NCMHCE Exam Practice Questions

NCMHCE Practice Tests & Review for the National Clinical Mental Health Counseling Examination

Mometrix Test Preparation
Table of Contents

Practice Test ................................................................................................................................. 1
Instructions .................................................................................................................................... 1
Simulation #1 ................................................................................................................................. 3
Simulation #2 ................................................................................................................................. 23
Simulation #3 ................................................................................................................................ 41
Simulation #4 ................................................................................................................................ 61
Simulation #5 ................................................................................................................................ 77
Simulation #6 ................................................................................................................................ 87
Simulation #7 ................................................................................................................................ 101
Simulation #8 ................................................................................................................................ 113
Simulation #9 ................................................................................................................................ 125
Simulation #10 ............................................................................................................................. 139
Practice Test

Instructions

You have an examination booklet that contains ten simulations. Each simulation starts with a paragraph that gives preliminary information about a patient/client. The sections which follow are identified with a capital letter. Each section begins with specific instructions about the number of responses to select. You will indicate your selection, or selections, by placing a mark in the square. After you make your selection or selections, you will want to check your answers as the answer explanations can provide insight and possibly additional information helpful in completing the other sections. The answers for each section are given on the following page.

“Information Gathering” sections generally instruct you to “select as many as you consider indicated.” Read all of the choices before you select the responses you consider appropriate at that time for the patient/client.

“Decision Making” sections generally instruct you to “select the most appropriate.” Read all of the choices and then select the response you believe is the best. Make sure you check your answer before moving on as you will have to make another selection if your response is incorrect.
Simulation #1

Debra is a 34-year-old divorced African-American woman residing in a transitional living center for the past 18 months. Reports indicate she is of normal intellectual capacity, and her current level of function is high. You have been called to evaluate her continued eligibility for services in the facility. Her presenting provisional DSM-5 diagnosis is Bipolar I Disorder, Most Recent Episode Depressed, Severe with Psychotic Features, Mood-Congruent (296.54). There have been at least 3 episodes of depressive decompensation, each time with accompanying psychotic features, over the past 3 years. Her last decompensation episode occurred within the last 60 days and was only resolved after involuntary hospitalization and medication administration.

NOW GO TO SECTION A.

Section A: Initial Information Gathering

Which of the following elements would be important in confirming or revising the presenting DSM-5 diagnosis?

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all selected answer choices.

☐ 1. Educational history.
☐ 2. Mental status examination.
☐ 4. Frequency and nature of bipolar episodes.
☐ 5. Family mental health history.
☐ 7. Medications compliance.
☐ 8. Current level of functioning.
☐ 10. Prior and/or current substance abuse.
☐ 11. Other psychiatric history.
☐ 12. Quality of existing family relationships.

NOW GO TO SECTION B.
Section A: Relevance and Initial Information Explored

1. Educational history
   NOT INDICATED (-1)
   High school graduate, of apparently normal intellectual functioning.

2. Mental status examination
   NOT INDICATED (-1)
   The formal record indicates “she is of normal intellectual capacity, and her current level of function is high.”

3. Current stressors
   INDICATED (+1)
   Unemployed and at risk of homelessness. Limited social support (no local family and few apparent friends, largely because the client is very quiet and introverted). Living in a group-style transitional setting. Ongoing issues of mental illness.

4. Frequency and nature of bipolar episodes
   INDICATED (+2)
   All decompensation episodes have been depressive in nature (i.e., no signs of mania). During the episodes, the client reported feelings of helplessness, hopelessness, hypersomnia, tearfulness, fatigue, poor concentration, and marked anhedonia. Over a period of two or more weeks, the symptoms escalated to include psychotic features (hallucinations, delusions, and intense agitation), resulting in involuntary psychiatric hospitalization. In between episodes, the client has been remarkably stable without apparent mood “coloring” of any kind.

5. Family mental health history
   INDICATED (+1)
   There is no family history of mental illness, and specifically none indicative of bipolar tendencies.

6. Past/Current medications prescribed
   INDICATED (+1)
   The client has no history of psychotropic medications use; current medication prescribed is lithium carbonate.

7. Medications compliance
   INDICATED (+2)
   The client is persistently noncompliant with her medications.

8. Current level of functioning
   NOT INDICATED (-1)
   The formal record indicates “her current level of function is high.”

9. Employment history
   NOT INDICATED (-1)
   The client resides in a transitional living residence and is unemployed. Past employment has involved clerical and house-cleaning jobs.
10. Substances of abuse
   NOT INDICATED (-1)
   The client has no past or current substance abuse.

11. Other psychiatric history
    INDICATED (+1)
    The client has no other known history of a psychiatric nature.

12. Quality of existing family relationships.
    NOT INDICATED (-2)
    The client has family who live on the opposite coast of the nation, and she has little contact with them.

**RESPONSE DEVELOPMENT:**
The client has been given a provisional Bipolar I Disorder diagnosis. Relevant criteria for this diagnosis require at least one manic episode or mixed mania and depression; however, the record indicates the client has had only depressive symptoms evident during decompensation. Cyclothymic Disorder can be ruled out, as it is characterized by only mild depression and also requires evidence of hypomania; the client has had severe depressive symptoms, sufficient to induce “psychotic features,” and has exhibited no mania. Bipolar II is a possible diagnosis, although the requisite “at least one hypomanic” episode appears to be lacking. The absence of substance abuse further suggests endogenous rather than exogenous factors. Finally, the lack of any family bipolar history is noteworthy, as two-thirds of all individuals with a bipolar diagnosis have a family history of the disorder. Certainly the provisional diagnosis warrants further investigation.
**Section B:** Based on the intake data, identify potential issues to be addressed:

DIRECTIONS: Select as many as seem correct and necessary. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Focus on employment needs.
☐ 2. Explore and address family relationship issues.
☐ 3. Improve the client’s insight into her illness.
☐ 4. Explore past symptoms of depression and coping.
☐ 5. Address medication noncompliance concerns.

NOW GO TO SECTION C.
Section B: Relevance of Potential Information to be Addressed:

1. Focus on employment needs.  
   NOT INDICATED (-1)  
The client is currently in a stable living situation, and staff at the transitional living center are charged with addressing the client’s employment status.

2. Explore and address family relationship issues.  
   NOT INDICATED (-1)  
No family issues have been presented, thus assume there are none.

3. Improve the client’s insight into her illness.  
   INDICATED (+2)  
The client is described as noncompliant with medications, and she has had repeated episodes of decompensation. She is clearly in need of education regarding her illness and its effects, the role of medications, how to head off impending episodes, decompensation, and coping skills.

4. Explore past symptoms of depression and coping.  
   INDICATED (+1)  
The client describes classic symptoms of depressive decompensation lasting more than two weeks, and she is in need of better coping skills, including medication compliance.

5. Address mediation noncompliance concerns.  
   INDICATED (+2)  
Of primary concern, given the provisional diagnosis, is medication compliance.
Section C: Additional Information Gathering

Which of the additional following elements would be most important in confirming or revising the presenting DSM-5 diagnosis?

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Income history.
☐ 2. The Beck Depression Inventory-II.
☐ 3. Duration of time between decompensation episodes.
☐ 4. Degree of medication noncompliance.
☐ 5. Seasonal mood patterns.
☐ 7. Unexplained weight gain or loss.
☐ 8. Medical history.
☐ 9. Postpartum depression.
☐ 10. Religious affiliation/attendance.
☐ 11. Traumatic life events.
☐ 12. Marital history.

NOW GO TO SECTION D.
Section C: Element Relevance and Secondary Information Obtained

1. Income history.
   NOT INDICATED (-1)
The client has no current income, but is in a stable total-care living situation.

2. The Beck Depression Inventory-II.
   NOT INDICATED (-2)
The client is not currently in a decompensated state; this evaluation for depression is not indicated.

3. Duration of time between decompensation episodes.
   INDICATED (+1)
   It is revealed that the client has annual episodes of decompensation, with remarkable stability between episodes. Decompensation is brief, and tends to be quickly resolved by involuntary hospitalization and medication administration.

4. Degree of medication noncompliance.
   INDICATED (+2)
The client is totally noncompliant with medications throughout all periods between decompensation episodes, and cannot be legally forced to comply.

5. Seasonal mood patterns.
   INDICATED (+1)
The client’s episodes of decompensation occur only during the last two weeks of August each year, suggesting a late-summer seasonal pattern.

   INDICATED (+1)
The client denies ever having attempted suicide, and denies ideation with any real intent (e.g., transient thoughts but absent any element of planning).

7. Unexplained weight gain or loss.
   INDICATED (+1)
   No significant weight loss or gain has been reported.

8. Medical history.
   INDICATED (+1)
The client has been medically evaluated. No history of head trauma, hormone imbalance, seizures, or other relevant disorders.

9. Postpartum depression.
   INDICATED (+2)
The client is gravida 2, para 2 (no spontaneous or therapeutic abortion history), and denies any problems with postpartum depression.

10. Religious affiliation/attendance.
    NOT INDICATED (-1)
    No issues regarding religiosity have been identified.
11. Traumatic life events.
INDICATED (+2)
Upon careful interview the client admits she was the driver of the vehicle in which her two children were killed, when struck by a drunk driver, in August 3 years ago.

12. Marital history.
NOT INDICATED (-1)
No issues of a marital nature have been identified. However, the divorce did occur shortly after the death of the children.

RESPONSE DEVELOPMENT:
Duration of time between decompensation episodes is significant as the average number of bipolar episodes is 8 to 10 over a lifetime, and this client is experiencing episodes at least annually. Issues of medication noncompliance are significant, as most individuals with bipolar disorder will tend toward symptoms of depression and/or mania when not medicated. This client, however, manages well for extended periods with no mood “coloring” in spite of the absence of medications. The seasonal nature of the client’s episodes (summertime only) is significant, as many individuals with bipolar disorder have seasonal variations (e.g., particularly depressive symptoms in the fall). The absence of postpartum depression is meaningful, as bipolar disorder is triggered by pregnancy and postpartum mood changes in up to 25% of diagnosed women. In summary, the client's decompensation frequency is higher than would be expected, stability off of medications is far better than would be expected (i.e., no mood “coloring” at all), the condition was not triggered nor exacerbated by pregnancy, there is no family history, as would be common, and the periods of onset are far too specific (i.e., limited to the last 2 weeks in August) than could be explained by a diagnosis of Bipolar I Disorder alone.
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Section D: Provisional Diagnosis Formulation

Based on the available information, what would appear to be the most appropriate provisional DSM-5 diagnosis?

DIRECTIONS: Select the most appropriate primary diagnosis indicated in this section. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Posttraumatic Stress Disorder (309.81).
☐ 2. Adjustment Disorder, with Mixed Anxiety and Depressed Mood (309.28).
☐ 3. Bereavement as “a focus of clinical attention” (V62.82).
☐ 4. Major Depressive Disorder, Recurrent, Severe With Psychotic Features (296.34).
☐ 5. Bipolar II Disorder (296.89).
☐ 6. Brief Psychotic Disorder, With Marked Stressors (298.8).
☐ 7. Schizoaffective Disorder (295.70).

NOW GO TO SECTION E.
Section D: Relevance and Diagnostic Formulation.

   NOT INDICATED (-1)
   The client meets PTSD criteria during episodes of decompensation, but lacks sufficient features for a full diagnosis of PTSD (primarily because of her success in blocking out the event outside the time immediately surrounding the “anniversary date” of the loss).

2. Adjustment Disorder, with Mixed Anxiety and Depressed Mood, chronic.
   NOT INDICATED (-1)
   DSM- specifies that the diagnosis of an adjustment disorder may not be given in situations related to bereavement, and cannot persist longer than 6 months. The client appears to have specific issues surrounding the loss of her children, and the problem has episodically resurfaced over the past 3 years.

3. Bereavement as “a focus of clinical attention.”
   NOT INDICATED (-1)
   As indicated in the DSM 5 manual, V codes represent things that are the focus of clinical attention but are not considered disorders. Given the severity and recurrent nature of this case, a V code would not be diagnostically sufficient.

4. Major Depressive Disorder, Recurrent, Severe With Psychotic Features.
   INDICATED (+3)
   The client has key features of depression, including feelings of helplessness, hopelessness, hypersomnia, tearfulness, fatigue, poor concentration, and marked anhedonia, eventually progressing to include psychotic features. Symptoms persisted for more than 2 weeks and only resolved with hospitalization and medication.

5. Bipolar II Disorder
   NOT INDICATED (-1)
   Requires at least 1 episode of hypomania in addition to an episode of Major Depression.

6. Brief Psychotic Disorder, With Marked Stressors
   NOT INDICATED (-1)
   The DSM notes that this diagnosis is only appropriate where disturbance is not better accounted for by a Depressive Disorder, With Psychotic Features. The client’s marked depressive symptoms more accurately fit Depressive Disorder criteria.

7. Schizoaffective Disorder
   NOT INDICATED (-1)
   For this diagnosis, there must have been an uninterrupted period of illness (the client’s symptoms completely resolve between episodes), and psychotic features must have persisted in the absence of prominent mood symptoms (the client’s mood symptoms persisted during psychosis).
RESPONSE DEVELOPMENT:
The client’s history is positive for a profoundly traumatic life event: the death of her 2 children, in August, 3 years prior (coinciding with the onset of decompensation episodes). This history suggests PTSD, and/or Major Depression, recurrent, severe, with psychotic features. The client lacks sufficient features for a full diagnosis of PTSD (primarily because of her success in blocking out the event outside the time immediately surrounding the “anniversary date” of the loss), although some features are present. The DSM-5 V code of V62.82 (bereavement) is inadequate, because it refers solely to issues of bereavement that are a focus of clinical attention, without addressing the severity of the problem. This leaves Major Depression, recurrent, severe, with psychotic features, with full interepisode recovery, as a full remission was attained between the mood disturbance episodes.
Section E: Based on the provisional diagnosis, what treatment methods and referrals would be appropriate for Debra?

DIRECTIONS: Select as many as you consider indicated in this Section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Individual Grief Therapy.
☐ 2. Family Counseling.
☐ 3. Participation in a bereavement support group.
☐ 5. Illness Insight Counseling.
☐ 6. Independent Living Education.
☐ 7. Medication Compliance Monitoring and Counseling.

NOW GO TO SECTION F.
Section E: Treatment Approach Relevance and Selection.

1. Individual Grief Therapy.
   INDICATED (+2)
   All signals are that the client has unresolved grief issues urgently in need of address. Worden (1991) indicates that “grief counseling” addresses uncomplicated or normal grief, while grief therapy utilizes specialized techniques to address abnormal or complicated grief: (1) prolonged grief; (2) grief manifested through somatic or behavioral symptoms; or (3) an exaggerated grief response.

2. Family Counseling.
   NOT INDICATED (-2)
   No family involvement described; must assume there are no relevant issues.

3. Participation in a bereavement support group.
   INDICATED (+1)
   The client's history suggests great fragility, and support group settings are generally insufficiently structured to ensure this client's best interests. After progress in one-on-one sessions, group work may well be indicated.

   INDICATED (+1)
   The client clearly has not coped well with the stressors surrounding her loss. This approach may be useful in conjunction with grief counseling.

5. Illness Insight Counseling.
   INDICATED (+2)
   The client is greatly in need of illness insight counseling, both to understand what is occurring in her life, and to more fully ensure treatment compliance.

6. Independent Living Education.
   NOT INDICATED (-2)
   All indications are that this previously married mother of two was functioning well prior to the traumatic loss of her children. There is no indication that she is in need of education regarding independent living skills.

7. Medication Compliance Monitoring and Counseling.
   INDICATED (+2)
   The constellation of symptoms described strongly suggests the need for psychiatric medications, and counseling and compliance monitoring to this end is particularly important.

   INDICATED (+2)
   This technique is most useful in situations where understanding (of illness) and behavioral change (medication compliance) are required.

   INDICATED (+2)
   Given the scenario presented, it is highly likely that this client will need medication support, and prompt follow-up with a psychiatrist is essential.
**Section F**: Based on the selected treatment modalities, what information and monitoring methods would be appropriate for Debra?

**DIRECTIONS**: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

1. Staff reports of progress in the transitional living program.
2. Mood graph.
3. Completion of homework assignments.
4. Medications monitoring
5. Affective functioning
6. Social interactions
7. Substance abuse monitoring.
8. Energy level.
9. Employment seeking
10. Cognitive functioning

NOW GO TO SECTION G.
Section F: Information and Monitoring Methods Relevance and Selection.

1. Staff reports of progress in the transitional living program.
   NOT INDICATED (-1)
   Transitional living activities and progress are not a substantial measure of grief work and progress.

2. Mood graph
   INDICATED (+2)
   Tracking mood on a graph aids in determining the client’s level of depression, as well as progress being made in coping, etc.

3. Completion of homework assignments.
   INDICATED (+1)
   This serves as a measure of compliance and motivation. Approaches may include 1) journaling, 2) bibliotherapy (reading assignments), 3) memorialization.

4. Medications monitoring
   INDICATED (+2)
   Pill counts and therapeutic blood levels (where indicated)

5. Affective functioning
   INDICATED (+1)
   The client’s affective presentation should signal any upcoming relapse and should be followed closely.

6. Social interactions
   INDICATED (+1)
   The client has been described as quiet and introverted, which may predispose relapse. Thus, careful monitoring of social interactions is important.

7. Substance abuse monitoring
   NOT INDICATED (-1)
   No issues of substance abuse have been identified.

8. Energy level.
   INDICATED (+1)
   Increasing fatigue, apathy, and listlessness may signal a relapse and should be followed closely.

9. Employment seeking
   NOT INDICATED (-1)
   This is a component of the facility’s program, and is largely unrelated to the current issues being addressed.

10. Cognitive functioning
    INDICATED (+1)
    The client struggled with poor concentration and distractibility during past periods of decompensation. This should also be carefully monitored.
Section G: In developing a collaborative treatment plan with the client, which of the following should be included?

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

- [ ] 1. Identify the goals of treatment appropriate to the issues being addressed.
- [ ] 2. Decide on the total number of sessions required.
- [ ] 3. Develop the specific objectives to meet the identified goals.
- [ ] 4. Determine the client’s post-counseling housing options.
- [ ] 5. Address confidentiality requirements and limits.
Section G: Treatment Plan Development Options – Relevance and Selection.

1. Identify the goals of treatment appropriate to the issues being addressed.
   INDICATED (+2)
   Shared efforts to identify the goals of treatment will elicit client buy-in to the process and outcomes of the therapeutic experience.

2. Decide on the total number of sessions required.
   NOT INDICATED (-1)
   While a general counseling course may be parsed if requested by the client, no effort should be made to delimit this important experience at the outset.

3. Develop the specific objectives to meet the identified goals.
   INDICATED (+2)
   Identification of the steps to goal achievement deepens client commitment and overall clarity of necessary steps and expectations.

4. Determine the client’s post-counseling housing options.
   NOT INDICATED (-2)
   This issue is being addressed by the transitional living program, and is not germane to the counseling issues being addressed.

5. Address confidentiality requirements and limits.
   INDICATED (+1)
   Every client needs to know the scope and limits of confidentiality in the context of counseling, and it should be addressed at the outset of the counseling experience.

SCORING: (Max = maximum possible; MPL = minimum passing level)

1A. Max 8; MPL 5
1B. Max 5; MPL 3
1C. Max 11; MPL 8
1D. Max 3; MPL 1
1E. Max 12; MPL 8
1F. Max 9; MPL 6
1G. Max 5; MPL 3
Simulation #2

Frank is a 32-year-old, slender, unemployed, never-married white man, living in a board and care home paid for by his well-to-do and politically well-connected parents. The care home operator brought him in to be seen, claiming that he was “disruptive, impulsive, and threatening.” Further, he seemed to have episodes of unexplained “crazy” behavior, talking to himself, sleeping very little for days and then “crashing,” and being verbally explosive at other times. The care home operator was concerned that he may be potentially dangerous to the other clients in the facility, including both developmentally delayed and frail elderly individuals.

Hygiene and grooming were fair-to-poor (e.g., uncombed hair, disheveled clothing, soiled hands and fingernails, mild body odor). His attire was very adolescent in appearance, ripped jeans, motorcycle boots, black leather vest, “gothic” skull rings, a long wallet chain, studded leather belt and wrist guard.

Frank was angry about having been confronted about his behavior, and did not feel he needed to be seen. He claimed that the board and care home was too restrictive, and that the care operator “had it out for him.” He had little positive to say about anyone in the facility. His eye contact was poor, psychomotor agitation was moderate-to-high, and he seemed to be manipulative and evasive in his overly aggressive verbal responses.

NOW GO TO SECTION A.

Section A: Initial Information Gathering

Which of the following elements would be important in formulating a provisional DSM-5 diagnosis?

DIRECTIONS: Select as many as you consider correct. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Residential history.
☐ 2. Medical history.
☐ 3. Educational history.
☐ 4. Interpersonal relationships.
☐ 5. Psychiatric history.
☐ 6. Substance abuse history.
☐ 7. Mood status.
☐ 8. Vocational/employment history.

NOW GO TO SECTION B.
Section A: Relevance and Initial Information Obtained

1. Residential history.
   INDICATED (+1)
   The client has lived in various group homes and board and care settings since late adolescence, based on behavioral problems and the presumptive presence of “some sort of mental illness.” He had often been evicted because of disruptive and aggressive behavior. He does not get along well with his parents, and states that they would not allow him back into their home.

2. Medical history.
   INDICATED (+1)
   No information relevant to a diagnosis was obtained. No reported history of head trauma, neurological disorders, endocrine (including thyroid) disorders, and no metabolic issues. Client is a chronic 3-pack/day smoker.

3. Educational history.
   NOT INDICATED (-1)
   Not relevant to formulating a DSM diagnosis. However, the client dropped out of high school in his junior year.

4. Interpersonal relationships.
   INDICATED (+1)
   An only child, he was functionally estranged from his parents, who nevertheless support him. All reported friendships were with adolescents and others much younger than him. Age-appropriate relationships were typically transient and problematic because of the client’s demanding nature.

5. Psychiatric history.
   INDICATED (+2)
   At least 1 prior psychiatric hospitalization for “schizophrenic-like” behavior, with suspicions of substance-induced psychosis (blood testing was positive for methamphetamine abuse). This hospitalization became the basis for his subsequent admissions to board and care homes. It also resulted in the assignment of a mental health case manager, largely serving only to relocate him to new living settings following his frequent evictions, and to manage his money.

   INDICATED (+2)
   Client admits remote history of amphetamine use, but denies any current use.

7. Mood status.
   INDICATED (+1)
   The client is often agitated, angry, and mercurial. Similar features evident during intake.

8. Vocational/employment.
   NOT INDICATED (-2)
   Not germane to the diagnostic process; client has no special skills or training. He has never been employed.
RESPONSE DEVELOPMENT:
The client is a 32-year-old adult with a history of substance abuse, disruptive, angry behavior, poor impulse control, moodiness, and possible psychotic behavior. He has poor educational achievement, negligible independent living skills, no vocational skills, and no employment history. Prior psychiatric hospitalization suggests the presence of mental illness. However, it is unclear whether presenting symptoms at the time of hospitalization were due to substance abuse or an underlying psychiatric condition. The care operator reports episodic symptoms of “talking to himself” that suggest attention to internal stimuli. However, these symptoms could also reflect ongoing substance abuse, as could his alternating episodes of insomnia and hypersomnia.
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**Section B**: Based on the intake data, identify potential issues to be addressed:

DIRECTIONS: Select as many as seem correct and necessary. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

- Family relationships.
- Suicidality
- Anger management.
- Mood swings.
- Educational issues.
- Impulse control.
- Employment issues.
- Explore possible substance abuse

**NOW GO TO SECTION C.**
Section B: Relevance of Potential Information Needing to be Addressed:

1. Family relationships.
   NOT INDICATED (-1)
   The client is an only child and is long estranged from his parents. This is not a pressing issue.

2. Suicidality
   NOT INDICATED (-1)
   There is no indication of depression, grief, or overt self-harm intent.

3. Anger management.
   INDICATED (+2)
   By all reports and presentation the client has anger management issues requiring address.

4. Mood swings.
   INDICATED (+1)
   Reports indicate that the client has frequent mood swings that compromise his ability to cope with relationships and other emotional issues (e.g., anger).

5. Educational issues.
   NOT INDICATED (-1)
   While it would be positive for the client to complete his high school education, it is not a pressing or relevant issue requiring address.

6. Impulse control.
   INDICATED (+2)
   By reports and presentation the client appears to have very poor impulse control.

   NOT INDICATED (-1)
   The client has no employment history. However, his living situation appears stable (outside of behavioral issues) and employment concerns do not need current address.

8. Explore possible substance abuse.
   INDICATED (+2)
   The client’s mental health symptoms could be explained by ongoing substance abuse, which needs to be explored further and then addressed if confirmed.
**Section C: Additional Information Gathering**

What assessment tools might offer meaningful information on this client?

DIRECTIONS: Select as many as you consider indicated in this Section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

- 1. The Minnesota Multiphasic Personality Inventory (MMPI-2)
- 2. The 16 Personality Factor Questionnaire (16PF).
- 3. Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
- 4. Drug Abuse Screening Test (DAST)
- 5. Beck Depression Inventory-II (BDI-II)
- 6. Thematic Apperception Test (TAT)

NOW GO TO SECTION D.
**Section C: Relevance of Proposed Assessment Tools:**

1. The Minnesota Multiphasic Personality Inventory (MMPI-2)  
   **INDICATED (+1)**  
   This widely used, well-validated personality instrument could provide objective insights into this client’s personality, but it may be difficult to administer to an individual with limited tolerance and impulse control.

2. The 16 Personality Factor Questionnaire (16PF).  
   **INDICATED (+2)**  
   This internationally used and well-validated multiple-choice personality questionnaire measures 16 primary traits, along with 5 higher-level “second-order” traits. The test is useful in predicting a wide variety of behaviors; most particularly for this case includes cognitive style, empathy and interpersonal skills, conscientiousness, self-esteem, frustration tolerance, and coping patterns.

3. Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)  
   **NOT INDICATED (-2)**  
   There is no information nor presentation pattern to suggest diminished cognitive capacity.

4. Drug Abuse Screening Test (DAST)  
   **NOT INDICATED (-1)**  
   There are suspicions of drug abuse, but the client denies such use. As a self-report instrument, this test is of no immediate value.

5. Beck Depression Inventory-II (BDI-II)  
   **NOT INDICATED (-1)**  
   The client is reportedly moody, but the primary emotion displayed is anger as opposed to depression.

6. Thematic Apperception Test (TAT)  
   **INDICATED (+1)**  
   This projective assessment tool may aid in uncovering useful unconscious material with this client.
Section D: Additional Data Gathering

To better determine the client's level of function, current behavioral problems, and possible substance abuse, what additional data may be helpful?

DIRECTIONS: Select the most appropriate options provided in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

- [ ] 1. Direct interviews with the care home operator and staff.
- [ ] 2. School records review.
- [ ] 3. Collateral contact with the mental health case manager.
- [ ] 4. Contact with the client's neighborhood friends.
- [ ] 5. Collateral contact with the client's parents.
- [ ] 6. Legal history review.
- [ ] 7. Medical records review.

NOW GO TO SECTION E.
Section D: Options Relevance and Findings.

1. Direct interviews with the care home operator and staff.
   INDICATED (+2)
   The operator has described the client as disruptive, impulsive, and threatening, with episodes of unexplained “crazy” behavior, talking to himself, sleeping very little for days and then “crashing,” and being verbally explosive at times. Other facility staff offered similar supporting views.

2. School records review.
   NOT INDICATED (-2)
   The client is 32 years of age and left school between 16 and 17 years of age. These records would be difficult to obtain (the client is unlikely to release them), and would offer only very remote history.

3. Collateral contact with the mental health case manager.
   INDICATED (+2)
   The mental health case manager, citing a client information release, notes that the client has had considerable behavioral problems for some years (evicted from more than 20 care homes). He confirms ongoing substance abuse (“I pulled needles out of his clothes last week, and if I don’t use a payee service to manage his money, he spends it all on methamphetamines”). He also seconds the suspicions that the client’s “mental health” issues are actually a direct result of his drug use, as the client tends to display psychotic features only when using drugs.

4. Contact with the client’s neighborhood friends.
   NOT INDICATED (-1)
   The client tends to associate only with minors. Friends and neighbors reveal the client has issues of confidentiality and other potential legal pitfalls.

5. Collateral contact with the client’s parents.
   NOT INDICATED (-1)
   The client specifically indicates that he is estranged from them. Reports indicate that the politically well-placed parents have “pulled strings” to secure mental health services for their son, and that they are very defensive of him to the point of covering and denying his behavior.

6. Legal history review.
   INDICATED (+2)
   Local law enforcement records indicate that the client has repeatedly been picked up for possession/purchase of methamphetamine. He was not prosecuted, however, as he was seen as a mental health client and was relinquished for psychiatric care.

7. Medical records review.
   INDICATED (+2)
   The client has had repeated emergency department visits at the local county hospital, having been brought in by law enforcement for “bizarre behavior” and being under the influence on numerous occasions, most recently within the last 30 days. Records indicate positive laboratory testing for amphetamines, and that his psychotic behavior and hallucinations (formication) typically cleared as soon as the intoxication had passed.
RESPONSE DEVELOPMENT:
The client has a positive ongoing history of drug abuse (methamphetamine, by report), which appears to be his primary mental health issue. With the case manager's description of syringes and needles in the client’s personal affects, it appears that intravenous drug abuse is a primary concern.
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Section E: Based on the information obtained, what provisional diagnosis would be appropriate for this client?

DIRECTIONS: Select the one most appropriate primary diagnosis. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Amphetamine-Induced Psychotic Disorder, With Delusions (292.9).
☐ 2. Schizophrenia, continuous (295.90).
☐ 3. Amphetamine-Induced Psychotic Disorder, With Hallucinations (292.9).
☐ 4. Intermittent Explosive Disorder (312.34).
☐ 5. Unspecified Attention-Deficit Hyperactivity Disorder (314.01).
☐ 6. Narcissistic Personality Disorder (301.81).

NOW GO TO SECTION F.
Section E: Element Relevance and Diagnostic Formulation

1. Amphetamine-Induced Psychotic Disorder, with Delusions (292.9).
   NOT INDICATED (-1)
   There is no report of delusions when the patient was in a substance-induced psychotic state.

2. Schizophrenia, continuous (295.90).
   NOT INDICATED (-2)
   Schizophrenia and most of the psychotic disorders cannot be diagnosed when the symptoms could be attributable to a drug. One of his main symptoms discussed, hallucinations, could be directly attributed to methamphetamine use.

3. Amphetamine-Induced Psychotic Disorder, with Hallucinations (292.9).
   INDICATED (+3)
   This would be the proper primary diagnosis. Clinical laboratory testing confirms that the client has abused amphetamines in the past. The substance was reportedly methamphetamine (an amphetamine-class drug). Psychotic behavior with hallucinations (formication) was medically documented as well.

4. Intermittent Explosive Disorder (312.34).
   NOT INDICATED (-2)
   The DSM indicates that the behavioral criteria for this diagnosis must not be met by “a general medical condition or substance use, including medications and drugs of abuse.”

5. Unspecified Attention-Deficit Hyperactivity Disorder (314.01).
   NOT INDICATED (-1)
   While the client does appear to be impulsive and easily agitated, the substance abuse may well be the primary cause of his erratic and hyperactive behavior, insomnia, etc.

6. Narcissistic Personality Disorder (301.81).
   NOT INDICATED (-2)
   This client clearly has features of narcissism, among other possible personality disorder traits. However, it is NEVER appropriate to produce a mental disorder diagnosis early in a clinical course, absent a substantial preponderance of relevant supporting evidence. Until all issues are clear, a clinician should enter 799.9: diagnosis deferred or an appropriate unspecified diagnosis.

RESPONSE FORMATION
The current provisional diagnosis for this client would be:
Amphetamine-Induced Psychotic Disorder, with Hallucinations (by prior history) (292.9)
Section F: Based on the provisional diagnosis, what theoretical approach might work best for this client?

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Person-Centered Therapy.
☐ 3. Freudian Therapy.
☐ 5. Adlerian Therapy.

NOW GO TO SECTION G.
Section F: Element Relevance and Commentary

1. Person-Centered Therapy.
   NOT INDICATED (-1)
   This approach works well for situational disorders or self-esteem issues, but it is not ideal for substance use problems.

   INDICATED (+2)
   This approach is ideal for substance abuse treatment; it can be readily focused on relapse prevention strategies.

3. Freudian Therapy.
   NOT INDICATED (-1)
   This therapeutic approach is best suited to short-term interventions around depression and anxiety, and long-term therapy with dissociative disorders and personality disorders.

   NOT INDICATED (-1)
   This approach is appropriate for individuals coping with stressors of a more minor nature, as opposed to a substance use issue.

5. Adlerian Therapy.
   NOT INDICATED (-1)
   The Adlerian approach is well suited to marital concerns, parent-child conflicts, acting out, and other emotive issues in otherwise healthy clients, but not for substance use problems.

   NOT INDICATED (-1)
   This approach works best for individuals coping with anxiety or depression, but not for substance abuse.
**Section G:** Based on the provisional diagnosis, what interventions and referrals might work best for this client?

DIRECTIONS: Select as many as you consider indicated in this Section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

- 1. Referral to a 12-step recovery and maintenance program.
- 2. Thought stopping.
- 3. Urine drug testing.
- 4. A combination of group and individual sessions.
- 5. Dream analysis.
- 6. Empathy.
Section G: Element Relevance and Commentary

1. Referral to a 12-step recovery and maintenance program.
   INDICATED (+2)
   This is ideal for treating a client with a substance use problem.

2. Thought stopping.
   INDICATED (+1)
   This intervention can be helpful for overcoming substance abuse problems, as well as for assisting a client to gain better control over inappropriate, negative, and/or aggressive thoughts and emotions.

3. Urine drug testing.
   INDICATED (+2)
   An important part of substance use disorder treatment.

4. A combination of group and individual sessions.
   INDICATED (+1)
   Combined individual and group therapy can be more effective in treating substance use disorder.

5. Dream analysis.
   NOT INDICATED (-2)
   Not indicated in the treatment of substance use disorder, but may be helpful in addressing potentially contributing factors (e.g., stress related to repressed memories, conflicts).

   NOT INDICATED (-1)
   This therapeutic approach is often too passive for the accountability-oriented requirements of substance use disorder treatment.

SCORING: (Max = maximum possible; MPL = minimum passing level)

2A. Max 8; MPL 5
2B. Max 7; MPL 4
2C. Max 4; MPL 2
2D. Max 8; MPL 5
2E. Max 3; MPL 2
2F. Max 2; MPL 1
2G. Max 6; MPL 4
Simulation #3

Lisa is a 14-year-old white female adolescent, brought in by her parents for oppositional behavior. She is the oldest of 4 children. The father describes her as routinely defiant, argumentative, frequently truant from school, and regularly sneaking out at night to “go places with her friends.” School teachers report frequent absences, noncompliance with homework, often distracted and poor attention to instruction, and disrespectful behavior toward authority figures (teachers and other school staff). Increasingly angry at any efforts to control her behavior, the daughter has taken to aggressive and even vindictive retaliation (e.g., scoring the paint on the automobile if they refuse to drive her places; breaking the glass in her bedroom window if locked shut; stealing money when denied requested funds). Her parents feel they have “done everything” to keep her attending school, staying in at night, and treating them and others respectfully. The daughter feels that the parents are overly strict, domineering, and refusing to “let her be herself and grow up the way she wants.” They are seeking further counsel and advice.

NOW GO TO SECTION A.

Section A: Initial Information Gathering

What intake information should be obtained and assessed to formulate a provisional DSM-5 diagnosis?

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and checking your answers it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Any history of learning disabilities.
☐ 2. Length of time the problematic behaviors have persisted.
☐ 3. Any history of drug use/abuse.
☐ 4. Major disruptive changes in the home.
☐ 5. Nature of her relationship with friends.
☐ 6. Any history of fighting.
☐ 7. Any history of cruelty or bullying others.
☐ 9. Length of absences when “sneaking away.”
☐ 10. Any history of stealing.
☐ 11. Any history of lying to specific advantage (“cons” others).
☐ 12. Excessive consumption of caffeine or sugar.
☐ 13. Major weight gain or loss.
☐ 14. Problems paying attention and/or coping with distractions.
☐ 15. Any history of fire-setting.

NOW GO TO SECTION B.
Section A: Element Relevance and Initial Information Obtained

1. Any history of learning disabilities.
   INDICATED (+1)
   Learning disabilities could relate to misbehavior in school, poor attention to educational tasks, easy distractibility, and even behavioral problems. Testing may be needed. However, the parents deny any past learning problems. The teen’s past academic record was quite good.

2. Length of time the problematic behaviors have persisted.
   INDICATED (+3)
   The parents report the problems have been pronounced and problematic for the last 8 to 9 months. This information is essential for some diagnoses.

3. Any history of drug use/abuse.
   INDICATED (+1)
   While no specific mention was made of drug use, early experimentation could contribute to the problems noted. At present, both the teen and the parents deny this.

4. Major disruptive changes in the home.
   INDICATED (+2)
   The parents experienced a later-life “surprise pregnancy,” and the baby is now about 6 months old. The parents admit that the mother has been more tired and less consistent in parenting since the birth of the child, and also began making more frequent requests for assistance from the teen daughter near the conclusion of the pregnancy and since the birth of the baby.

5. Nature of her relationship with friends.
   INDICATED (+2)
   The parents note, and the teen admits to a major change in friends. The child is involved with an older, rougher “high school” crowd. When confronted the daughter admits to "seeing" a 19-year-old man who lives where this crowd often gathers. She refuses to address whether or not she is sexually active with the man.

6. Any history of fighting.
   INDICATED (+1)
   Parents and the teen deny any fighting with others.

7. Any history of cruelty or bullying others.
   INDICATED (+1)
   No relevant history.

   NOT INDICATED (-1)
   No problems mentioned or noted.

9. Length of absences when “sneaking away.”
   INDICATED (+1)
   The parents are aware of 2 occasions when their daughter did not return home from school until the next day.
10. Any history of stealing.
   INDICATED (+1)
   The parents and the teen deny any such history.

11. Any history of lying to specific advantage ("cons" others).
   INDICATED (+1)
   The teen has frequently lied to gain advantage, principally to escape responsibilities in the home, avoid school and homework, and be with friends.

12. Excessive consumption of caffeine or sugar.
   NOT INDICATED (-2)
   While this could be minor issue, it is not diagnostically relevant.

13. Major weight gain or loss.
   NOT INDICATED (-2)
   This is not relevant from the material presented.

14. Problems paying attention and/or coping with distractions.
   INDICATED (+1)
   Reports of poor attention and being easily distracted have been noted by the teen’s teachers. However, the parents report that this was never any problem until the current school year when the problematic behaviors began.

15. Any history of fire-setting.
   INDICATED (+1)
   A necessary to “rule out” certain diagnoses.

RESPONSE DEVELOPMENT:
From the information provided the teen does not fully meet criteria for a diagnosis of “Conduct Disorder” (lacks the core sociopathic-like features). Learning disabilities do not appear to be likely, nor does the teen appear to meet the essential features of Attention-Deficit/Hyperactivity Disorder (the history of poor attention and distractibility appears to be only of recent origin and DSM 5 requires onset of symptoms to begin before age 12, and falls short of the more graphic, impulsive, and pronounced qualities found in an ADHD diagnosis). Recent events in the home (the unexpected late-life birth) complicate the picture somewhat. What is clear, however, is that the teen is contentious, argumentative, disrespectful of authority figures, frequently truant from school, suffering academically, episodically absent from the home without permission, and dishonest to achieve specific problematic goals (to avoid school, homework, in-home responsibilities) and to be with friends. She appears also to be involved with a young man 5 years her senior, perhaps even sexually.
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Section B: Based on the intake data, identify early issues that need to be addressed:

DIRECTIONS: Select as many as seem correct and necessary. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Focus on improving academic performance.
☐ 2. Address parent-child conflicts.
☐ 3. Explore possible sexual abuse.
☐ 4. Refer for learning disabilities testing.
☐ 5. Assist in creating an in-home behavior management plan.
☐ 6. Formally evaluate for symptoms of ADHD.
☐ 7. Increase respectful behavior toward figures of authority.
☐ 8. Educate the parents on reporting runaway concerns.

NOW GO TO SECTION C.
Section B: Element Relevance of Potential Information to Be Addressed:

1. Focus on improving academic performance.
   NOT INDICATED (-2)
   Other behavioral problems and basic school attendance must be addressed and stabilized before it would be possible to effectively address primary academic performance.

2. Address parent-child conflicts.
   INDICATED (+3)
   This is a priority issue that must be addressed promptly, and must closely involve the parents.

3. Explore possible sexual abuse.
   INDICATED (+3)
   Given the teen's admission of “seeing” a young man 5 years her senior, it is reasonable to suspect sexual activity. This must be addressed immediately.

4. Refer for learning disabilities testing.
   NOT INDICATED (-2)
   The teen's academic history is not problematic. Rather, it is only her recent academic performance that has been poor. Thus, it is not reasonable to presume the need for further evaluation in this regard.

5. Assist in creating an in-home behavior management plan.
   INDICATED (+2)
   It would appear that the parents have not produced a behavioral management plan involving rewards and consequences. This must be undertaken early on to begin to ward off further behavioral deterioration and the need for more serious steps.

6. Formally evaluate for symptoms of ADHD.
   NOT INDICATED (-1)
   While the teen's current teachers have noted issues of poor attention and easy distractibility, there is no history of problems of this nature. In fact, the teen's past academic performance was reportedly very good (the parents note she qualified to participate in “gifted” educational programs in the past). DSM 5 diagnosis of ADHD also requires that onset of symptoms begins before age 12.

7. Increase respectful behavior toward figures of authority.
   INDICATED (+2)
   It is important that the teen's negative thought patterns regarding authority figures will need to be addressed, challenged, and modified to reduce the incidences of disrespectful behavior in the home and at school.

8. Educate the parents on reporting runaway concerns.
   INDICATED (+2)
   The parents will need to learn how to access the juvenile justice system, and obtain additional support in order to stop the teen's early evidence of runaway tendencies (absent overnight at least twice, returning only after school the next day).
Section C: Additional Information Gathering

What assessment tools might offer meaningful information on this client?

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. The Scholastic Aptitude Test.
☐ 2. The Behavioral Assessment Rating Scales.
☐ 3. Rorschach testing.
☐ 6. The Bender-Gestalt II.

NOW GO TO SECTION D.
Section C: Relevance of Proposed Assessment Tools:

1. The Scholastic Aptitude Test.
   NOT INDICATED (-1)
   Reports indicate that the teen's academic capacity is more than adequate. The issues are behavioral, rather than aptitude- or capacity- based.

2. The Behavioral Assessment Rating Scales.
   INDICATED (+3)
   There are a variety of well-validated behavioral assessment tools that are appropriate for use in the home and at school. By using a standardized assessment tool, everyone involved can carefully follow the teen’s progress and rate of improvement, and can adjust interventions and consequences accordingly.

3. Rorschach testing.
   NOT INDICATED (-2)
   This projective tool looks at personality issues, and is not particularly useful for adolescent behavioral problem evaluation.

   NOT INDICATED (-1)
   Although some mention of distractibility and poor attention was made by some teachers, the teen has no longstanding history of inattentive, hyperactive, distracted, and impulsive behavior of sufficient magnitude to warrant early evaluation.

   INDICATED (+3)
   This tool can offer broad evaluation of both deficits and strengths in an adolescent, aiding the clinician to target key problems and capitalize on key strengths.

6. The Bender-Gestalt II.
   NOT INDICATED (-2)
   Based on the information provided, it does not appear that a neurological assessment tool would provide any particular insights or benefits.
Section D: Additional Data Gathering

To better determine the client’s level of function, what additional data may be helpful?

DIRECTIONS: Select the most appropriate options provided in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Evaluate the quality of current peer relationships.
☐ 2. Review school records.
☐ 3. Seek collateral contact with a school counselor.
☐ 4. Complete a mental status evaluation.
☐ 5. Review diet and exercise patterns.
☐ 6. Initiate drug testing.
☐ 7. Determine if the parents feel the teen’s behavior is beyond control.
☐ 8. Explore the teen’s capacity to cope with the new baby in the home.

NOW GO TO SECTION E.
Section D: Options Relevance and Findings:

1. Evaluate the quality of current peer relationships.
   INDICATED (+3)
   Further evaluation revealed that this teen has been primarily associating with older high school
   adolescents, causing her to strive to prematurely “grow up” and inappropriately introducing her to
   more mature issues that she is not prepared to properly handle.

2. Review school records.
   NOT INDICATED (-1)
   Ample information is available by direct interview of the parents and teachers. If the primary
   concern were related to learning disabilities, a records review might be more meaningful.

3. Seek collateral contact with a school counselor.
   INDICATED (+2)
   A school counselor can be an important source of additional information, as well as a key
   participant in any behavioral change plan.

4. Complete a mental status evaluation.
   NOT INDICATED (-2)
   There is no indication that this teen has neurological processing deficits. She presents as oriented to
   person, place, time, and situation, and has no evidence or complaint of hallucinations or delusions,
   nor complaints of impaired memory or cognitive function.

5. Review diet and exercise patterns.
   NOT INDICATED (-1)
   Nothing presented suggests issues of a dietary or physiological nature.

6. Initiate drug testing.
   NOT INDICATED (-1)
   There is, as of yet, no evidence of drug use or abuse.

7. Determine if the parents feel the teen’s behavior is beyond control.
   INDICATED (+3)
   When questioned, the parents feel that they cannot cope with the teen’s ongoing behaviors, and
   therefore aggressive and timely intervention will be necessary.

8. Explore the teen’s capacity to cope with the new baby in the home.
   INDICATED (+1)
   Some information suggests that decreased parental support and increased demands for help were
   due to the presence of the new baby.
Section E: Provisional Diagnosis Formulation

Based on the available information, what would appear to be the most appropriate primary provisional DSM-5 diagnosis?

DIRECTIONS: Select the most appropriate primary diagnosis indicated in this section. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

1. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4).
2. Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type (314.00).
3. Conduct Disorder, Adolescent-Onset Type (312.82).
4. Oppositional Defiant Disorder (313.81).
5. Unspecified Disruptive, Impulse-Control and Conduct Disorder (312.9).
6. Sexual Abuse of Child (V61.21).

NOW GO TO SECTION F.
Section E: Element Relevance and Diagnostic Formulation:

1. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4).
   NOT INDICATED (-1)
   While there is a new and disruptive change in the home (the birth of the new baby), it is not the primary cause of the teen's behavioral problems, nor has she cited it as an overwhelming stressor of any kind.

2. Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type (314.00).
   NOT INDICATED (-1)
   Information already in evidence indicates that this would not be the primary diagnosis for this teen client. Current issues of inattention and distractibility are of recent origin, and do not meet threshold criteria.

3. Conduct Disorder, Adolescent-Onset Type (312.82).
   NOT INDICATED (-1)
   The key features of this diagnosis are far more serious and longstanding than those in evidence by this teen client. While some features are present (e.g., stealing, damaging property), they are not substantial or serious enough to warrant this diagnosis.

4. Oppositional Defiant Disorder (313.81).
   INDICATED (+3)
   This teenager has been oppositional and defiant with her parents, teachers, and other authority figures, and is displaying behavior that is impairing her relationships, her academic performance, and her overall well-being and safety.

5. Unspecified Disruptive, Impulse-Control and Conduct Disorder (312.9).
   NOT INDICATED (-1)
   As the teenager meets criteria for ODD, she will not meet criteria for this unspecified disorder.

6. Sexual Abuse of Child (V61.21).
   NOT INDICATED (-1)
   While the chances are good that this teenager may be sexually involved with an older individual, this conduct is not the focus of the clinical intervention and would not be the "primary" diagnosis.

RESPONSE FORMATION
The current provisional diagnoses for this client would be:
1. 313.81 Oppositional Defiant Disorder (primary).
2. V61.21 Sexual Abuse of Child.
Section F: Identify appropriate short-term goals for this client.

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

1. Placing the teen in a residential treatment center.
2. Exploring childhood memories.
3. Educating the parents in behavior modification techniques.
4. Improving school grades.
5. Introducing better patterns of parent-child communication.
6. Referring the case to Child Protective Services to explore possible sexual abuse.

NOW GO TO SECTION G.
Section F: Relevance of Short-Term Goals Identified:

1. Placing the teen in a residential treatment center.
   NOT INDICATED (-3)
   All other options and intervention avenues should be exhausted before this option would be considered (exception: if the safety of the parents or teen will be profoundly compromised in the current living situation).

2. Exploring childhood memories.
   NOT INDICATED (-2)
   This approach would not allow for timely address of the serious presenting problems.

3. Educating the parents in behavior modification techniques.
   INDICATED (+3)
   This is the first and most important step in the intervention process.

4. Improving school grades.
   NOT INDICATED (-2)
   Academic performance will improve as a matter of course when other behavioral problems are remedied and resolved.

5. Introducing better patterns of parent-child communication.
   INDICATED (+2)
   Addressing communication patterns will assist in decreasing confrontational, disrespectful, and argumentative encounters between the teen and other authority figures.

6. Referring the case to Child Protective Services to explore possible sexual abuse.
   INDICATED (+3)
   Every state has laws requiring that even suspicions of child sexual abuse be reported. The allowable age discrepancy between two teens varies, but no state allows a disparity of 5 or more years.
Section G: Identify appropriate treatment outcomes for this client.

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Decreased verbal disrespect toward authority figures.
☐ 2. Better study habits.
☐ 3. Improved peer relationships.
☐ 4. Decreased incidents of truancy.
☐ 5. Increased exercise and intake of nutritional food.
☐ 6. Decreased incidents of leaving or failing to return home.
☐ 7. Reduced occurrences of property damage and theft.

NOW GO TO SECTION H.
Section G: Treatment Outcomes Relevance and Selection:

1. Decreased verbal disrespect toward authority figures.
   INDICATED (+2)
   This is an essential goal, both in the home and at school.

2. Better study habits.
   NOT INDICATED (-2)
   Academic performance will improve as other behavioral issues are resolved.

3. Improved peer relationships.
   INDICATED (+2)
   It is essential that the teen client reestablish with an appropriate peer group. Continuing to associate with poorly chosen friends who are much older will lead to additional problems.

4. Decreased incidents of truancy.
   INDICATED (+2)
   Failure to make progress in this area can result in legal action.

5. Increased exercise and intake of nutritional food.
   NOT INDICATED (-3)
   There have been problems identified related to food and exercise.

6. Decreased incidents of leaving or failing to return home.
   INDICATED (+2)
   This is an area that will lead to legal intervention if left unaddressed.

7. Reduced occurrences of property damage and theft.
   INDICATED (+2)
   Continued problems in this area will quickly lead to damaging legal issues.
**Section H:** Identify various interventions that would be appropriate.

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

- 1. Role play.
- 2. Challenging negative thoughts.
- 3. Contracting.
- 4. Guided imagery.
- 5. Positive reinforcement.
- 6. Resolving unfinished business.

**NOW GO TO SECTION I.**
Section H: Intervention Relevance and Selection:

1. Role play.  
   INDICATED (+2)  
   This technique can aid by demonstrating proper methods of communication and conflict resolution.

2. Challenging negative thoughts.  
   INDICATED (+1)  
   Inaccurate and unproductive views about the role and nature of authority figures can be improved through this approach.

3. Contracting.  
   INDICATED (+1)  
   This technique establishes mutual expectations, benefits/rewards, and consequences, and is especially helpful in a behavioral modification process.

4. Guided imagery.  
   NOT INDICATED (-2)  
   This technique is most useful in addressing situations where a client is avoiding or overwhelmed by a difficult or fearful situation or memory.

5. Positive reinforcement.  
   INDICATED (+3)  
   This technique is highly effective in situations of behavioral problems, and can be effective in both home and school settings.

6. Resolving unfinished business.  
   NOT INDICATED (-3)  
   This technique is used with adults who have past issues that remain unresolved.
Section I: Identify the optimum theoretical approach for this situation.

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Psychoanalysis.
☐ 2. Transactional analysis.
☐ 4. Reality therapy.
☐ 5. Behavioral modification.
Section I: Relevance and Selection of an Optimal Theoretical Approach:

1. Psychoanalysis.
   NOT INDICATED (-1)
   This approach addresses unconscious conflicts, rather than conscious choices.

2. Transactional analysis.
   NOT INDICATED (-1)
   This approach does not focus on feelings important to a teenager, and is overly intellectual.

   NOT INDICATED (-1)
   While this approach could be helpful in this situation, it is not the best option available.

4. Reality therapy.
   NOT INDICATED (-1)
   This is an approach that could be helpful in this situation, but it is not the best option.

5. Behavioral modification.
   INDICATED (+3)
   This approach would be optimal in addressing a behavioral disorder.

SCORING: (Max = maximum possible; MPL = minimum passing level)

3A. Max 16; MPL 10
3B. Max 12; MPL 8
3C. Max 6; MPL 4
3D. Max 9; MPL 6
3E. Max 3; MPL 2
3F. Max 8; MPL 5
3G. Max 10; MPL 7
3H. Max 7; MPL 4
3I. Max 3; MPL 2
Simulation #4

Julie is a 20-year-old Asian college student. She is enrolled in a demanding premedical course of study. Her parents feel strongly that she should become a physician, but the rigorous curriculum has been taxing her capacity. Consequently her grade point standing may not be adequate to ensure later medical school admission. She would prefer to become a nurse, but her father will not accept this alternative. A roommate brought her into the University Counseling Center, concerned because she has lost a great deal of weight. Julie, however, does not feel concerned about her weight loss and feels she looks just fine. Over the last semester or two, her weight has fallen from 118 lb to 84 lb on her small-built 5 ft 5 in frame. Consulting a weight-height chart, her roommate notes that a medically healthy weight for a woman of her build is 117 to 130 lb. The roommate is concerned.

NOW GO TO SECTION A.

Section A: Initial Information Gathering

What intake information should be obtained and assessed to formulate a provisional DSM-5 diagnosis?

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

1. Employment history and current situation.
2. Past and current eating patterns and appetite.
3. Presence or absence of “binge and purge” episodes.
4. Educational goals.
5. Feelings about her weight.
6. Self-esteem and weight relationships.
7. Number and order of siblings in family of origin.
8. Any use of laxatives or diet pills.
9. Psychosocial stressors.
10. Irregular eating rituals.

NOW GO TO SECTION B.
Section A: Element Relevance and Initial Information Obtained:

1. Employment history and current situation.
   NOT INDICATED (-2)
   The client’s employment status and past history is not relevant, unless if finances were at the root of her weight loss (i.e., unable to obtain food). In this scenario, resources are adequate to meet food requirements.

2. Past and current eating patterns, appetite, and weight.
   INDICATED (+2)
   Eating frequency, quantity consumed at any given meal, and any significant weight changes are all relevant in determining a diagnosis.

3. Presence or absence of “binge and purge” episodes.
   INDICATED (+1)
   She does not now “binge” (eat heavily) and then “purge” (throw up) her food, nor has she done so in the past.

4. Educational goals.
   NOT INDICATED (-2)
   The client’s education goals are not relevant to the problem being addressed.

5. Feelings about her weight.
   INDICATED (+1)
   The client acknowledges that maintaining an “ideal” weight is very important to her. She sees weight management as a measure of personal adequacy. She is now at 72% of her expected body weight and experiencing amenorrhea.

6. Self-esteem and weight relationships.
   INDICATED (+2)
   In her family of origin, weight gain was deeply frowned on. She admits having always been very eager to obtain approval from her parents, and carefully working to keep her weight in control, especially during puberty and late adolescent years. According to her parents (and her mother in particular) excessive weight gain represents “slovenliness,” a lack of self-respect, gluttony, selfishness, poor self-control, and a host of other negative and stereotypic traits and prejudices.

7. Number and order of siblings in family of origin.
   NOT INDICATED (-2)
   The birth order and number of siblings is unlikely to have any bearing on the presenting problem.

8. Any use of laxatives or diet pills.
   INDICATED (+1)
   Very relevant. However, the client denies any such use.
9. Psychosocial stressors.
INDICATED (+2)
Psychosocial stressors can contribute to weight issues and reduced self-esteem. The client reports considerable academic stress. Academic (and later professional) achievement is often presented in her family as a measure of acceptability. The client feels great pressure to perform academically in premedical studies, as selected for her by her parents, but is not finding the academic success necessary for subsequent medical school admission.

10. Irregular eating rituals.
INDICATED (+1)
The client admits that she enjoys cooking, but does not enjoy eating. She often cooks “gourmet meals” for family, friends, and others, but cannot enjoy eating the food she cooks.
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Section B: Based on the intake data, identify the psychosocial and/or environmental stressors that appear:

DIRECTIONS: Select as many as seem correct and necessary. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Economic problems.
☐ 2. Occupational problems.
☐ 3. Educational problems.
☐ 4. Socio-environmental problems.
☐ 5. Primary support group problems
☐ 6. Health care access problems.

NOW GO TO SECTION C.
Section B: Identify the relevant psychosocial and/or environmental stressors that appear:

1. Economic problems.
   NOT INDICATED (-1)
   The client reportedly has stable finances.

2. Occupational problems.
   NOT INDICATED (-1)
   The client is a student, and is not working. No relevant occupational problems.

3. Educational problems.
   INDICATED (+2)
   The client is struggling academically to meet threshold grade point standards necessary for later admission to medical school.

4. Socio-environmental problems.
   NOT INDICATED (-1)
   Her social life and living and educational environments are not yet impaired.

5. Primary support group problems.
   INDICATED (+2)
   The client’s parents are not accepting of her situation, and will not support her in making academic and career choices better suited to her ambitions, capacity, and life goals.

6. Health care access problems.
   NOT INDICATED (-1)
   No information suggests that the client has problems with health care service access in any way.
Section C: Provisional Diagnosis Formulation

Based on the available information, what would appear to be the most appropriate primary provisional diagnosis?

DIRECTIONS: Select the most appropriate primary diagnosis indicated in this Section. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Unspecified Eating Disorder (307.50).
☐ 2. Anorexia Nervosa, Restricting Type (307.1).
☐ 3. Anorexia Nervosa, Binge Eating/Purging Type (307.1).
☐ 4. Bulimia Nervosa, Non-purging Type (307.51).
☐ 5. Bulimia Nervosa, Purging Type (307.51).
☐ 6. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4).

NOW GO TO SECTION D.
Section C: Relevance and Diagnostic Formulation:

1. Unspecified Eating Disorder (307.50).
   NOT INDICATED (-1)
   There is sufficient information to make a more specific provisional diagnosis.

2. Anorexia Nervosa, Restricting Type (307.1).
   INDICATED / CORRECT (+3)

3. Anorexia Nervosa, Binge Eating/Purging Type (307.1).
   NOT INDICATED (-1)
   The client specifically denies binging/purging, and there are no collateral indicators (i.e., Russell sign, dental problems) to suggest otherwise. She does not participate in the misuse of laxatives, diuretics, enemas, or other medications, or excessive exercise.

4. Bulimia Nervosa, Non-purging Type (307.51).
   NOT INDICATED (-1)
   The client does not exhibit “binge” eating, but rather is restrictive in her overall caloric intake.

5. Bulimia Nervosa, Purging Type (307.51).
   NOT INDICATED (-1)
   The client does not exhibit “binge” eating, but rather is restrictive in her overall caloric intake. She does not participate in the misuse of laxatives, diuretics, enemas, or other medications, or excessive exercise.

6. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4).
   NOT INDICATED (-1)
   While the client is coping with specific stressors (school), the resultant behavior is very explicit and more properly falls within the Eating Disorder category. Thus, this would not be the primary diagnosis, but it could be identified as a secondary problem warranting further clinical attention.
Section D: Decision Making

Identify the services you can provide to help the client:

DIRECTIONS: Select the most appropriate options provided in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Body dysmorphic/body image education.
☐ 2. Hospitalization.
☐ 3. Healthy eating education.
☐ 4. Eating disorder medications.
☐ 5. Counseling regarding locus of control issues.

NOW GO TO SECTION E.
Section D: Options Relevance and Findings:

1. Body dysmorphic/body image education.
INDICATED (+1)
Issues of body image are typically at the heart of anorexia.

2. Hospitalization.
NOT INDICATED (-1)
While the client is thin, there is no indication that her health is threatened. Alternatives, including outpatient treatment, should be explored first, with hospitalization pursued only as a last resort.

3. Healthy eating education.
INDICATED (+1)
The client requires education on eating patterns and food selection to maintain an appropriate body weight.

4. Medications.
INDICATED (+1)
Medications often help in situations of anorexia. They include antipsychotic drugs such as chlorpromazine; antidepressants such as the tricyclics clomipramine and amitriptyline; and cisapride and erythromycin, which can aid in restoring gastric motility issues associated with anorexia nervosa has been reported to increase the weight gain in some patients.

5. Counseling regarding locus of control issues.
INDICATED (+2)
The client is cornered between parental wishes and personal capacity and desires. There are also cultural issues that complicate the situation. Individual counseling could help address some of the “need to please” and perceived loss of control issues that appear to be at work in this situation.
Section E: Based on the information obtained, identify appropriate short-term treatment goals for this client.

DIRECTIONS: Select the short-term treatment goals indicated. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Increased self-esteem.
☐ 2. Awareness of repressed memories.
☐ 3. Meaningful and sustained weight gain.
☐ 4. New recreational activities.
☐ 5. Recognition of the need to control in anorexia.

NOW GO TO SECTION F.
Section E: Treatment Goal Relevance and Rationale:

1. Increased self-esteem.
   INDICATED (+2)
   There is a direct relationship between self-esteem and the disorder.

2. Awareness of repressed memories.
   NOT INDICATED (-2)
   There is no history of repressed memories or occult psychological trauma.

3. Meaningful and sustained weight gain.
   INDICATED (+2)
   Changing patterns and practices to facilitate weight gain is crucial.

4. New recreational activities.
   NOT INDICATED (-1)
   The information gleaned suggests that the client already has a reasonably active and positive social life.

5. Recognition of the need to control in anorexia.
   INDICATED (+2)
   In this client’s situation, the need to identify avenues through which to assert personal control is crucial.

   NOT INDICATED (-1)
   There is no history of binging or purging.
Section F: Identify potential effective treatments

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Abreaction.
☐ 2. Reality testing.
☐ 3. Engage prior effective coping skills.
☐ 5. Keep a food diary.
☐ 7. Relaxation training.
☐ 8. Social skills training.

NOW GO TO SECTION G.
Section F: Element Relevance and Commentary

1. Abreaction.
   NOT INDICATED (-1)
   This psychoanalytical technique involves the expression and release of emotional tension associated with repressed ideas, and has not been determined to be effective for the treatment of eating disorders (though it may be useful for other comorbidities having collateral influence on the disorder).

2. Reality testing.
   NOT INDICATED (-1)
   Not generally indicated for eating disorders.

3. Engage prior effective coping skills.
   INDICATED (+1)
   Always a useful approach.

   NOT INDICATED (-1)
   Efforts are focused on bringing the client back to the pre-disordered level of coping and function. Confrontation is most effective when higher than preexisting levels of functioning are necessary.

5. Keep a food diary.
   INDICATED (+2)
   A very helpful intervention in this situation.

   INDICATED (+1)
   Useful for enhancing issues of self-esteem.

7. Relaxation training.
   INDICATED (+2)
   Can aid in improving the client's sense of control and self-esteem.

8. Social skills training.
   NOT INDICATED (-1)
   The client does not exhibit poor social skills.
Section G: Following a successful course of counseling (the client's weight moves into the healthy range), identify optimal ways to monitor client progress following therapy.

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

- [ ] 1. Offer follow-up telephone consultations if/as requested by the client.
- [ ] 2. Have the roommate report on the client’s ongoing maintenance and progress.
- [ ] 3. Request daily telephone reports from the client.
- [ ] 4. Taper off the frequency of office visits until no longer needed.
Section G: Element Relevance and Commentary:

1. Offer follow-up telephone consultations if/as requested by the client.
   INDICATED (+2)
   This requires a proactive level of self-evaluation the client may not achieve.

2. Have the roommate report on the client's ongoing maintenance and progress.
   NOT INDICATED (-2)
   This would be a breach of the proper therapist-client relationship.

3. Request daily telephone reports from the client.
   NOT INDICATED (-1)
   An overly inflexible and continuous (as opposed to tapering) response to a process of closure.

4. Taper off the frequency of office visits until no longer needed.
   INDICATED (+2)
   This allows the client to develop increasing levels of autonomous monitoring and independence as desired and needed.

SCORING: (Max = maximum possible; MPL = minimum passing level)

4A. Max 10; MPL 7
4B. Max 4; MPL 3
4C. Max 3; MPL 2
4D. Max 5; MPL 3
4E. Max 6; MPL 4
4F. Max 6; MPL 4
4G. Max 4; MPL 3
Simulation #5

Joseph is a 26-year-old African-American man who returned from an 18-month tour of duty in an active war zone in the Middle East. He had been trained and served as a combat paramedic. He is a married college graduate with a young child. He did not reenlist upon his return, and instead obtained work at a local fire department as a paramedic. He made an appointment to see you, but did not disclose his reason at that time.

NOW GO TO SECTION A.

Section A: Initial Information Gathering

Indicate the questions that would be appropriate to ask in determining the client’s reason for seeking help.

DIRECTIONS: Select as many as you consider correct. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

1. Who told you to see a counselor?
2. Why have you come in today?
3. Do you feel you have problems?
4. Can you describe your problem for me?
5. What do you hope to accomplish through therapy?
6. Are you willing to complete assignments between sessions?

NOW GO TO SECTION B.
**Section A**: Element Relevance and Initial Information Obtained

1. Who told you see a counselor?  
   NOT INDICATED (-2)  
   Suggests the client is not self-motivated and is disrespectful.

2. Why have you come in today?  
   INDICATED (+3)  
   This is a good, open-ended question. The client responds that the fire house supervisor indicated he needed to “get help for his anger.”

3. Do you feel you have problems?  
   NOT INDICATED (-2)  
   This question invites a “yes/no” closed answer, and would not elicit important information. It is also disrespectful and overly negative.

4. Can you describe your problem for me?  
   INDICATED (+3)  
   This question allows open client expression, and elicits his perspective on the issues of concern. The client states that he has been short-tempered at home and at work. Further questioning reveals that he has ongoing nightmares, unresolved anger, and persistent fatigue after his military service. When he feels overwhelmed, he tends to strike out at others, including his spouse and certain coworkers.

5. What do you hope to accomplish through therapy?  
   INDICATED: (+2)  
   This question encourages the client to form ideas of a positive and hopeful nature. The client responds that he just wants to “get over” the problems he developed during his military service.

6. Are you willing to complete assignments between sessions?  
   NOT INDICATED (-2)  
   This is not an appropriate intake question, as it will not reveal any purpose in pursuing therapy and may dissuade the client from wanting to engage the process.
Section B: Identify the least useful information to provide the client during an intake session:

DIRECTIONS: Select the single answer of which the information would be least likely to be helpful to the client at intake. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. A review of confidentiality boundaries.
☐ 2. A summary of the purpose of counseling.
☐ 3. The therapist/counselor’s private personal biases.
☐ 4. A summary of this first working (intake) session.
☐ 5. The need for client commitment to the counseling process.

NOW GO TO SECTION C.
**Section B:** The value and relevance of potential information to share:

1. A review of confidentiality boundaries.
   USEFUL (-1)
   This is essential information, allowing the client to understand the limits of privacy in the relationship.

2. A summary of the purpose of counseling.
   USEFUL (-1)
   This information will help the client clarify the benefits and reduce any unrealistic expectations regarding the counseling process.

3. The therapist/counselor’s private personal biases.
   NOT USEFUL (+3)
   This is not information that would be proper or helpful to provide the client.

4. A summary of this first working (intake) session.
   USEFUL (-1)
   Providing a summary at the close of the first session can bolster the therapeutic relationship as it addresses goals, problems, progress, and challenges.

5. The need for client commitment to the counseling process.
   USEFUL (-1)
   Addressing the need for commitment can help bolster proper levels of engagement in the counseling experience, and more quickly lead to therapeutic success.
Section C: Diagnostic Formulation

Identify the most likely diagnosis, given the available information:

DIRECTIONS: Select the single most likely diagnosis in this situation. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4).
☐ 2. Substance-Induced Anxiety Disorder (292.89).
☐ 3. Posttraumatic Stress Disorder (309.81).
☐ 4. Acute Stress Disorder (308.3).
☐ 5. Generalized Anxiety Disorder (300.02).
☐ 6. Intermittent Explosive Disorder (312.34).

NOW GO TO SECTION D.
Section C: Relevance of Diagnosis Options:

1. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4).
   NOT INDICATED (-1)
The stress-related disturbance must not better fit the criteria for another specific disorder, and this one does.

2. Substance-Induced Anxiety Disorder (292.89).
   NOT INDICATED (-2)
There is no indication of substance abuse.

3. Posttraumatic Stress Disorder (309.81).
   INDICATED (+3)
The client acknowledges “nightmares” since returning from the war zone. Under further questioning he admits to loss of interest in life, insomnia, “flashback” memories, and feelings of emotional “numbness” toward important relationships and activities. The duration has been longer than 1 month.

4. Acute Stress Disorder (308.3).
   NOT INDICATED (-1)
The disturbance must last for a minimum of 3 days and no longer than one month. This issue has persisted for many months.

5. Generalized Anxiety Disorder (300.02).
   NOT INDICATED (-1)
The client’s issues are far too specific for this diagnostic category.

6. Intermittent Explosive Disorder (312.34).
   NOT INDICATED (-1)
This diagnosis requires several discrete episodes of aggression that result in serious assultive acts or destruction of property. To this juncture, the client has not reached this threshold of conduct.
Section D: Clinical Response

The client is charged with battery for striking out at another. If a court order is issued for the counseling records, indicate the best response:

DIRECTIONS: Select the single most appropriate option provided in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Direct the client to respond to the court order.
☐ 2. Disclose client information to a colleague to obtain helpful advice.
☐ 3. Have the client sign an information release for the spouse, and have her respond.
☐ 4. Inform the client of confidentiality limits and release the information.
☐ 5. Respond to the court personally, indicating possible harm to the client from this disclosure.

NOW GO TO SECTION E.
Section D: Options Review and Findings:

1. Direct the client to respond to the court order.
   NOT INDICATED (-3)
   The therapist is responsible for these records, not the client.

2. Disclose client information to an outside colleague to obtain helpful advice.
   NOT INDICATED (-1)
   Advice must not involve the disclosure of confidential information to an outside party.

3. Have the spouse sign an information release for the client, and have her respond.
   NOT INDICATED (-3)
   This is a violation of client confidentiality, and the spouse cannot release the client's information.

4. Inform the client of confidentiality limits and release the information.
   NOT INDICATED (-1)
   The client should have been informed of confidentiality limits at the outset of the therapeutic relationship, and this advance disclosure does not necessarily entitle the therapist to release information that may be harmful to the client.

5. Respond to the court personally, indicating possible harm to the client from this disclosure.
   INDICATED (+3)
   Inform the client in advance of the release, and release only information that is necessary and required.
**Section E:** Assume that you work in a large counseling center with multiple counselors. One in particular has specific experience and training in PTSD and could provide particularly effective service to this client. However, you feel you would enjoy working with this client and feel that he would connect well with you. Given the situation, indicate the proper disposition of this case in the agency.

**DIRECTIONS:** Select the one most-appropriate disposition of the case. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

- □ 1. Continue your work with Joseph, knowing that the client-therapist bond is particularly important.
- □ 2. Refer Joseph to the PTSD specialist for the most effective intervention.
- □ 3. Try to refer Joseph, and if he declines the referral then continue to work with him out of obligation, in spite of your lack of PTSD experience.
- □ 4. Turn Joseph away without any other referral if the PTSD specialist is not available, knowing that your skills in PTSD treatment are inadequate.
Section E: Disposition Relevance and Diagnostic Formulation:

1. Continue your work with Joseph, knowing that the client-therapist bond is particularly important.
   NOT INDICATED (-1)
   NBCC Section B, #10 stipulates that a counselor should not offer a service outside his or her skill, training, or professional capacity. Appropriate alternative referrals should be provided. If the referral is declined, the counselor need not continue to provide services.

2. Refer Joseph to the PTSD specialist for the most effective intervention.
   INDICATED (+3)
   NBCC Section B, #10 stipulates that a counselor should not offer a service outside his or her skill, training, or professional capacity. Appropriate alternative referrals should be provided. If the referral is declined, the counselor need not continue to provide services.

3. Try to refer Joseph, and if he declines the referral then continue to work with him out of obligation, in spite of your lack of PTSD experience.
   NOT INDICATED (-1)
   NBCC Section B, #10 stipulates that a counselor should not offer a service outside his or her skill, training, or professional capacity. Where the relationship was already established, the counselor should suggest reasonable referrals. If the referral is declined, the counselor need not continue to provide services.

4. Turn Joseph away without any other referral if the PTSD specialist is not available, knowing that your skills in PTSD treatment are inadequate.
   NOT INDICATED (-1)
   NBCC Section B, #10 stipulates that a counselor should not offer a service outside his or her skill, training, or professional capacity. Appropriate alternative referrals should be provided. Every counselor should remain familiar with necessary referral sources in order to make quality referrals as needed. If the referral is declined, the counselor need not continue to provide services.

SCORING: (Max = maximum possible; MPL = minimum passing level)

5A. Max 8; MPL 5
5B. Max 3; MPL 2
5C. Max 3; MPL 2
5D. Max 3; MPL 2
5E. Max 3; MPL 2
Simulation #6

You are a private practice counselor and you are contacted by a man who wants to enter marriage counseling for himself and his spouse. He is 38 years old, has a graduate degree in business, and is successful in his career. She is 30 years of age, has completed some college, and is the stay-at-home mother of two children ages 5 and 2. They have been married for 6 years. He states that they have a “high-conflict, high-drama” marriage and he is hoping that counseling will calm things down and help them become a calmer couple.

NOW GO TO SECTION A.

Section A: Initial Information Gathering

Indicate the questions that would be appropriate to ask in determining the couple’s primary presenting problem.

DIRECTIONS: Select as many as you consider correct. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Tell me why you’ve come to see me.
☐ 2. Describe how you each feel about your marriage.
☐ 3. How well do you relate to your in-laws?
☐ 4. Explain your greatest concerns as a couple.
☐ 5. What your future career goals?
☐ 6. Describe your relationship with each other.
☐ 7. Tell me about your children.
☐ 8. Has your marriage been “mostly good” or “mostly difficult”?

NOW GO TO SECTION B.
Section A: Selection Relevance and Initial Information Obtained:

1. Tell me why you’ve come to see me.
   INDICATED (+2)
   Good open-ended question. The husband reiterates his fatigue over their “high-conflict, high-drama” relationship. The wife states she’s there because she’s not happy in the relationship.

2. Describe how you each feel about your marriage.
   INDICATED (+1)
   Open-ended request. The husband states he feels burdened by his wife’s constant unhappiness. The wife states she feels that her husband “never loved her.”

3. How well do you relate to your in-laws?
   NOT INDICATED (-2)
   Not an immediately pertinent question. Other questions would be better at this early juncture.

4. Explain your greatest concerns as a couple.
   INDICATED (+2)
   Open-ended request. He states that they will end up divorced. She states that she is not loved and doesn’t come first in his life.

5. What your future career goals?
   NOT INDICATED (-3)
   Not relevant to any of the expressed concerns. The husband has a “successful career.”

6. Describe your relationship with each other.
   INDICATED (+1)
   Open-ended request. He states that their relationship seems “two-dimensional and hollow.” She states that their relationship is sometimes good, sometimes bad.

7. Tell me about your children.
   NOT INDICATED (-2)
   Not relevant to any immediately expressed concerns. A better question for much later in the counseling relationship.

8. Has your marriage been “mostly good” or “mostly difficult”?
   INDICATED (+1)
   Not as open-ended a question as others, but useful. He states “mostly difficult.” She states “sometimes good, sometimes difficult.”
Section B: Identify additional information needed to formulate a DSM-5 diagnosis:

DIRECTIONS: Select additional information likely to be helpful in making a DSM-5 diagnosis. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. What specific behaviors cause problems in the marriage?
☐ 2. Are there specific issues in trust?
☐ 3. Are verbal threats a problem?
☐ 4. What kind of medical problems affect the relationship?
☐ 5. Does irrational or bizarre behavior affect the relationship?
☐ 6. Are there patterns of violence?
☐ 7. How frequently does the couple make time for recreation?
☐ 8. How long have major problems existed in the relationship?

NOW GO TO SECTION C.
Section B: Relevance of additional information selected to make a DSM-5 diagnosis:

1. What specific behaviors cause problems in the marriage?
   INDICATED (+2)
   Open-ended question. The husband indicates that the wife is extremely demanding (e.g., calling/visiting him multiple times daily on the job until work is threatened; always “upset over something”; arguing long into the night), which leaves him constantly overwhelmed and fatigued. The wife reports the husband works too much and is too open with his parents about their marital problems. She states that other than her husband she does not have any close relationships.

2. Are there specific issues in trust?
   INDICATED (+1)
   Open-ended question. The husband notes that he feels extremely untrusting of the wife, as she fabricates (or, more frequently, leads others to believe) things about him when talking with others. The wife states she feels he is not fully committed to the marriage. Both deny that there is a problem with provocative behavior.

3. Are verbal threats a problem?
   INDICATED (+1)
   Open-ended question. The husband notes the wife routinely brings up divorce, states she’s “leaving” him, and demands that he “move out” (resulting in multiple separations). The wife states simply that the husband is often angry, and admits it is usually because she declares he is unhappy and presses him.

4. What kind of medical problems affect the relationship?
   NOT INDICATED (-2)
   There was no mention of medical problems in this case, though parsing this area is typically important in case something relevant does exist.

5. Does irrational or bizarre behavior affect the relationship?
   INDICATED (+2)
   Open-ended question. The husband is deeply upset because he feels bizarre behaviors are common in their relationship. The wife has frequently complained of panic attacks, depression, and suicidal thoughts (resulting in 1 prior overdose and a related emergency department visit—precipitated when he didn’t come home mid-workday when she demanded his return). She has abandoned their children alone in the home when she’s upset, and ran into the street in her underclothing when she’s “out of it” during an argument. The wife admits to these events, but blames the husband for “making her feel insecure.” When asked how he makes her feel insecure, she has no answer, acknowledging that he is typically gentle with her, hears her out, is worried for her well-being, and is attentive.

6. Are there patterns of violence?
   INDICATED (+2)
   The husband indicates that the wife frequently strikes out at him when angry (e.g., tearing clothing, scratching, running at him and trying to knock him down), throws things at him, and chases after him at high speeds in the car even when the children are with her. Further, the arguments are typically “out of the blue” and unrelated to any specific behaviors on his part—arising, he discovered over time, from extraneous influences (e.g., television shows she watched during the day, fears that emerged when talking with friends about married life, magazine articles she read).
The wife, however, seems unable to make these connections and indicates instead that these events occur primarily when “he makes me feel insecure.”

7. How frequently does the couple make time for recreation?
   NOT INDICATED (-3)
   The problems experienced by this couple are well beyond too little recreation, and there was no indication this was a problem in the scenario provided, so no such problems should be presumed.

8. How long have major problems existed in the relationship?
   INDICATED (+2)
   The husband indicates that “drama” was present from the time of their dating forward. However, the wife always presented her issues as situational, based on “if only…” (e.g., things were different, such as work hours, new home, more money) or “if he would do things differently.” He thought the problems could be remedied. A major complaint of his is that she routinely tells him how “horrible a person” he is, and demands that he leave her (e.g., leave the house immediately to sleep on the street in his car, or even move out or divorce her, sometimes followed by throwing his things outside). This is invariably followed later by dramatic and tearful apologies and statements that he is “the best person in the world,” and pleadings of “please don’t leave me.” The wife expresses feelings of embarrassment at having these behaviors disclosed and is unsure if she wants to continue counseling.
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Section C: Diagnostic Formulation

Identify the most likely diagnosis of the wife, given the available information:

DIRECTIONS: Select the single most likely diagnosis in this situation. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Adjustment Disorder, with Mixed Anxiety and Depressed Mood (309.28).
☐ 2. Substance-Induced Anxiety Disorder (292.89).
☐ 3. Relationship Distress with Spouse or Intimate Partner (V61.10).
☐ 4. Histrionic Personality Disorder (301.50).
☐ 5. Borderline Personality Disorder (301.83).
☐ 6. Narcissistic Personality Disorder (301.81).
☐ 7. Intermittent Explosive Disorder (312.34).

NOW GO TO SECTION D.
Section C: Relevance of DSM-5 diagnosis selected:

1. Adjustment Disorder, with Mixed Anxiety and Depressed Mood (309.28).
   NOT INDICATED (-1)
   While the wife does complain of episodes of both anxiety and depression, they are not in response to any identifiable stressors occurring specifically within the preceding 3 months.

2. Substance-Induced Anxiety Disorder (292.89).
   NOT INDICATED (-2)
   There is no suggestion that either the husband or the wife have ever had issues with substance abuse.

3. Relationship Distress with Spouse or Intimate Partner (V61.10).
   INDICATED (+3)
   The features of this diagnosis include behaviors such as “recurring arguments and conflict between two individuals” that “distract from activities of daily living,” “inappropriate kinds of communication” that may include “unrealistic expectations, withdrawal, or criticism,” “stress related to threat of marital separation,” “arguments which never resolve due to insufficient conflict resolution strategies.” Certainly these kinds of problems are readily apparent in this relationship.

4. Histrionic Personality Disorder (301.50).
   NOT INDICATED (-1)
   While the wife seems to have a “pervasive pattern of excessive emotionality and attention seeking” since “early adulthood,” other key features may be absent (i.e., seductive or provocative behavior, using her physical appearance to draw attention to herself, being easily influenced by others or circumstances, considering relationships to be more intimate than they actually are).

5. Borderline Personality Disorder (301.83).
   NOT INDICATED (premature) (-1)
   The wife certainly appears to have a “pervasive pattern of instability of interpersonal relationships, self-image, and affects,” as well as “marked impulsivity” that began by at least early adulthood. Further, she appears to have demonstrated “frantic efforts to avoid real or imagined abandonment” at times (e.g., begging for the husband’s return after ordering him away), “alternating between extremes of idealization and devaluation” (e.g., telling her husband that he’s a “horrible” person and then telling him he’s the “best person in the world”), marked “impulsivity” (e.g., speeding in high-speed pursuit of her husband feeling her anger), “suicidal gestures” (e.g., the overdose in the past), intense episodes of “dysphoria, irritability, or anxiety,” chronic feelings of “emptiness,” and “frequent displays of temper, constant anger, recurrent physical fights.”

6. Narcissistic Personality Disorder (301.81).
   NOT INDICATED (-1)
   While certain features of exaggeration or “grandiosity (in fantasy or behavior)” and a “lack of empathy” do seem evident since early adulthood, there is no evidence that she “exaggerates achievements and talents,” is “preoccupied with fantasies of unlimited success, power, brilliance, beauty,” that she has an inordinate focus on “special or high-status people or institutions,” that she is arrogant or haughty with others, or that she “requires excessive admiration.” Thus, the diagnostic fit appears to be somewhat limited.
7. Intermittent Explosive Disorder (312.34).

NOT INDICATED (-2)

It is clear that she has “episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property” (e.g., throwing and breaking things), and that her aggression is often “grossly out of proportion to any precipitating psychosocial stressors.” However, her aggressive episodes are definitely “better accounted for by another mental disorder.

RESPONSE DEVELOPMENT:

It would appear that the wife may meet diagnostic criteria for Borderline Personality Disorder. It also appears that she have may “traits” of both Histrionic and Narcissistic personality disorders. However, these types of disorders are virtually never diagnosed in only 1 visit. Barring substantial collateral information from prior professional sources, numerous visits and ample background information would be required before such a diagnosis would be extended at an initial visit (and then it would be identified as “by history” to clarify that it was not a first-hand determination). Therefore, in this situation, the proper provisional diagnosis would be “Relationship Distress with Spouse or Intimate Partner”, as the situation readily arises to that threshold. Over time, the suspected disorder may be extended. At that juncture, given the scenario provided, it would likely be seen as the primary diagnosis, as the V code diagnosis, above, requires that any other primary mental health diagnosis first be ruled out.
**Section D:** Based on the transitional, provisional diagnosis, identify appropriate treatment methods for this situation.

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Develop and practice interaction skills for caring relationships.
☐ 2. Referral to a psychiatrist for a medication evaluation.
☐ 3. Increase the understanding of each individual’s own role in initiating, maintaining, and resolving conflict.
☐ 4. Dream analysis to explore repressed subconscious issues.
☐ 5. Identify conflict-escalating behaviors and communications.
☐ 6. Introduce controlled, nonaggressive, and assertive communication skills.
☐ 7. Provide ongoing parenting-skill assessments and education.
☐ 8. Cognitive-behavioral therapy to address anger management, cognitive distortions, and conflict resolution skills.
Section D: Treatment Approach Relevance and Selection.

1. Develop and practice interaction skills for caring relationships.
   INDICATED (+1)
   Clearly these skills are not in evidence for this couple.

2. Referral to a psychiatrist for a medication evaluation.
   NOT INDICATED (-2)
   Nothing described at this juncture suggests a need for medications.

3. Increase the understanding of each individual’s own role in initiating, maintaining, and resolving conflict.
   INDICATED (+2)
   Particularly important for both parties in this marriage.

4. Dream analysis to explore repressed subconscious issues.
   NOT INDICATED (-2)
   Dream analysis is far too removed from the primary issues requiring address.

5. Identify conflict-escalating behaviors and communications.
   INDICATED (+2)
   Both parties are particularly likely to cope more successfully with further education and practice in this regard.

6. Introduce controlled, nonaggressive, and assertive communication skills.
   INDICATED (+1)
   An understanding and practice of proper ways to put forth one’s views is needed.

7. Provide ongoing parenting-skill assessments and education.
   NOT INDICATED (-3)
   There is no information provided regarding parenting issues.

8. Cognitive-behavioral therapy to address anger management, cognitive distortions, and conflict resolution skills.
   INDICATED (+2)
   A Cognitive-behavioral approach would be among the most effective for this couple's situation.
RESPONSE DEVELOPMENT:
Individuals who would be particularly responsive to this form of treatment are typically coping with a clearly defined problem that can normally be resolved within approximately 10 sessions. If more lengthy treatment is necessary, a more formal mental health diagnosis usually exists. In situations of a personality disorder such as borderline personality disorder (BPD), treatment may require many years. Approximately 50% of BPD patients are able to control the more destructive elements of the condition after about 10 years of treatment.

SCORING:  (Max = maximum possible; MPL = minimum passing level)

6A. Max 7; MPL 4
6B. Max 10; MPL 7
6C. Max 3; MPL 2
6D. Max 8; MPL 5
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Simulation #7

Mr. Gonzalez is an 86-year-old man who was brought in to your medical center with a self-inflicted gunshot wound to the head. He was widowed 6 weeks before, he has no children, and he has outlived his closest friends. He was still ambulatory, though troubled with arthritis, and had poor vision and moderately impaired hearing. He is no longer able to drive, and has had to give up most pleasurable activities. The injury was inflicted when he took a .22 caliber rifle (his only firearm), put it into a vice in his basement, and attempted to shoot himself in the right temple. However, as he was unable to position himself against the rifle properly, the bullet simply passed behind his eyes and effectively blinded him. There is no apparent brain involvement from the bullet, and he is in remarkably little pain following the injury. You have been asked to evaluate his mental status and recommend post-medical psychiatric care, as needed.

NOW GO TO SECTION A.

Section A: Initial Information Gathering

What background information would be important in formulating a provisional DSM-5 diagnosis?

DIRECTIONS: Select as many as you consider correct. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Vocational/employment history.
☐ 2. Any history of prior suicide attempts (if so, when).
☐ 3. Any history of suicide attempts by family members or close friends (if so, when).
☐ 4. Duration of suicidal thoughts and feelings before taking action.
☐ 5. When he had to stop driving.
☐ 6. Alcohol or substance abuse history.
☐ 7. Mood status: level of depression (1 to 5; with level 5 being most severe) (e.g., hopelessness, helplessness, sleep/eating patterns).
☐ 8. Health insurance coverage.
☐ 9. Mental Status Exam.

NOW GO TO SECTION B.
Section A: Element Relevance and Initial Information Obtained

1. Vocational/employment history.
   NOT INDICATED (-3)
   There is nothing to indicate that work history would be relevant. He attended a trade school and then worked throughout his adult life as a machinist.

2. Any history of prior suicide attempts (if so, when).
   INDICATED (+2)
   A prior history of suicidal ideation and gestures is predictive of later suicide attempts (as is age; the risk of completed suicide increases with age). He has no history of prior suicide attempts.

3. Any history of suicide attempts by family members or close friends (if so, when).
   INDICATED (+2)
   A prior history of suicide in a family and among close friends does increase the risk of suicide. He does not report any history of suicide attempts by family members or past friends. He has ambivalent feelings about his wife's death, as she refused "invasive" surgical and chemotherapy treatment for her cancer at some point before her death. He wondered if more might could have been done.

4. Duration of suicidal thoughts and feelings before taking action.
   INDICATED (+2)
   He had begun to contemplate suicide even before his wife's death, wondering if he would want to continue on after her demise. He was her primary caregiver during the later years of her life, and she had been much of his "reason for living." Although he thought briefly about other ways to end his life (e.g., auto "accident," poisoning, cutting himself to achieve exsanguination, jumping off a high place), he ruminated most about use of the firearm. He felt it would produce a rapid and painless demise, and he did not want to pursue a public event, endanger others, or be overly "messy" for others (e.g., jumping). He firmed up his plans within just a week or so before the attempt, during which he labored to get his "affairs in order."

5. When he had to stop driving.
   NOT INDICATED (-2)
   There is nothing to indicate that his suicide attempt related to a loss of driving privileges. He states that he voluntarily stopped driving about 8 years earlier, when he was 78 years of age.

6. Alcohol or substance abuse history.
   NOT INDICATED (-1)
   There was nothing in the presenting information to indicate that there were any substance abuse issues. Further, the patient denied any such history.

7. Mood status: level of depression (1 to 5; with level 5 being most severe) (e.g., hopelessness, helplessness, sleep/eating patterns).
   INDICATED (+3)
   Depressed mood is a major risk factor for suicide. However, the patient does not present as depressed. Indeed, he is affectively expressive, briskly and calmly responsive to questions, and he even uses humor at regular junctures in the conversation ("Well, if I thought my eyesight was a problem before I've certainly done it in now!" and "If my wife was still alive she'd say something like, 'Well that was a silly thing to do!'"), followed by outright chuckling.
8. Health insurance coverage.
NOT INDICATED (-2)
Health insurance is not a primary concern at this juncture. Even so, the patient has Medicare and a supplemental policy that results in 100% coverage of all costs after a modest out-of-pocket copayment.

9. Mental Status Exam.
INDICATED (+2)
A full mental status exam evaluates overall cognitive and personal functioning. It covers: 1) Appearance; 2) Attitude; 3) Behavior; 4) Mood and Affect; 5) Speech; 6) Thought processes; 7) Thought Content; 8) Perceptions; 9) Cognition; 10) Insight; 11) Judgment. The Mini-Mental State Exam (MMSE) is an abbreviated examination, which only briefly addresses: 1) Orientation to person, place, time, and circumstance; 2) Registration (recognizing and comprehending three words); 3) Attention and Calculation; 4) Memory (recall); 5) Language; 6) Visual-Spatial functioning. Completion of the MMSE was flawless, as the patient performed well and comfortably on all elements requested (he was only unable to complete portions requiring visual appraisal (e.g., recognition of objects, drawing shapes).

RESPONSE DEVELOPMENT:
The patient is an 86-year-old widowed man, status-post suicide attempt with a .22 caliber rifle. The client presents as alert, oriented, clean, and well-dressed, cognitively intact, and briskly and readily responsive. His mood is modestly decreased and frustrated, but not overtly depressed. Indeed, he is affectively responsive, expresses himself well, uses humor appropriately, and speaks at a normal rate and rhythm. When asked why he endeavored to harm himself, he provides a number of pragmatic reasons: he is now alone and has lost his caregiver role, so he feels he has little to offer. He has no children and has outlived all of his long-term friends, so isolation is an issue. His hearing, vision, and knees are becoming problematic and have begun to greatly limit his independence. Given this, he felt a natural desire to avoid these unpleasant consequences. The result was a very deliberate, pragmatic plan to take his life.
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Section B: Based on the intake data, identify potential issues that need to be addressed:

DIRECTIONS: Select as many as seem correct and necessary. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Bereavement and loss.
☐ 2. Suicidality.
☐ 3. Mood swings.
☐ 4. Late-life goal development.
☐ 5. Social supports.
☐ 6. Impulse control.
☐ 7. In-home support/assisted living.
☐ 8. Extended family relationships.

NOW GO TO SECTION C.
Section B: Element Relevance of Potential Information to Be Addressed:

1. Bereavement and loss.
   INDICATED (+3)
   Issues of familial (spousal) loss, as well as many other losses (e.g., caregiver role, friends, health, independence, sight), will all need to be addressed.

2. Suicidality.
   INDICATED (+2)
   He denies further suicidal intent at the time of the interview. However, although it appears that his attempt was not the product of typical “depression, despair, helplessness, and hopelessness,” it was nevertheless a traumatic decision, regardless of how carefully and thoughtfully it was produced. To ensure the patient does not resort to this end again, specific address and exploration will be necessary.

3. Mood swings.
   NOT INDICATED (-1)
   There is no indication of lability of mood. While this cannot be fully confirmed at a single initial interview and without collateral confirmation from others, it does appear that the patient is stable in mood and emotions.

4. Late-life goal development.
   INDICATED (+1)
   It will be necessary to explore with the patient his late-life goals, to fully ensure that he is able to live on purposefully and meaningfully, needs common to all individuals.

5. Social supports.
   INDICATED (+1)
   Social isolation is emotionally enervating, and it is necessary to aid the patient in broadening his social circle. This will reduce the potential for self-isolation and subsequent determination to end his life.

6. Impulse control.
   NOT INDICATED (-2)
   There is no indication that the patient is overmastered by impulses or other injudicious actions or decisions.

7. Referral for in-home support or assisted living.
   INDICATED (+2)
   It will be necessary to that this newly blinded individual receives the necessary support he needs in his home or in an assisted-living setting.

8. Extended family relationships.
   INDICATED (+2)
   While there are no immediate children, there may be extended family members who are unaware of the patient’s current situation. Therefore, efforts to reach and reunite the patient with his more extended relatives will be important.
Section C: Additional Information Gathering

What assessment tools might offer meaningful information about this client?

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. The Folstein Mini-Mental State Exam (MMSE)
☐ 2. Covi Anxiety Scale
☐ 3. Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
☐ 4. CAGE Questionnaire
☐ 5. Beck Depression Inventory-II (BDI-II)
☐ 6. Beck Hopelessness Scale (BHS)
☐ 7. Rorschach Psychodiagnostic Test

NOW GO TO SECTION D.
Section C: Relevance of Proposed Assessment Tools:

1. The Folstein Mini-Mental State Exam (MMSE)
   INDICATED (+1)
   This is a widely used, well-validated screening instrument that can aid in determining if broad evidence of cognitive deficits exists, potentially influencing a patient’s choices and behaviors.

2. The Covi Anxiety Scale
   INDICATED (+2)
   This tool provides a method for measuring the severity of anxiety symptoms in patients. It provides a rating based on 3 dimensions: verbal report, behavioral symptoms, and somatic symptoms. It has been relatively accurate in distinguishing between patients with depressive symptoms and those with anxiety symptoms. A score greater than 8 is frequently used as a cut-off for clinically significant generalized anxiety. The patient scored 6.3 on the Covi Anxiety Scale, which is within acceptable parameters.

3. Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
   NOT INDICATED (-2)
   There is no information or presentation pattern to suggest diminished cognitive capacity.

4. CAGE Questionnaire
   NOT INDICATED (-2)
   CAGE is a brief, widely used screening tool for alcoholism, named after an acronym of key words in its 4 questions. It has no application in this scenario.

5. Beck Depression Inventory-II (BDI-II)
   INDICATED (+2)
   While the patient does not present as overtly depressed, it can be very helpful (and sometimes surprising) to quantify mood via this type of scale. In this way, the likelihood the occult depression will be identified is higher. A total score between 0 and 13 is considered minimal range, 14 and 19 is mild, 20 and 28 is moderate, and 29 and 63 is severe. The client scored 15.

6. Beck Hopelessness Scale (BHS)
   INDICATED (+2)
   The client has already attempted suicide, and survived only by accident. The Beck Hopelessness Scale is designed specifically to be used in conjunction with the Beck Depression Inventory to identify issues of suicidality. Three primary characteristics of hopelessness are evaluated: 1) feelings about the future; 2) loss of motivation; 3) personal expectations. A total score less than 3 is minimal; 4 to 8 is mild; 9 to 14 is moderate; and greater than 14 is severe. The client scored 8.

7. Rorschach Psychodiagnostic Test
   NOT INDICATED (-1)
   This projective assessment tool may aid in uncovering useful unconscious material relative to this patient’s situation. However, its administration requires the patient to respond to ink-blot images, which this patient cannot do secondary to his new condition of blindness.
Section D: Based on the information obtained, what provisional diagnosis would be appropriate for this client?

DIRECTIONS: Select the one most appropriate primary diagnosis. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Generalized Anxiety Disorder (300.02).
☐ 2. Acute Stress Disorder (308.3).
☐ 3. Bereavement (V62.82).
☐ 4. Unspecified Disruptive, Impulse-Control, and Conduct Disorder (312.9).
☐ 5. Phase of Life Problem (V62.89).
☐ 6. Adjustment Disorder with Disturbance of Conduct (309.3).
Section D: Element Relevance and Diagnostic Formulation

1. Generalized Anxiety Disorder (300.02).
   NOT INDICATED (-1)
   This diagnosis addresses excessive anxiety and worry that occur “more days than not for at least 6 months,” and that involve “a number of events or activities.” Not only does this patient score low on the Covi Anxiety Scale, but the primary concern has only been problematic for 6 weeks, as opposed to 6 months.

2. Acute Stress Disorder (308.3).
   NOT INDICATED (-1)
   This diagnosis is used when an individual has been exposed to a traumatic event in which the person “experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” and where the individual responded with “intense fear, helplessness, or horror.” No such event or response was involved in this situation.

3. Bereavement (V62.82).
   NOT INDICATED (-1)
   This V code category can be used when the focus of clinical attention is a reaction to the death of a loved one, but with symptoms generally not outside the realm of “normal” grief responses. However, this category specifically excludes thoughts “that he or she would be better off dead or should have died with the deceased person.”

4. Unspecified Disruptive, Impulse-Control, and Conduct Disorder (312.9).
   NOT INDICATED (-2)
   This diagnosis involves individuals who recurrently fail to resist impulsive behaviors that may be harmful to themselves or others. In this situation, however, the suicide attempt was well thought out and prepared some time in advance. Thus, there was nothing impulsive about it in any way.

5. Phase of Life Problem (V62.89).
   NOT INDICATED (-1)
   This code is used if the focus of clinical attention is on a problem involving a developmental phase or life circumstance that does not constitute a mental disorder or, if it is secondary to a mental disorder, it still requires independent clinical attention. Examples are problems with marriage, divorce, and retirement. By designation, V-Codes are not used where any other mental disorder diagnosis is warranted, and another is available in this situation.

6. Adjustment Disorder with Disturbance of Conduct (309.3).
   INDICATED (+3)
   This diagnosis involves emotional or behavioral symptoms that occur “in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).” The symptoms or behaviors must be seen as “clinically significant” as evidenced by “marked distress” beyond that normally expected, or that result in “significant impairment in social or occupational (academic) functioning.” It is specified that the symptoms must “not represent normal bereavement.” However, it appears that this client’s conduct did not result from typical bereavement symptoms (i.e., grief-driven depression brought on by the loss of his spouse). Rather, it was a pragmatic decision based on perceptions of irremediable isolation and declining health. The timing was, however, related to the death of his wife, as he had no caregiver role nor any other reason, as he saw it, to continue living under the burdens of aging and declining health. Some argument might be made for a "Phase
of Life” diagnosis (i.e., physician-assisted suicide is not allowed in Oregon, and it is not deemed an action taken in response to a mental aberration). The sub-specifier here is “Acute,” as the disturbance has lasted less than 6 months (as opposed to “Chronic,” if the disturbance lasts for 6 months or longer).

SCORING: (Max = maximum possible; MPL = minimum passing level)

7A. Max 11; MPL 8
7B. Max 11; MPL 8
7C. Max 7; MPL 4
7D. Max 3; MPL 2
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Simulation #8

John, a never-married man in his mid-40s, was referred to you by his personal physician. He has been treated for some time for the symptoms of acquired immunodeficiency syndrome (AIDS), due to infection with the human immunodeficiency virus (HIV). He is also coping with herpes simplex virus (HSV). When he called to make his appointment, he stated only that he was “dealing with a lot of anger.”

NOW GO TO SECTION A.

Section A: Initial Information Gathering

Recognizing that this will be your first contact, select the topics of questioning that would be useful in learning why this client is seeking counseling:

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. What he does for a living
☐ 2. What he hopes to accomplish through counseling.
☐ 3. How well his AIDS symptoms are controlled.
☐ 4. His sexual orientation.
☐ 5. Who is included in his support system
☐ 6. How long he has been seeing the referring physician
☐ 7. If he has a current or past history of substance abuse.
☐ 8. What he feels is causing and sustaining his anger

NOW GO TO SECTION B.
Section A: Element Relevance and Initial Information Obtained

1. What he does for a living.
   NOT INDICATED (-2)
   The client’s occupation is unlikely to reveal much about his reasons for seeking counseling.

2. What he hopes to accomplish through counseling.
   INDICATED (+2)
   This is a meaningful, open-ended question. The client states that he would like to gain some control over his angry feelings, which are focused primarily on the issue of unfairness of his worsening AIDS symptoms.

3. How well his AIDS symptoms are controlled.
   INDICATED (+1)
   An understanding of the nature of the burdens of the client’s profound illness is very important to understanding his desire for help through counseling. The client indicates that in recent weeks his CD4 immune cell (T cell) counts have been dropping dramatically lower, making him increasingly susceptible to recurring infections.

4. His sexual orientation.
   NOT INDICATED (-1)
   This is a pertinent question, as it could reveal much about his infection, life stressors, support system, etc. However, it could be deemed offensive during a first visit. Assume that the client spontaneously reveals that he is “straight” and that he acquired HIV from an encounter with a prostitute.

5. Who is included in his support system.
   INDICATED (+2)
   It is important to know the level of support versus isolation that this individual faces when confronted with a chronic, progressive, life-threatening illness. The client has never married, has no children, and lives far away from any immediate family members. He has casual work friends, and one “fairly close” friend he met through a “singles-meeting-singles” group. However, their relationship largely revolves around discussions of, and attending, social activities (i.e., no discussions revealing personal issues or problems).

6. How long he has been seeing the referring physician.
   NOT INDICATED (-1)
   While it may be incidentally useful to know the length of the physician-patient relationship, depending upon personalities and engagement style, it may have little to do with their level of rapport and mutual investment. Regardless, it is clearly not useful diagnostically nor in determining why this client is seeking counseling.

7. If he has a current or past history of substance abuse.
   INDICATED (+2)
   Individuals coping with emotional issues sometimes turn to substance abuse (whether alcohol or drugs) as a way to alleviate their distress. It is also a potential vector for the contraction and/or dissemination of HIV (e.g., needle-sharing), and may further complicate AIDS treatment. Therefore, it is a relevant issue to explore for the client’s well-being, ultimate readiness for counseling, the therapeutic approaches considered, and as a possible issue for which he may be seeking counseling.
8. What he feels is causing and sustaining his anger.

INDICATED (+2)

The client has already indicated that he is “dealing with a lot of anger.” This requires further exploration. The client previously indicated that he contracted HIV from a prostitute, and now adds that he feels that his anger is “like a volcano” in intensity. He alternates between a desire to control and overcome his anger, and an intense need to act on it. His primary acting-out intent is to transmit the disease to as many prostitutes as he can during the limited healthy time he has left. He states, “They should all get this, just like me. They deserve it for what they did to me.”
Section B: Based on the intake data, identify potential issues to be addressed:

DIRECTIONS: Select as many as seem correct and necessary. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Ensure that he is compliant with his AIDS treatment regimen.
☐ 2. Focus on employment needs.
☐ 3. Ask if he has been actively seeking out prostitute liaisons.
☐ 4. Ask if he is engaging in unprotected sex.
☐ 5. Address his fears about dying from AIDS.
☐ 6. Discuss the need to keep others safe from infection.
☐ 7. Explore alternative treatment options.
☐ 8. Review methods of "safe sex" to ensure his understanding.

NOW GO TO SECTION C.
Section B: Relevance of Potential Information to Be Addressed:

1. Ensure that he is compliant with his AIDS treatment regimen.
   NOT INDICATED (-1)
   There is no indication that the client is noncompliant with treatment, nor has the client expressed this as a concern.

2. Focus on employment needs.
   NOT INDICATED (-2)
   There is no indication that the client has employment issues, so it should not be presumed.

3. Ask if he has been actively seeking out prostitute liaisons.
   INDICATED (+2)
   Given the client’s statement that he struggles not to act on his anger, to specifically try to infect prostitutes with HIV, this is an area that needs to be explored. It will reveal not only his capacity (or lack of capacity) to control his anger, but also relate to other issues of dangerousness in the community. The client states that he is actively seeking out prostitutes as frequently as time and resources allow, typically 1 to 3 times per week.

4. Ask if he is engaging in unprotected sex.
   INDICATED (+2)
   Given the client’s statement that he struggles not to act on his anger, to specifically try to infect prostitutes with HIV, this is an area that needs to be explored. The client states that he never uses protection, and that he even presses for “rough sex” experiences to increase the likelihood of transmission.

5. Address his fears about dying from AIDS.
   NOT INDICATED (-1)
   While this is an important issue, it would not be an appropriate topic for a first contact session, unless the client spontaneously and specifically invited this discussion.

6. Discuss the need to keep others safe from infection.
   INDICATED (+3)
   Exploration of the obligation to safeguard others who have no culpability for his past infection is in order. The client insists that “they are all the same,” and is persistently unwilling to differentiate between the person who infected him and others he subsequently engages in sexual activity with.

7. Explore alternative treatment options.
   NOT INDICATED (-2)
   Treatment choices and options are a matter for the client’s physician.

8. Review methods of “safe sex” to ensure his understanding.
   INDICATED (+2)
   A review of safe-sex practices is always in order when an individual has a chronic, sexually communicable disease. The client easily demonstrates adequate knowledge of safe-sex practices.
Section C: Ethical Decision Making

Given the client’s stated desire and efforts to disseminate the disease, select the best response given what you know.

DIRECTIONS: Select the best response available in this section. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Contact the local Public Health Department and report the client’s situation and behavior.
☐ 2. Based on Tarasoff directives, contact local law enforcement and seek criminal charges against the client.
☐ 3. Place the client on an involuntary hold because of his self-proclaimed danger to others.
☐ 4. Ignore the problem and seek to minimize the issue in counseling.
☐ 5. Focus intensely on counseling the client to cease the dangerous behavior.
☐ 6. Seek legal advice from competent counsel regarding your obligation.
☐ 7. Contact friends or family to intervene in his dangerous behavior.
☐ 8. Report your concerns to the client’s physician, who will then be obligated to act.

NOW GO TO SECTION D.
Section C: Relevance of the option chosen.

1. Contact the local Public Health Department and report the client’s situation and behavior.
   NOT INDICATED (-1)
   Reports to the Public Health Department are normally initiated in the medical setting, not via the counseling arena.

2. Based on Tarasoff directives, contact local law enforcement and seek criminal charges against the client.
   NOT INDICATED (-1)
   Tarasoff dictates that a known potential victim be notified of likely danger; in this situation there is no foreknown victim.

3. Place the client on an involuntary hold because of his self-proclaimed danger to others.
   NOT INDICATED (-1)
   Typically, the client must pose a known and immediate threat to others. In this situation, the threat is generalized and uncertain (transmission of the disease is not a foregone conclusion with any particular liaison). Most involuntary hold statutes were not designed for this kind of situation.

4. Ignore the problem and seek to minimize the issue in counseling.
   NOT INDICATED (-2)
   The problem is serious, and must be meaningfully addressed until resolved.

5. Focus intensely on counseling the client to cease the dangerous behavior.
   NOT THE BEST ANSWER (-1)
   While this response is part of the answer, it is not the best option available. During such counseling, however, it would certainly be appropriate to reveal to the client that such behavior constitutes criminal conduct, and that (depending on relevant state laws) engaging in unsafe sex and/or needle-sharing when knowingly HIV positive and without disclosure may be punishable by up to 20 or more years in prison.

6. Seek legal advice from competent counsel regarding your obligation.
   INDICATED! (+3)
   State laws vary widely; confidentiality requirements in the therapeutic relationship and regarding disclosure of an HIV/AIDS disclosure also vary widely from state to state. It is essential that the clinician adhere to both the law and the ethical obligations involved.

7. Contact friends or family to intervene in his dangerous behavior.
   NOT INDICATED (-1)
   While family and/or friends may be in the best situation to monitor the client’s behavior, it would be inappropriate to violate confidentiality in this way, as well as to place them in a situation of monitoring the client’s behavior.

8. Report your concerns to the client’s physician, who will then be obligated to act.
   NOT INDICATED (-1)
   You may seek to obtain the client’s permission to talk with the physician, but it is not ethical to seek to relieve oneself of the obligation to respond to this issue by unloading it onto another professional.
Section D: Provisional Diagnosis Formulation

Based on the available information, what would appear to be the most appropriate provisional diagnosis?

DIRECTIONS: Select the most appropriate primary diagnosis indicated in this section. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4).
☐ 2. Sexual Sadism Disorder (302.84).
☐ 3. Conduct Disorder (312.8).
☐ 4. Posttraumatic Stress Disorder (309.81).
☐ 5. Factitious Disorder (300.19).
☐ 6. Paranoid Personality Disorder (301.0).
☐ 7. Oppositional Defiant Disorder (313.81).
☐ 8. Unspecified Disruptive, Impulse-Control and Conduct Disorder (312.9).
☐ 9. Adult Antisocial Behavior (V71.01).
Section D: Relevance and Diagnostic Formulation.

1. Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4).
   INDICATED (+3)
   While various elements of other disorders may be present, the clinical scenario and subsequent
   supporting information best supports this diagnosis. The client has had a sudden decrease in his
   CD4 count (over the past few weeks), and has suddenly found himself significantly more
   immunosuppressed, vulnerable to many infections, and experiencing greater fatigue, and he is
   likely sensing the potential for his impending death. As no information has been obtained indicating
   precisely how long his abusive behavior (direct efforts to infect others) has been going on, this is
   the most likely diagnosis: he has been coping with anger and feelings of revenge, secondary to a
   profound adjustment to major health changes.

2. Sexual Sadism Disorder (302.84).
   NOT INDICATED (-1)
   There is no indication that he has been experiencing “sexually arousing fantasies, sexual urges, or
   behaviors” involving humiliation and/or pain.

3. Conduct Disorder (312.8).
   NOT INDICATED (-2)
   This diagnosis is most often given to adolescents and children. Other than his intended targets, the
   client does not seem to be engaging in violating the rights of others as a whole.

4. Posttraumatic Stress Disorder (309.81).
   NOT INDICATED (-1)
   This disorder is predicated upon the witnessing of an event or events that produced emotional
   trauma. A clear, external precipitating event, as well as classic symptoms, such as flashbacks,
   intrusive recollections, or nightmares, are not evident in this individual.

5. Factitious Disorder (300.19).
   NOT INDICATED (-2)
   This disorder is diagnosed when an individual feigns illness in order to assume the “sick role.” This
   client is actually sick with the illness involving his primary concern.

6. Paranoid Personality Disorder (301.0).
   NOT INDICATED (-2)
   The client voices no sense of paranoia (i.e., that others are currently “out to get him”) but rather
   that a prior specific event (and outcome) justifies a very specific retaliatory and vengeful outcome.

7. Oppositional Defiant Disorder (313.81).
   NOT INDICATED (-2)
   This is a disorder is often associated with childhood and adolescence. In this case, the client does
   not meet the criteria for the disorder as there is no indication that he is defiant of any authority
   figures in his regular life. Also it does not seem that his attempts to seek revenge are having an
   effect on other parts of his life at this time.

8. Unspecified Disruptive, Impulse-Control and Conduct Disorder (312.9).
   NOT INDICATED (-1)
   There is no indication that the client suffers from recurrent poor impulsive control. On the contrary,
   the client voices very deliberate planning to do harm for a clearly premeditated reason.
9. Adult Antisocial Behavior (V71.01).
NOT INDICATED (-2)
This is a V code that is typically used for less severe diagnostic issues. Further, “antisocial behavior” that qualifies under this diagnostic category must not be better explained by another mental disorder, and does not necessarily follow any precipitating event. Common examples include stealing, dealing illegal substances, or swindling, as opposed to violent acts without remorse.

SCORING: (Max = maximum possible; MPL = minimum passing level)

8A. Max 9; MPL 6
8B. Max 9; MPL 6
8C. Max 3; MPL 2
8D. Max 3; MPL 2
Simulation #9

As a contract clinician for a home health agency, you have been asked to evaluate an 82-year-old white widowed woman, Mrs. Schaffer. The presenting problem is her "deteriorating mental status and questionable appropriateness for continued home health care." The client is cared for in the home by her 52-year-old daughter, in conjunction with in-home support services provided by the agency, consisting of weekly visits from a chore-worker (who assists with home cleaning, laundry, etc.) and an attendant caregiver (who assists with bathing and dressing needs each morning, 6 days a week). Another 58-year-old daughter provides weekend care once or twice a month, as "respite" for the primary caregiving daughter. All agree that the client’s mental status seems to have deteriorated. Symptoms include anomia (word-finding problems, as she often attempts to describe previously familiar items she now cannot name); confusion (she appears unable to follow even simple instructions when dressing, and gets information turned around easily); forgetfulness (she seems unable to remember appointments, dates, time, etc., and even has nighttime confusion about whether she is living in her own home or not); perseveration (repeatedly talking about and fixating on things that have been addressed and/or resolved); and increased enuresis (significant incontinence of the bladder, especially at night).

NOW GO TO SECTION A.

Section A: Initial Information Gathering

Select the areas that need to be explored to better understand the client’s status, both cognitively and functionally, in the home:

DIRECTIONS: Select as many as you consider indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. The client’s psychiatric history.
☐ 2. Recent changes in the client’s medication regimen.
☐ 3. Date of the patient’s last medical exam.
☐ 4. The patient’s level of education.
☐ 5. The onset timing of the cognitive changes seen.
☐ 6. The presence or absence of depressive symptoms.
☐ 7. Family mental health history.
☐ 8. Functional capacity in the home (e.g., ambulation, balance, safety).

NOW GO TO SECTION B.
Section A: Relevance and Initial Information Explored

1. The client’s psychiatric history.
   NOT INDICATED (-1)
   The presenting problem explicitly indicates relatively recent changes in cognition, so remote psychiatric history should not be relevant.

2. Recent changes in the client’s medication regimen.
   INDICATED (+2)
   Medication changes and overmedication are potential precipitants for mental status changes, particularly in elderly patients. The “start low, and go slow” geriatrician’s phrase reflects this. The caregivers, however, indicate that there have been no changes in the client’s medications in some months.

3. Date of the patient’s last medical exam.
   INDICATED (+2)
   Elderly clients routinely need to be “medically cleared” before any psychiatric conclusions can be reached. The client’s last medical exam was 8 weeks ago.

4. The patient’s level of education.
   NOT INDICATED (-1)
   Prior educational attainment would not be relevant at this time, given that all agree that the client’s cognitive capacity was not in question in the past. Regardless, the client has a tenth-grade education, with previously normal intellectual functioning.

5. The onset timing of the cognitive changes seen.
   INDICATED (+2)
   Knowing the onset timing and pattern of cognitive change can be diagnostically crucial. Certain neurocognitive disorders (e.g., Alzheimer, Pick syndrome, neurocognitive disorder with Lewy bodies) are typically slow and gradual in onset; vascular neurocognitive disorder (due to hemorrhagic or occlusive stroke, small vessel disease, or high blood pressure) is often much more abrupt (with many secondary neurological symptoms, as well). Illness (particularly when accompanied by fever), sudden-onset diabetes, and other conditions may also precipitate more rapid changes. Caregivers note that the patient’s condition has deteriorated rather abruptly over a period of about 2 to 3 weeks.

6. The presence or absence of depressive symptoms.
   INDICATED (+2)
   Deep depression can often produce a “pseudodementia” presentation. The caregivers indicate that the patient did seem depressed for some weeks prior to the appearance of cognitive decline. She seemed withdrawn, unusually quiet, lethargic, and uninterested in prior activities (e.g., music, television, eating, talking on the telephone). Further, she was having difficulty sleeping, was losing weight, and was very restricted in her emotional and affective (expressive) responses (i.e., she “looked sad a lot and it seemed like we couldn’t pick up her mood”).

7. Family mental health history.
   NOT INDICATED (-2)
   The presenting problem explicitly indicates relatively recent changes in cognition; therefore, her family psychiatric history should not be relevant.
8. Functional capacity in the home (e.g., ambulation, balance, safety).

INDICATED (+1)

While not strictly psychiatric in nature, some understanding of the client’s level of physical function is relevant. Questions about ambulatory capacity (e.g., recent falls), continence of bowel and bladder, and ability to carry out “activities of daily living” (e.g., dressing, eating, bathing) are relevant. The caregivers indicate the client has been unable to dress and bathe herself for some time, but this was due to her severe osteoarthritis, and not cognitive deficits. Her mobility was limited to a wheelchair for the same reason. However, up until about 3 weeks ago, she was entirely able to direct her own affairs.
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Section B: Based on the intake data, identify the most important intervention needed at this time:

DIRECTIONS: Select the most important intervention needed at this time. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Contact a psychiatrist to evaluate the client for antidepressant medications.
☐ 2. Explore and address family relationship issues.
☐ 3. Improve the caregivers’ insight into the client’s illness.
☐ 4. Formally evaluate the client’s symptoms of depression.
☐ 5. Recommend a pharmacist medication evaluation.
☐ 8. Arrange for a complete medical evaluation.

NOW GO TO SECTION C.
Section B: Relevance of Potential Information Needing to Be Addressed:

1. Contact a psychiatrist to evaluate the client for antidepressant medications.
   NOT INDICATED (-1)
   Until it is determined whether or not the client is experiencing depression secondary to physiological symptoms of illness, an evaluation for the prescription of antidepressant medications would be premature.

2. Explore and address family relationship issues.
   NOT INDICATED (-2)
   Family relationship issues are not at issue here.

3. Improve the caregivers’ insight into the client’s illness.
   NOT INDICATED (-2)
   The presence or absence of any new illness (beyond the osteoarthritis) has not been confirmed. Therefore, education to increase caregiver “insight” would not yet be possible.

4. Formally evaluate the client’s symptoms of depression.
   NOT INDICATED (-1)
   At this juncture it is quite possible that the client’s vegetative symptoms of depression (anorexia, insomnia, fatigue, and impaired attention) could be due to a medical condition. Therefore, a depression evaluation would likely be skewed and distorted by the medical conditions involved.

5. Recommend a pharmacist medication evaluation.
   NOT INDICATED (-1)
   The client’s medications have not changed in “months,” and are unlikely to be the source of the cognitive changes.

   NOT INDICATED (-1)
   Until the client has been medically evaluated, any mental status findings could be badly skewed or distorted. Evaluating and recording medically generated failings in cognitive function could become seriously problematic if they are formally entered into a record. Therefore, the medical clearance must take place first.

   NOT INDICATED (-1)
   The caregivers note that the client’s physical capacity was already dramatically curtailed due to advanced, severe osteoarthritis. Therefore, an in-home functional assessment would yield very little information. Rather, evaluation of cognitive functioning will be paramount after the client is medically evaluated and/or treated (as needed).

8. Arrange for a complete medical evaluation.
   CORRECT (+3)
   Before any appropriate psychiatric evaluation of this patient can be completed, it is imperative that she has a quality medical evaluation.
RESPONSE DEVELOPMENT:

It is always essential that a client be medically evaluated and stabilized before any meaningful psychiatric evaluation can be completed. Any formal evaluation prior to this time is counterproductive and distressing to the compromised patient, and, if recorded in any permanent record, could be profoundly misleading. In this situation, the client was found to have multiple relevant other medical conditions. 1) She had an undiagnosed urinary tract infection. It led to the development of a low-grade fever, fatigue, and some of the client’s evident confusion. Reduced kidney function, secondary to the progression of the undetected infection, had limited the patient’s capacity to clear some of the medications she was taking, which had led to toxic levels of the medications in her bloodstream, which in turn worsened her cognitive presentation. She was displaying many of the classic features of delirium, rather than possible major neurocognitive disorder (formerly dementia). The key presenting feature was the sudden nature of the client’s cognitive change, absent frank neurological symptoms (as would accompany a sudden stroke). When the infection was treated and her medications were adjusted, the client returned to baseline physiological functioning. However, some symptoms of depression were still apparent, specifically, she continued to struggle with the vegetative symptoms of depression (lethargy, insomnia, anorexia, and poor attention span).
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Section C: Additional Information Gathering

Given what is evident to this juncture, which of the additional following would be most important in formulating an appropriate provisional diagnosis?

DIRECTIONS: Select as many as you consider diagnostically indicated in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

1. Income history.
2. The Beck Depression Inventory-II.
3. Degree of medication compliance.
5. Suicidal ideation/attempts.
6. Weight gain or loss.
7. Medical history.
8. Level of fatigue or lethargy.
9. Patterns of insomnia or hypersomnia.
10. Past traumatic life events.

NOW GO TO SECTION D.
Section C: Diagnostic Relevance of Secondary Information Explored:

1. Income history.
   NOT INDICATED (-2)
   Income history would not have relevance to establishing a diagnosis.

2. The Beck Depression Inventory-II.
   INDICATED (+2)
   The client is clearly presenting with vegetative signs of depression (lethargy, reduced appetite, insomnia, and reduced attention). The Beck Depression Inventory-II is designed to aid in the identification of depression. A total score of 0 to 13 is considered minimal range, 14 to 19 is mild, 20 to 28 is moderate, and 29 to 63 is severe. The client scored 28.

3. Degree of medication compliance.
   NOT INDICATED (-1)
   Mismanagement of medications is always a concern when abrupt changes of cognition are seen in previously stable elderly clients. In this case, however, no mention or later discovery of medication toxicity was discovered in either the opening vignette or subsequent information.

   INDICATED (+1)
   Mood patterns are often indicative of depression, particularly when the mood is more problematic in the morning. This client exhibited poor mood in the morning, and increasing depression and discouragement as the night drew closer (primarily over her failing health and increasing isolation).

5. Suicidal ideation/attempts.
   NOT INDICATED (-1)
   There is no mention of suicidal tendencies, and none should be assumed.

6. Weight gain or loss.
   INDICATED (+1)
   Initial weight loss due to anorexic tendencies is more the norm, particularly during the initial phases of progressing major neurocognitive disorder (formerly dementia). This client had lost 12 lb because of lack of interest in eating.

7. Medical history.
   NOT INDICATED (-1)
   There is no indication that remote medical information was relevant to this scenario, nor would it be diagnostically significant at this juncture.

8. Level of fatigue or lethargy.
   INDICATED (+2)
   This is an important indicator of depression. The client continued to present as fatigued, lethargic, and under-motivated, well after her medical problems had been treated and resolved.

9. Patterns of insomnia or hypersomnia.
   INDICATED (+1)
   Depression is often most evident in individuals struggling with insomnia. Waking early and being unable to return to sleep is perhaps more common than other patterns in those who are clinically
depressed. This client exhibited this classic pattern even after her other medical problems had been treated and resolved.

10. Past traumatic life events.
NOT INDICATED (-1)
There is nothing to suggest that past life events were problematic in this client’s situation, and none should be presumed. Current health changes, her recent illness, and increasing isolation appear to be more concerning.
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Section D: Provisional Diagnosis Formulation

Based on the available information, what would appear to be the most appropriate provisional diagnosis?

DIRECTIONS: Select the most appropriate primary diagnosis indicated. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Mild Neurocognitive Disorder Due to Another Medical Condition (331.83).
☐ 2. Adjustment Disorder with Depressed Mood (309.0).
☐ 3. Insomnia Disorder (780.52).
☐ 4. Major Depressive Disorder, Single Episode, Moderate (296.22).
☐ 5. Unspecified Delirium (780.09).
☐ 6. Malingering (V65.2).
☐ 7. Diagnosis Deferred (799.9).
Section D: Relevance and Diagnostic Formulation:

1. Mild Neurocognitive Disorder Due to Another Medical Condition (331.83).
   NOT INDICATED (-1)
   Most neurocognitive disorders have a very slow and insidious progression (with the exception of traumatic brain injuries and vascular issues which were ruled out for this patient in the previous scenarios and rationales), over many months to years. This client had a relatively abrupt onset of confusion and overall cognitive decline. Also, the medical conditions listed in the scenario have been corrected.

2. Adjustment Disorder with Depressed Mood (309.0).
   NOT INDICATED (-2)
   There is no precipitating event, and the client had symptoms far in excess of psychic distress.

3. Insomnia Disorder (780.52).
   NOT INDICATED (-1)
   This diagnosis is utilized when the insomnia present is a focus of clinical attention. In this situation, the client’s insomnia should resolve as her depression is treated and improves.

4. Major Depressive Disorder, Single Episode, Moderate (296.22).
   CORRECT (+3)
   This diagnosis is used for situations where the depression exists, at a moderate level, and has not be recurrent. There is no known history of prior major depressive episodes for this client, and the current level of depression is moderate (a score between 20 and 28 is considered moderate on the Beck Depression Inventory-II, and the client scored 28).

5. Unspecified Delirium (780.09).
   NOT INDICATED (-1)
   This condition had resolved prior to the current diagnostic workup. While it could be entered secondarily as “resolved,” it would typically not be entered as the focus of clinical attention is elsewhere.

6. Malingering (V65.2).
   NOT INDICATED (-2)
   This diagnosis refers to feigning a condition to achieve secondary ends (e.g., avoiding duty, achieving a financial settlement or award). It has no bearing on this particular case.

7. Diagnosis Deferred (799.9).
   NOT INDICATED (-1)
   This diagnosis is entered where insufficient information is available to arrive at an appropriate diagnosis. In the current situation, there is ample diagnostic information, and a proper provisional diagnosis can be entered. When possible it is preferred to use an “unspecified” diagnosis rather than diagnosis deferred.

SCORING: (Max = maximum possible; MPL = minimum passing level)

9A. Max 9; MPL 6
9B. Max 3; MPL 2
9C. Max 7; MPL 4
9D. Max 3; MPL 2
Simulation #10

A client comes to your office by referral from a student health center at a local college. As a 23-year-old single man, he brings with him a referral form indicating that he is "coping with considerable stress" in school, as well as the "recent loss of his father." The referring nurse indicates that he is experiencing episodes of tachycardia, tachypnea, and paresthesias (transient extremity numbness and tingling), secondary to his "high levels of stress." The request is that he be "evaluated" and provided "appropriate counseling intervention."

NOW GO TO SECTION A.

Section A: Initial Information Gathering

Given the information provided, which of the following additional information areas would be important in formulating a provisional DSM-5 diagnosis?

DIRECTIONS: Select as many as you consider correct. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Educational history.
☐ 2. Interpersonal relationships/Support systems.
☐ 3. Type, onset, and duration of physiological symptoms.
☐ 4. Medical history.
☐ 5. Psychiatric history.
☐ 6. Substance abuse history.
☐ 7. Mood status.
☐ 8. Vocational/Employment history.

NOW GO TO SECTION B.
Section A: Relevance and Initial Information Obtained:

1. Educational history.
   NOT INDICATED (-1)
   This information is not necessary for the formulation of a DSM diagnosis.

2. Interpersonal relationships/Support systems.
   INDICATED (+1)
   This information may be diagnostically helpful in determining contributing/causal factors related to his stress and coping issues. The client reveals that he has various friends and acquaintances at school, but that his primary emotional (and financial) support has been through his family. His father died about 2 months before, at the outset of the semester, and he has been coping with that loss and the realization that his family can no longer contribute to his support or continued education.

3. Type, onset, and duration of physiological symptoms.
   INDICATED (+2)
   The client confirms the increasingly common episodes of tachycardia, tachypnea, and transient extremity numbness. They beset him in class, during study periods in the library, and at home.

4. Medical history.
   NOT INDICATED (-1)
   The client has been seen by a medical professional, and the problem was narrowed down to stress-related symptoms.

5. Psychiatric history.
   INDICATED (+2)
   Diagnostically, it would be important to know if there are any collateral factors contributing to the presenting issues. The information provided already indicates mild psychiatric disturbance, so further questioning is relevant. The client denies any contributing psychiatric history (i.e., he has never been seen psychiatrically in the past, never been on psychiatric medications, no psychiatric hospitalizations, and no major psychiatric symptoms previously to the current issue in his life).

6. Substance abuse history.
   NOT INDICATED (-1)
   The information provided makes no reference to any such issues, and it should not be assumed.

7. Mood status.
   INDICATED (+2)
   The client's mood is integral to the formulation of a diagnosis, as well as in understanding his current stress burden. He presents as discouraged, dysphoric, and depressed. He admits to recent loss of appetite, difficulty sleeping, low-level agitation, and difficulty concentrating on his studies, all beginning with and gradually worsening after his father's demise. Being away at college for 2 consecutive semesters, he had not been able to see his father in some time, and he felt guilt at the stress and burdens he father had been carrying on his behalf. Further, the father died from a heart attack when relatively young (54 years of age), and the client admits to a pronounced preoccupation with the possibility of dying himself. When coaxed, he admits to spending nights outside the local hospital, fearing he may have a heart attack and be unable to get help. There are intense “attacks” of fear whenever he thinks of his father's death, and stress or anxiety subsequently causes his heart rate to increase.
8. Vocational/Employment history.
NOT INDICATED (-1)
Vocational and employment history is not relevant to a DSM diagnostic formulation. The client has only worked episodically during summers at various labor and unskilled jobs (e.g., janitorial work, fast food service).

**RESPONSE DEVELOPMENT:**
Further discussion with the client revealed that he was experiencing recurring periods of intense fear of dying. During this time, he would experience tachycardia (racing heart beat), tachypnea (rapid breathing), paresthesias (transient extremity numbness and tingling), occasional cardiac dysrhythmias (disturbances of the heart’s rhythm, such as missed beats or alternations in rhythm), tremors, diaphoresis (cold sweats), vertigo (dizziness), and mild angina (chest pain). The symptoms were accompanied by a sense of dread or doom, leaving him feeling that he was in imminent danger of dying. Reaching a peak within 10 minutes or so, the sensations would subside if he just entered the emergency department waiting area.

On careful consideration it was clear that the numbness and tingling he was feeling were secondary to mild hyperventilation as he responded to the various sensations of stress and fear.
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Section B: Based on the intake data available, identify the most significant or "primary" issue needing to be addressed:

DIRECTIONS: Select the most crucial or "primary" concern needing attention. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Housing concerns.
☐ 2. Educational goals.
☐ 3. Employment goals.
☐ 4. Stress coping skills.
☐ 5. Family relationships.

NOW GO TO SECTION C.
Section B: Relevance of Potential Information Needing to be Addressed:

1. Housing concerns.
   NOT PRIMARY (-1)
   While it appears that the client is losing financial support, and may need to make new housing arrangements, it is not the primary issue to be addressed.

2. Educational goals.
   NOT PRIMARY (-1)
   Given that the client is losing financial support, it appears that he may need to reevaluate his educational plans. Even so, it is not the primary issue needing to be addressed.

3. Employment goals.
   NOT PRIMARY (-1)
   Because the client is losing financial support following his father’s death, he may need to consider employment needs. However, it is not the primary issue needing to be addressed.

4. Stress coping skills.
   PRIMARY (+3)
   The client is experiencing overwhelming stress responses to his father’s death, which are substantially interfering with his capacity to function on a daily basis. This is the primary issue that needs the most immediate address.

5. Family relationships.
   NOT PRIMARY (-1)
   It is clear that the client and his family have experienced a profound loss, and therefore will have much relationship work to do together. However, it is not the primary issue needing to be addressed.

   NOT PRIMARY (-1)
   The client is struggling with many emotions following the loss of his father, and there is important bereavement/grief work to be done. Even so, it is not the primary issue needing to be addressed, though it is very closely coupled with the primary issue, and is likely to need concurrent attention.
Section C: Provisional Diagnosis Formulation

Based on the available information, what would appear to be the most appropriate primary provisional diagnosis?

DIRECTIONS: Select the most appropriate primary diagnosis indicated. Check your answer. If your answer is not the one indicated write down your point value, then choose another answer and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. Acute Stress Disorder (308.3).
☐ 2. Generalized Anxiety Disorder (300.02).
☐ 3. Obsessive-Compulsive Disorder (300.3).
☐ 4. Anxiety Disorder Due to Cardiac Irregularities (293.84).
☐ 5. Panic Disorder (300.01).
☐ 6. Adjustment Disorder with Anxiety (309.24).
☐ 7. Bereavement (V62.82).

NOW GO TO SECTION D.
Section C: Potential Relevance and Diagnostic Formulation

1. Acute Stress Disorder (308.3).
   NOT INDICATED (-1)
   This diagnosis is used when an individual has been personally exposed to a traumatic event that threatened death or serious injury, and for which stress symptoms have not persisted longer than 4 weeks (beyond which, the proper diagnosis would be posttraumatic stress disorder). This client did not personally experience a traumatic event, and the symptoms he is experiencing have been ongoing for about 2 months.

2. Generalized Anxiety Disorder (300.02).
   NOT INDICATED (-1)
   The diagnosis of Generalized Anxiety Disorder is used when an individual is excessively anxious or worried about multiple events for a period of at least 6 months. The client has only been experiencing anxious symptoms for approximately 2 months, and his primary focus has been concerns about a heart attack and dying (as opposed to many issues and concerns with little predominance of any one thing).

3. Obsessive-Compulsive Disorder (300.3).
   NOT INDICATED (-1)
   Compulsions are repetitive behaviors that an individual feels they cannot control (e.g., repetitive handwashing, organizing things, fact checking). Repetitive behaviors in this sense are not the client's issues. Obsessions are persistent and intrusive thoughts, but the client's presentation is dominated by a sense of fear, rather than by demanding thought patterns that the client simply cannot control.

4. Anxiety Disorder Due to Cardiac Irregularities (293.84).
   NOT INDICATED (-1)
   In this diagnostic situation, the symptoms of anxiety must be the direct physiological consequence of a general medical condition. However, in this situation, the physiological symptoms in evidence have come secondary to emotional stress, rather than from a specific medical disorder.

5. Panic Disorder (300.01).
   CORRECT (+3)
   The client's physiological symptoms are all characteristic of Panic Disorder, and they have persisted "1 month (or more)" and have included "(a) persistent concern about having additional attacks; (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy"), and (c) a significant change in behavior related to the attacks." There is no agoraphobia (fear of social situations) component to the disorder.

6. Adjustment Disorder with Anxiety (309.24).
   NOT INDICATED (-1)
   This diagnosis would only be used where the situation does not meet the criteria for another specific mental disorder. In this situation there is a more appropriate diagnosis.

7. Bereavement (V62.82).
   NOT INDICATED (-1)
   This category is used when the symptoms of grief do not fit any other diagnostic criteria and are the focus of clinical attention. There is another, more appropriate diagnosis in this situation.
Section D: Decision Making

DIRECTIONS: Select the most appropriate early intervention options that you can provide in this section. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Education about the body's “fight-or-flight” response and the associated physiological sensations.
☐ 2. Psychiatric hospitalization.
☐ 3. Relaxation and imagery techniques.
☐ 4. Psychiatrist referral to explore the use of anxiolytics and/or antidepressants.
☐ 5. Biofeedback, involving either audio or visual feedback to enhance the learning of relaxation skills.
☐ 6. Therapeutic massage.

NOW GO TO SECTION E.
Section D: Options Relevance and Findings.

1. Education about the body’s “fight-or-flight” response and the associated physiological sensations.
   INDICATED (+1)
   This approach can be particularly helpful in reducing the client’s level of fear related to the compelling feelings of panic.

2. Psychiatric hospitalization.
   NOT INDICATED (-1)
   This would not be considered an “early” intervention, and would only be used in the most severe situations.

3. Relaxation and imagery techniques.
   INDICATED (+2)
   Teaching the client relaxation and imagery techniques can be among the most effective of the interventions available.

4. Psychiatrist referral to explore the use of anxiolytic and/or antidepressant medications.
   NOT INDICATED (-1)
   In most situations, this would not be an “early” intervention, unless the situation was extremely severe (more so than seen in this client) and/or other options were not effective. In any event, it would not be used unless combined with other counseling techniques.

5. Biofeedback, involving either audio or visual feedback to enhance the learning of relaxation skills.
   INDICATED (+1)
   Biofeedback can be especially helpful for a client who is trying to induce an effective relaxation response, as it can help identify their degree of success.

6. Therapeutic massage.
   NOT INDICATED (-1)
   There is no research to support the use of this intervention in the treatment of panic disorder, nor is this a generally accepted counseling technique.
Section E: Based on the information obtained, identify appropriate short-term treatment goals for this client.

DIRECTIONS: Select appropriate short-term treatment goals from among the following. After making your selections and scoring your answers, it is beneficial to read the rationales and extended scenarios for all answer choices.

☐ 1. Increased understanding of the physiological symptoms of panic.
☐ 2. Awareness of impending panicky feelings and triggers.
☐ 4. New recreational activities.
☐ 5. Mastery of calming imagery and relaxation exercises.
☐ 6. Biofeedback validation of relaxation and imagery skills.

NOW GO TO SECTION F.
Section E: Treatment Goal Relevance and Rationale:

1. Increased understanding of the physiological symptoms of panic.
   INDICATED (+1)
   This is a valid and necessary short-term treatment goal for this client.

2. Awareness of impending panicky feelings and triggers.
   INDICATED (+1)
   This is a valid and necessary short-term treatment goal for this client.

   NOT INDICATED (-1)
   The client’s scholastic success, while laudable, is not an appropriate short-term treatment goal.

4. New recreational activities.
   NOT INDICATED (-1)
   Although the client may benefit from engaging in recreational activities, this is not an appropriate therapeutic goal for this client.

5. Mastery of calming imagery and relaxation exercises.
   INDICATED (+2)
   This is a crucial short-term therapeutic goal for this client.

6. Biofeedback validation of relaxation and imagery skills.
   INDICATED (+1)
   This is a helpful short-term goal for this client.
Section F: Identify the two most effective therapeutic approaches for use in this situation:

DIRECTIONS: Select the two most appropriate therapeutic approaches in this section. Check your answers. If your answers are not the ones indicated write down your point value, then choose other answers and check your score again. Your score from this section will be the numbers added together. (For example: If your first choice was not indicated and had a score of -1, and your second answer choice was the one indicated with a score of +3, your score for this section would be a +2.)

☐ 1. A psychoanalytic approach.
☐ 2. Gestalt therapy.
☐ 3. An Adlerian approach.
☐ 4. Therapeutic confrontation.
☐ 5. A cognitive-behavioral approach.
☐ 6. An existential approach.
☐ 8. A person-centered approach.
Section F: Element Relevance and Commentary

1. A psychoanalytic approach.
   NOT INDICATED (-1)
   This therapeutic approach is more effective in the treatment of depression and anxiety than panic disorders; it is also useful as a long-term therapeutic approach when working with personality and dissociative disorders.

2. Gestalt therapy.
   NOT INDICATED (-1)
   This approach emphasizes the therapeutic evaluation of experiences in the “present moment” and focuses on personal responsibility in the environmental and social contexts of a person’s life. It is not an optimum approach for the treatment of panic disorder.

3. An Adlerian approach.
   NOT INDICATED (-1)
   The Adlerian approach is optimally effective in addressing marital concerns, parent-child conflicts, and other interpersonal issues. It is not considered an ideal treatment approach for panic disorder.

4. Therapeutic confrontation.
   NOT INDICATED (-1)
   This approach is more suited to substance abuse, domestic violence offenders, and other similar situations where strict accountability is essential.

5. A cognitive-behavioral approach.
   INDICATED (+2)
   The strength of this approach is its focus on awareness, understanding, and the change and/or revision of behaviors that contribute to psychological problems. It can be very effective in treating panic disorder.

6. An existential approach.
   NOT INDICATED (-1)
   This therapeutic approach addresses inner conflicts within a person, particularly those due to confrontation with the inevitable conditions of existence (e.g., death, suffering). While it has been used in the treatment of panic disorder, it is not generally seen as an optimum approach.

   INDICATED (+2)
   This approach teaches individuals to detect and dispute “irrational beliefs” that underlie their psychological problems, and can be very effective in the treatment of panic disorder.

8. A person-centered approach.
   NOT INDICATED (-1)
   This approach is more appropriate for self-esteem issues or situational disorders, but it is not optimally effective in treating panic disorder.
SCORING: (Max = maximum possible; MPL = minimum passing level)

10A. Max 7; MPL 4
10B. Max 3; MPL 2
10C. Max 3; MPL 2
10D. Max 5; MPL 3
10E. Max 5; MPL 3
10F. Max 4; MPL 3