injury grows, our understanding of this mysterious behavior has vastly improved. We now know that the majority of people who self-

When Carla’s clinician spent some time with her, evaluating her progress, a stronger push was made to increase attention on the causes and function of her self-injurious behavior, continuing the CBT framework that had been used to help with her depression. Carla agreed to this clinical goal, but expressed ambivalence about ceasing self-injurious behavior. Over the course of treatment it became evident that Carla viewed her self-injury in a positive manner, and that lack of progress in reducing self-injury may not have been a function of lacking appropriate coping skills, but instead an issue of low motivation for change. At this point, the clinician decided that specific focus on motivation was needed, and began work with motivational interviewing. During this motivational work, further exploration yielded additional insight from Carla, and she expressed the view that self-injury was an acceptable way for her to manage her anxiety. She also stated that because it was “her body” and the behavior did not harm anyone else, and the behavior was highly effective in her stress management, she didn’t understand why she should discontinue the behavior. Of note, these arguments can be difficult to refute in a clinical scenario, as the “right” to injure oneself is a philosophical argument to some degree. In any case, a clinician should meet such claims with disinterest, and remain steadfast in the insistence that self-injury is never a healthy, appropriate, or acceptable coping response.

In the last weeks of Carla’s treatment, she began to demonstrate further irritation at the clinician’s desire for her to reduce self-injury, and in fact moved the opposite direction, her positive opinion of self-injury becoming more entrenched. Her depression symptoms went into full remission during this time, which she attributed to the success of CBT, and she expressed a desire to discontinue therapy. The clinician validated her desire to cease therapy based on her progress with her depression, but also disagreed that she no longer needed therapy, primarily because of her continued self-injurious behavior. The clinician spent the last part of therapy trying to guide Carla into acknowledging that a high-functioning adult with strong emotional management skills does not need self-injury to cope with stressful situations, but Carla’s resistance continued. At the time Carla discontinued therapy, she continued to self-injure at her initial frequency, but the clinician expressed hope that motivational interviewing had laid a foundation for future realization of the deleterious nature of self-injurious behavior, and would some day lead to subsequent behavior change.

injure do not do so to upset or manipulate others, but rather to cope with upsetting emotions that they are experiencing or to increase positive feelings. Furthermore, there are a number of approaches that can be taken to improve the treatment of those who self-injure, particularly using psychological treatment methods. As clinicians and educators, and society at large, become more familiar with self-injury, what causes self-injury, and what can be done to help those who self-injure, a behavior that might otherwise be intimidating instead will be seen as a struggle to cope with upsetting emotions in an individual needing additional support and intervention.

Resources

Assessment Tool

- **Self-Injurious Thoughts and Behaviors Interview (SITBI)**
This is a clinical interview recommended in the assessment of self-injury behaviors. It is freely available from the developer’s website. To download the interview, go to the developer’s (Dr. Matthew Nock’s) website, click on the publications tab, scroll down to 2007, and identify the paper published in Psychological Assessment. The long or short form of the SITBI interview can also be downloaded.
Website: <http://nocklab.fas.harvard.edu/tasks>

Informational Websites

- **Adolescent Self Injury Foundation**
This organization supports both patients who self-injure and their families, and provides helpful information on the warning signs for self-injury, advice for how parents can help, and advice on what persons who self-injure can do to help themselves.
Website: www.adolescentselfinjuryfoundation.com
- **American Academy of Child and Adolescent Psychiatry (AACAP)**
This organization aims to promote the awareness and understanding of various adolescent mental health concerns, including self-injury, as well as to improve the current

research concerning and treatment of adolescents. The AACAP website has many resources for basic information on eating disorders, as well as resources for professionals and the public.

Website: www.aacap.org

- **Self-Injury Facts for Families**

Website: www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Self-Injury-In-Adolescents-073.aspx

- **American Foundation for Suicide Prevention (AFSP)**

Because self-injury is so highly associated with suicide, it can be important for clinicians, families, and patients to look into foundations supporting suicide prevention and improving the understanding of suicide.

Website: www.afsp.org

- **Cornell University: Self-Injury and Recovery Research and Resources**

This program provides an informational website maintained by researchers at Cornell University that contains a number of helpful resources, videos, a blog, and research opportunities related to self-injury.

Website: www.selfinjury.bctr.cornell.edu

- **Self-injury Outreach & Support**

This international outreach organization, which is part of a collaboration between the University of Guelph and McGill University, offers an informative website that provides informational materials, resources for help and recovery from self-injury, patient stories and videos, and research opportunities related to self-injury.

Website: www.siuoutreach.org

Books and Treatment Manuals

- **Cutting Down: A CBT Workbook for Treating Young People Who Self-Harm**, Lucy Taylor, PhD, Mima Simic, PhD, and Ulrike Schmidt, PhD, Routledge, New York, NY, 2015.

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This CBT guide for reducing self-injury, particularly for adolescents, may be useful for clinicians wanting to engage in manual-assisted CBT for self-injury.

- **Freedom from Self-Harm: Overcoming Self-Injury with Skills from DBT and Other Treatments**, Kim Gratz, PhD, and Alexander Chapman, PhD, New Harbinger Publications, Oakland, CA, 2009.

This book is a useful guide for clinicians and patients wanting to work on improving self-injury through dialectical behavior therapy (DBT) skills. This is an especially good book for beginners who are just starting to work with individuals who self injure.

- **The Oxford Handbook of Suicide and Self-Injury**, Edited by Matthew K. Nock, PhD, Oxford University Press, London, UK, 2014.

This book includes information on the assessment, functions, and treatment options for self-injury. Although geared toward clinicians, it can nonetheless be useful for patients.

- **Self-Injury: Simple Answers to Complex Questions**, Edited by Jason J. Washburn, PhD, Alexian Brothers Press, Hoffman Estates, IL, 2014.

This book serves as a guide to the nature and treatment of self-injury, with contributions from various experts in the field. This book focuses on demystifying self-injury and answers a number of common questions from clinicians, patients, and families.

- **Treating Self-Injury: A Practical Guide, 2nd edition**, Barent W. Walsh, PhD, Guilford Press, New York, NY, 2012.

This book is a comprehensive and thorough guide regarding psychoeducation about self-injury, as well as recommended treatment approaches. This guide is useful for clinicians, patients, and families.

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SELF INJURY IN ADULTS AND ADOLESCENTS, 2ND EDITION

Final Examination Questions

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86. The currently preferred term for specifically describing *self-injurious behavior* in the absence of suicidal intent is:
 - a. Parasuicidal behavior.
 - b. Nonsuicidal self-injury.
 - c. Suicidal gestures.
 - d. Self-mutilation.
87. The best example of behavior that falls within the typical definition of direct self-injury is:
 - a. Smoking cigarettes.
 - b. Attempting suicide.
 - c. Driving recklessly.
 - d. Cutting oneself with a razor.

88. The highest rates of self-injury are reported for individuals:
 - a. Younger than 10 years old.
 - b. Between ages 11 and 19.
 - c. Between the ages of 20 and 30.
 - d. Over 30 years old.
89. Nonsuicidal self-injury disorder with full diagnostic criteria was introduced in:
 - a. DSM-II.
 - b. DSM-III.
 - c. DSM-IV-TR.
 - d. DSM-5.
90. Among those who begin self-injuring during adolescence, as they mature the frequency and severity of their self-injury will:
 - a. Likely decrease.
 - b. Remain unchanged.
 - c. Increase drastically.
 - d. Fluctuate regularly.
91. An issue that has emerged over the past two decades and may be particularly relevant to adolescents who self-injure is:
 - a. The emergence of websites promoting self-injury.
 - b. The understanding that the behavior is the same all the time.
 - c. That new methods of self-injury have developed.
 - d. That self-injury has become less medically severe.
92. What percentage of a woman's increased risk for developing self-injury can be attributed to genetics?
 - a. 11%.
 - b. 35%.
 - c. 59%.
 - d. 92%.
93. A known social risk factor for self-injury is:
 - a. Minority sexual orientation status.
 - b. Being held back a grade in school.
 - c. Parental divorce.
 - d. Low family income.
94. An adolescent male in a juvenile detention center setting is provided medical attention for a recent self-injury. When asked why he self-injured, the adolescent states that he wanted to avoid work responsibilities. Which function of self-injury does this adolescent's actions serve?
 - a. Self-punishment.
 - b. Automatic negative reinforcement.
 - c. Feeling generation.
 - d. Anti-suicide.
95. Many who self-injure do so because they desire to experience pleasant physical sensations, satisfaction, excitement, or relief. This function of self-injury is referred to as:
 - a. Self-punishment.
 - b. Social negative reinforcement.
 - c. Feeling generation.
 - d. Anti-suicide.
96. The emotional cascade model of self-injury suggests that those who self-injure do so in order to reduce distressing emotional experiences by using pain or the sight of blood to distract from:
 - a. Ineffective coping skills.
 - b. Their responsibilities.
 - c. Low self-esteem.
 - d. Ruminative thoughts.
97. The level of risk for a later suicide attempt in an adolescent or adult who self-injures is:
 - a. Zero.
 - b. Slight.
 - c. Moderate.
 - d. High.
98. A major drawback to using standard in-person or semi-structured interviews to clinically assess for self-injury is that these types of interviews:
 - a. Can result in different self-injury estimates with different interviewers.
 - b. Do not allow for clarification of responses.
 - c. Require extensive training to properly administer.
 - d. Do not assess self-injury symptoms as accurately as self-report measures.
99. One particular advantage to using the Self-Injurious Thoughts and Behaviors Interview (SITBI) is that it:
 - a. Is self-administered.
 - b. Minimizes and stigmatizes self-injury.
 - c. Is a briefer and more convenient assessment.
 - d. Includes a thorough assessment of suicidal ideation and behavior.
100. Self-injury is a common problem among persons with eating disorders, particularly for those diagnosed with:
 - a. Anorexia nervosa – binge-purge subtype.
 - b. Anorexia nervosa – restricting subtype.
 - c. Anorexia nervosa – unspecified subtype.
 - d. Binge eating disorder.
101. A clinician conducts an assessment of an adolescent suspected of self-injuring. During the course of the interview, the only behavior the adolescent reports is frequent and compulsive picking of skin and scabs to the point of causing bleeding. This behavior is best classified as:
 - a. Direct self-injury.
 - b. Excoriation.
 - c. Trichotillomania.
 - d. Indirect self-injury.
102. Which psychological treatment is most indicated for an adolescent or adult who self-injures frequently and has a co-occurring diagnosis of borderline personality disorder?
 - a. Dialectical behavior therapy.
 - b. Cognitive behavioral therapy.
 - c. Supportive therapy.
 - d. Motivational interviewing.
103. Treatment of self-injury in adolescents can be enhanced by including families because:
 - a. Family treatments are well-studied interventions for self-injury.
 - b. Adolescents need a safe space to blame their families for the self-injury.
 - c. Families can regularly monitor the adolescent's self-injurious behavior.
 - d. Adolescents will refuse to stop self-injury without encouragement from their families.
104. Assessing self-injury can be particularly challenging because some individuals:
 - a. Do not realize they have been self-injuring.
 - b. Provide too much detail about their self-injury.
 - c. Cannot complete self-injury assessments in primary education settings.
 - d. Are fearful of the consequences of disclosing self-injury.
105. For the many individuals who are reluctant to stop self-injury or who see it as a reasonable coping skill, the best treatment technique is:
 - a. Motivational interviewing.
 - b. Narrative therapy.
 - c. Family intervention.
 - d. Nutritional counseling.

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