CONTENTS

PART II

SPECIFIC DISORDERS

10

MAJOR DEPRESSIVE DISORDER

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DESCRIPTION OF THE DISORDER

Both depression and the often comorbid condition of anxiety, as Dozois and Dobson (2004) recently observed, "are frequently referred to as the common colds of mental disorders" (p. 1). Though accurate in its reflection of the widespread nature of depression, such a view fails to reflect just how debilitating and costly this condition is to those who experience it and to society in general (Dozois & Dobson, 2004).

Accurate assessment of clinical depression is a critical step in the conceptualization and treatment planning process, and a central element of such assessment is clinical interviewing. After a brief review of the depressive disorders, we will examine interviewing strategies in general and in the context of major depressive disorder and then consider behavioral assessment and differential diagnosis. Finally, we will address the implications for assessment in terms of treatment planning, with particular emphasis on cognitive-behavioral models of case formulation as an avenue through which ideographic information is applied to a general and empirically supported intervention.

DSM-IV-TR Depressive Disorders

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR;* American Psychiatric Association [APA], 2000) includes under "Mood Disorders" the conditions with the defining feature of a disturbance in mood. Three categories are delineated: the depressive disorders, the bipolar disorders, and two disorders based on etiology, mood disorder due to a general medical condition and substance-induced mood disorder. The absence of past manic, mixed, or hypomanic episodes distinguishes the depressive from the bipolar disorders. The focus of the present discussion is on the depressive disorders, including major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified, each of which is briefly discussed in turn. Before addressing these disorders, we will outline the diagnostic criteria for a major depressive episode because these criteria are crucial in diagnosing the various depressive disorders.

Major Depressive Episode. A major depressive episode is defined as a period of at least 2 weeks involving a range of symptoms that represent a change from prior functioning and are present for most of the day, nearly every day. At least five of nine specific symptoms are required, with at least one of the symptoms involving either a predominantly depressed or irritable (i.e., in children or adolescents) mood or markedly diminished interest or pleasure in all or almost all activities. Additional symptoms include a significant change in appetite or weight; change in sleep patterns (insomnia or hypersomnia); psychomotor disturbance (agitation or retardation); fatigue or loss of

energy; feelings of worthlessness or excessive guilt; diminished ability to think or concentrate, or indecisiveness; and recurrent thoughts of death, suicidal ideation, or a suicide attempt or specific plan. Such symptoms must cause clinically significant distress or impairment in functioning and do not meet criteria for a mixed episode, which involves symptoms of a manic episode in addition to a major depressive episode. Furthermore, the symptoms must not be caused a substance or general medical condition and are not better accounted for by bereavement, which is defined as a period of grief occasioned by the death of a lost one, lasting less than 8 weeks.

Major Depressive Disorder. The defining feature of major depressive disorder (MDD) is the presence of one or more major depressive episodes in the absence of a manic, mixed, or hypomanic episode. The presence of a single major depressive episode results in the diagnosis of MDD, single episode, whereas two or more major depressive episodes separated by at least 2 consecutive months result in the diagnosis of MDD, recurrent. A number of specifiers are available to further elaborate the clinical status and features of the current episode.

Current severity is indicated as mild, moderate, or severe (with or without psychotic features, which may be mood-congruent or-incongruent). The *chronic* specifier is indicated if criteria for MDD have been met continuously for at least 2 years. The *catatonic features* specifier is indicated when the clinical picture is characterized by marked psychomotor disturbance (including symptoms such as motoric immobility, excessive and apparently pointless motor activity, and peculiar or stereotyped movements). A loss of pleasure or a lack of reactivity to usually pleasurable stimuli, in addition to symptoms such as early morning awakening and excessive or inappropriate guilt, indicates the *melancholic features* specifier. The *atypical features* specifier is indicated by mood reactivity and at least two additional features, such as significant weight gain or increased appetite, hypersomnia, and sensitivity to interpersonal rejection. The *postpartum onset* specifier is used when the onset is within 4 weeks postpartum. Finally, longitudinal course specifiers include *with and without full interepisode recovery,* determined by whether full remission is attained between major depressive episodes, and the *seasonal pattern* specifier indicates a seasonal pattern to the onset and remission of major depressive episodes.

Dysthymic Disorder. Dysthymic disorder has as its central feature a chronically depressed mood for most of the day, more days than not, that lasts at least 2 years. In addition, at least two of the following symptoms are present: appetite disturbance, sleep disturbance, low energy or fatigue, low self-esteem, poor concentration or indecisiveness, and hopelessness. During the 2-year period, the person has never been without these symptoms for more than 2 months at a time and has never experienced MDD. However, the diagnosis may be made if a person experienced MDD with full remission before developing dysthymic disorder. Also, after the initial 2 years of dysthymic disorder, a person may experience superimposed episodes of MDD, resulting in both diagnoses (also called double depression). Specifiers for dysthymic disorder include *early onset* (before age 21 years) and *late onset* (21 years or older), and with *atypical features,* which follows the criteria as defined for MDD.

Depressive Disorder Not Otherwise Specified. The *DSM-IV-TR* (APA, 2000) includes the not otherwise specified (NOS) category for conditions with depressive features that do not meet criteria for other depressive disorders. Examples include premenstrual dysphoric disorder, minor depressive disorder, recurrent brief depressive disorder, and postpsychotic depressive disorder of schizophrenia (suggested research criteria for these conditions are provided in the *DSM-IV-TR*'s Appendix B: "Criteria Sets and Axes Provided for Further Study"). Also falling in the depressive disorder NOS category are instances wherein MDD is superimposed on another disorder, such as delusional disorder, psychotic disorder NOS, or the active phase of schizophrenia, as long as the symptoms do not better meet the diagnosis of schizoaffective disorder. The NOS category is also used when it is unclear whether a depressive disorder is primary or due to a substance or general medical condition.

The Impact and Cost of MDD

The depressive disorders take a substantial toll on both the individuals who experience them and society at large. Depression has been rated by the World Health Organization as the number one

cause of disability in the world (Muñoz, Le, Clarke, & Jaycox, 2002) and has been found to negatively affect physical health (e.g., increased rates of cardiac problems) and interpersonal relationships (e.g., troubled parent-child relationships, increased rates of divorce) (Dozois & Westra, 2004; Gotlib & Hammen, 2002). Depression is also associated with significant role impairment, comparable to that caused by seriously impairing chronic physical disorders (Kessler, 2002). For example, a recent large-scale epidemiological examination of MDD, the National Comorbidity Survey Replication (NCS-R), found that of respondents with MDD, 96.9% reported at least some, 87.4% at least moderate, 59.3% severe or very severe, and 19.1% very severe role impairment associated with their depression (Kessler et al., 2003). Given its early age of onset (i.e., median age of onset is in the mid-20s), depression can also negatively affect critical life course role transitions, including educational attainment, entry into the labor force, parenting, and marital timing and stability (Kessler, 2002).

The social cost of depression is high as well. Much of the role impairment caused by the disorder is seen as reduced work performance, with some estimates placing the annual cost of depression in terms of lost productivity in the United States at more than $33 billion (Kessler, 2002). For example, the NCS-R found that respondents with 12-month MDD reported an average of 35.2 days in the past year when they were unable to work or carry out normal activities, which is more than twice the less than 15 days recently reported for most chronic conditions (Kessler et al., 2003). Depression is not only one of the most common disorders faced by mental health professionals but also one of the most costly (Dozois & Westra, 2004).

The Epidemiology of MDD

Given recent estimates, such as that almost 20% of the U.S. population at one point in their lives will experience a clinically significant episode of depression, the disorder is among the most common psychiatric conditions (Gotlib & Hammen, 2002). In terms of point prevalence, community self-report surveys indicate that as many as 20% of adults and 50% of children and adolescents report experiencing depressive symptoms for recall periods between 1 week and 6 months (Kessler, 2002). Rates of *DSM* major depression, as identified by structured diagnostic interviews, are much lower, at less than 1% in children, up to 6% in adolescents, and 2–4% in adults (Kessler, 2002). This discrepancy in findings between symptom screening measures and diagnostic interviews is worth consideration because it underlines the importance of attending to subsyndromal symptoms, particularly given evidence that such symptoms may predict later onset of major depression (Kessler, 2002).

Large-scale epidemiological investigations of the prevalence of depression have varied in their findings. For example, findings from the most recent epidemiological survey carried out in the United States, the NCS-R, which was conducted in 2001–2002 and used *DSM-IV* criteria, estimated the prevalence of MDD to be 16.2% for lifetime and 6.6% for the 12 months before assessment (Kessler et al., 2003). These estimates are much higher than those from the Epidemiological Catchment Area study carried out approximately two decades earlier, which estimated prevalence rates for MDD using *DSM-III* criteria to be 3.0–5.9% for lifetime and 1.7–3.4% for 12 months (Weissman, Bruce, Leaf, Florio, & Holzer, 1991). A number of reasons for such discrepancy have been proposed, including methodological differences across surveys, less reluctance to admit depression in more recent cohorts, and a genuine increase in the prevalence of depression in recent cohorts (Kessler, 2002), particularly among young people (Gotlib & Hammen, 2002).

The Course of MDD

The typical onset of depression is in adolescence, and the disorder is increasingly being understood as often involving a chronic or recurring course (Gotlib & Hammen, 2002). Epidemiological data indicate that the risk of initial onset of depression is fairly low until the early teens, when it begins to rise in a linear fashion, and the slope of this increase has become increasingly steep in more recent age cohorts (Kessler, 2002; Kessler et al., 2003). The course of an untreated major depressive episode is variable but typically lasts 4 months or longer (APA, 2000). Although they may change in severity, the specific symptoms endorsed by people with major depressive disorders appear to remain stable over

the course of the disorder (Minor, Champion, & Gotlib, 2005).

Even after recovery from an episode after treatment, many people continue to experience symptoms and psychosocial impairment, and residual symptoms are associated with a more severe relapsing and chronic course of the disorder (Judd et al., 1998, 2000). More than 80% of people with a history of major depression experience recurrent episodes (Kessler, 2002), and rates of recurrence increase and time between episodes decreases with each successive episode (Boland & Keller, 2002). A number of risk factors for recurrent depression have been identified, including a history of frequent or multiple episodes, double depression, and long duration of individual episodes (Boland & Keller, 2002).

Comorbidity and MDD

It has been noted that "the existence of 'pure' depressive states may be quite rare" (Clark, Beck, & Alford, 1999, p. 23) and that comorbidity among people with depression is the "norm" (Kessler, 2002). Particularly high rates of comorbidity are observed between depressive disorders and anxiety disorders, schizophrenia, substance abuse, and eating disorders, and depression often is comorbid with a range of medical conditions (Belzer & Schneier, 2004; Dozois & Dobson, 2002). For example, the NCS-R found that 72.1% of respondents with lifetime MDD also met criteria for at least one of the other *DSM-IV* disorders assessed, with the highest rate of comorbidity observed with anxiety disorders (59.2%), followed by impulse control disorders (30.0%; e.g., bulimia, conduct disorder, antisocial personality disorder) and substance use disorders (24.0%) (Kessler et al., 2003).

In the event of comorbidity, depression generally is secondary, occurring after the onset of the comorbid condition. This pattern occurs more often for some comorbid conditions, such as anxiety disorders, than for others, such as substance use disorders, and more often among men than women (Kessler, 2002; Kessler et al., 2003). Consideration of comorbid conditions in the assessment of depression is critical because comorbidity is generally associated with greater psychosocial impairment and poorer treatment response and outcome (Boland & Keller, 2002; Dozois & Dobson, 2002).

Interviewing Strategies

Structured Diagnostic Interviews

Structured diagnostic interviewing has been called a necessary tool in assessing psychological disorders, given the complexity of current diagnostic systems such as the *DSM-IV-TR* (Barbour & Davison, 2004). Structured diagnostic interviews exhibit a number of advantages over their unstructured or less structured counterparts. For example, they lessen the possible impact of interviewer bias, they are generally more comprehensive and ensure adequate coverage of symptoms, and they have been shown to improve diagnostic reliability (Groth-Marnat, 1999). Therefore, structured and semistructured diagnostic interviews have become the standard in research situations and are becoming the "hallmark of empirically driven clinical practice" as well (Summerfeldt & Antony, 2002, p. 3).

The selection of a particular interview is based on a number of potential considerations, including coverage and content. Coverage includes whether the interview covers the disorders of interest and such factors as time period of interest and course of the disorder. *Content* refers to such issues whether the interview was developed for and validated with (or is generally applicable to) the population of interest; psychometric factors, involving consideration of reliability and validity in terms of the diagnoses and population of interest; and practical issues, such as length of the interview and training requirements (Summerfeldt & Antony, 2002). The Schedule for Affective Disorders and Schizophrenia (SADS) and the Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID) are commonly used examples of structured diagnostic interviews that exhibit excellent psychometric properties and have been identified as the best methods for diagnosing mood disorders (Dozois & Dobson, 2002). Each of these structured interviews will be addressed in turn.

Schedule for Affective Disorders and Schizophrenia. The SADS (Endicott & Spitzer, 1978) is one of the earliest attempts to address diagnostic error through structured interviewing. Developed before the *DSM-III,* which introduced the use of explicit diagnostic criteria, the SADS relies on the research diagnostic criteria (RDC) of Spitzer,

Endicott, and Robins (1978). Since its introduction, the SADS has undergone a number of expansions, and several versions are available, each developed for a specific purpose (Summerfeldt & Antony, 2002). Some versions differ in terms of the temporal focus of assessment; the regular version (SADS) differentiates symptoms experienced over the past year from past history of mental disorders, the lifetime version (SADS-L) considers all current and past symptoms, and the change version (SADS-C) assesses change in symptoms over time. Other versions have been developed for use with specific disorders; for example, the SADS-LB provides expanded coverage of bipolar disorder, the SADS-LA does so for anxiety disorders, and recent versions, such as the SADS-LA-IV, have begun to incorporate *DSM-IV* in addition to RDC criteria (Summerfeldt & Antony, 2002).

Of the available versions, the SADS and SADS-L are the most widely used. The SADS-L provides lifetime coverage, and the SADS provides more information about current episodes (Summerfeldt & Antony, 2002). Twenty-three major diagnostic categories, as defined by the RDC, are covered by the SADS, with the mood disorders category including major depressive, manic-depressive, and minor depressive disorders. Scores on eight dimensional summary scales are also provided, four of which assess aspects of depression, including depressive mood and ideation, endogenous features, depressive-associated features, and suicidal ideation and behavior.

Although the general format differs across versions, the SADS generally consists of three components. The first component is a brief overview of the client's background and demographics, such as education, peer relations, and hospitalizations, and an assessment of the course of any past illnesses. Part I of the diagnostic part of the SADS assesses individual symptoms of the disorders covered, both for the worst period of the current episode and for the current period, defined as the past week, which is meant to minimize the impact of daily symptom fluctuation. Most symptoms are rated on multipoint scales (i.e., three- or six-point scales) in terms of frequency and intensity, with a rating of 0 applied if the item is not applicable or there is no information available. Cut points on these scales identify clinically significant symptoms, and numeric ratings are also accompanied by descriptive severity anchors.

Whereas Part I focuses on individual symptoms, Part II is organized by specific syndrome, with questions for each section that assess screening criteria, individual symptoms, degree of impairment or severity, and associated features. Specific symptoms are rated in a dichotomous fashion ("yes" or "no"), and clinically significant ratings are used to determine RDC diagnosis. As a semistructured interview, the SADS provides a number of levels of inquiry for each symptom, including standard questions, optional probes, and nonstandardized questions to clarify responses. Also, the interviewer may choose to skip sections of the interview based on the interviewee's responses to screening questions. Additional sources of information, such as medical records and family members, may also be consulted to enhance diagnostic accuracy.

The SADS displays strong psychometric properties. Evidence from a number of studies indicates good to excellent reliabilities for the SADS at all levels of assessment, including diagnosis, summary scales, and specific symptoms (Summerfeldt & Antony, 2002). There is also considerable evidence for the validity of SADS diagnoses (e.g., concurrent, predictive validity); for example, SADS diagnosis and summary scale scores have been found to predict course, symptoms, and outcome for a range of disorders, including schizophrenia, bipolar disorder, and major depression (Summerfeldt & Antony, 2002). In terms of the assessment of depression in particular, the SADS has demonstrated high interrater reliability, and has been found to correlate with independent measures of depression (Dozois & Dobson, 2002).

The SADS is not without limitations (Summerfeldt & Antony, 2002). The SADS assesses fewer diagnoses than other diagnostic interviews. With an administration time of approximately 90–120 minutes, the SADS is also quite lengthy, and its use takes considerable training, both of which may limit its use in clinical settings (Dozois & Dobson, 2002). However, its strengths include its ability to make fine distinctions between subtypes of mood disorder and its strong psychometric properties and extensive research base (Dozois & Dobson, 2002; Summerfeldt & Antony, 2002). Although its utility in some clinical situations may be limited, the SADS is particularly suited to research situations requiring diagnostic precision (Dozois & Dobson, 2002).

Structured Clinical Interview for DSM-IV *Axis I Disorders.* The SCID-I (First, Spitzer, Gibbon, & Williams, 1995, 1996) probably is the most widely used semistructured diagnostic interview among North American researchers (Summerfeldt & Antony, 2002). Originally introduced to increase diagnostic reliability by operationalizing *DSM-III* diagnostic criteria, the SCID has undergone a number of revisions, with the most recent version reflecting *DSM-IV* criteria. A separate version of the SCID is available for diagnosing Axis II personality disorders (SCID-II), and there are two primary versions of the SCID available for assessment of Axis I disorders: a clinical version (SCID-CV) and a research version (SCID-I). The SCID-CV was designed to assess the disorders most commonly seen in clinical settings (e.g., mood, substance use, and anxiety disorders), whereas the SCID-I is much longer and allows assessment of more disorders and more in-depth examination of subtypes and course and severity specifiers.

The SCID allows the assessment of 51 *DSM-IV* Axis I disorders, organized in terms of nine diagnostic modules (mood episodes, psychotic symptoms, psychotic disorders differential, mood disorders differential, substance use disorders, anxiety disorders, somatoform disorders, eating disorders, and adjustment disorders), and the interview can be customized to include only the modules deemed relevant. Like the SADS, the SCID begins with an open-ended overview of demographic information and the patient's current presenting complaint and level of functioning, as well as history of psychopathology and treatment, which not only provides the interviewer with important information but also assists in building rapport and providing context for the subsequent interview (Summerfeldt & Antony, 2002). A series of 12 questions are then administered to determine which modules to administer before the interview proper begins.

Depending on the modules used, the SCID varies in length. Each diagnostic section includes both required probe questions and suggested follow-up questions. Based on the respondent's answers, the interviewer determines whether diagnostic criteria are absent, subthreshold, or present, with a fourth option available if information is insufficient to rate a given item. Both probe and follow-up questions, which may involve asking for specific examples, are used as necessary, and a skip-out option is also available if the interviewee does not meet a critical criterion required for a given disorder. Administration time generally varies between 45 and 90 minutes, although the average interview for depressed people generally takes less than 60 minutes (Dozois & Dobson, 2002).

The SCID for *DSM-IV* is new, and therefore there is little evidence supporting its psychometric properties (Nezu, Nezu, McClure, & Zwick, 2002). However, reliability data are available for earlier versions of the SCID, which indicate wide variability in interrater agreement (as assessed by the kappa coefficient) across disorders and within categories, including depression (Dozois & Dobson, 2002). Findings in general indicate acceptable reliabilities for disorders commonly seen in clinical settings, including major depressive disorder and anxiety disorders (Summerfeldt & Antony, 2002). As Summerfeldt and Antony observe, the variability in reported kappas may result at least in part from variation in the skill and training of the interviewer because the SCID relies largely on clinical judgment and diagnostic skill. The validity of the SCID depends largely on the validity of the *DSM-IV,* to which it is aligned. There is some evidence for correspondence between the SCID and other standardized measures and symptom ratings, but determining validity is difficult given the lack of a diagnostic gold standard (Dozois & Dobson, 2002). As Summerfeldt and Antony observe, further investigation of the validity of the SCID is warranted.

The SCID shares a number of the limitations of the SADS, including the need for training on the part of interviewers. Summerfeldt and Antony (2002) note a number of other limitations, including possible threats to reliability arising from its semistructured format, greater susceptibility to response styles and deliberate faking because of its high face validity, and the fact that information about subthreshold conditions is lost because of its decision tree format and use of skip-outs. However, these authors also point to the SCID's many advantages, including its breadth of coverage and its alignment with the *DSM*. Compared with the SADS, the SCID is more comprehensive, takes less time to administer, is more congruent with *DSM-IV* criteria, and offers a clinician version; therefore, it may be the preferred structured interview in diagnosing depression (Dozois & Dobson, 2002).

Clinician Rating of Symptoms: The Hamilton Rating Scale for Depression. The Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960, 1967) is the most commonly used clinician rating instrument of depressive symptoms (Dozois & Dobson, 2002). Widely used in both clinical and research settings, the HRSD is commonly viewed as a gold standard among depression scales and was designed to assess severity of symptoms among people diagnosed with a depressive disorder and to assess change in symptoms over time (Nezu et al., 2002). The HRSD is not a structured interview, but it does rely on information gathered through an interview procedure. Specifically, the scale consists of 21 items and takes approximately 10 minutes to complete after a 30-minute, open-ended interview to gather the required information. Other sources may also be interviewed if the accuracy of the patient's report is in question (Hamilton, 1967). Of the 21 items of the original HRSD, 17 are scored in terms of severity during the past few days or week. Items focus largely on behavioral and somatic symptoms of depression, such as insomnia, psychomotor retardation, and appetite and weight change, although specific items differ across versions (Nezu, Ronan, Meadows, & McClure, 2000).

The fact that numerous versions of the HRSD are in use complicates examination of the scale's psychometric properties across investigations. However, the HRSD appears to be a reliable measure that is sensitive to treatment change, and several lines of evidence support its validity (Dozois & Dobson, 2002; Nezu et al., 2002; Nezu, Ronan, et al., 2000). Some of the identified limitations of the HRSD include an emphasis on somatic items relative to mood and cognitive symptoms, lack of evidence for discriminant validity, inconsistent item weightings, and a focus on symptoms over the past week rather than 2 weeks, as required by *DSM-IV* diagnostic criteria (Dozois & Dobson, 2002). Despite these limitations, the measure exhibits high clinical utility and research applicability (Nezu, Ronan, et al., 2000); given its utility in assessing treatment targets and outcome, along with its widespread use, Dozois and Dobson recommend routine use of the HRSD in clinical practice.

Clinical Interviewing

As noted earlier, structured interviews, such as the SADS and SCID, probably represent the optimal assessment strategy if the goal is diagnosis and are particularly well suited to research situations necessitating a high degree of diagnostic precision (Dozois & Dobson, 2002). The utility of such measures in clinical situations is limited, however, and clinicians are more likely to use less structured and formal interviews, often called clinical interviews, in order to assess client symptoms (Barbour & Davison, 2004). As Dozois and Dobson (2002, p. 272) observe, "much of the information necessary for the assessment of depression results from the clinical interview."

The format and specific content of the clinical interview depend on a number of factors, including the particular goal of the assessment and the theoretical orientation of the interviewer (Barbour & Davison, 2004; Groth-Marnat, 1999). For example, whereas a more client-centered clinician might work to enhance the process of self-change through a more nondirective interview style, a behavioral interview probably would work to obtain particular information about external consequences of behavior through more structured questioning (Groth-Marnat, 1999). Some general areas of assessment include the history of the problem, such as initial onset, antecedents and consequences, and treatment history; family background, including family constellation, cultural background, and emotional and medical history; and personal history, including pertinent information regarding infancy, childhood, adolescence, and early, middle, and late adulthood (Groth-Marnat, 1999). A combination of both open-ended and more directive questioning is generally used, depending on client characteristics and the type of information required. Several texts are available that provide in-depth information and recommendations for the initial clinical interview (e.g., Morrison, 1995; Othmer & Othmer, 1994).

Among the greatest advantages of less structured interviewing are its flexibility and ideographic focus, which allows in-depth exploration of particular issues through follow-up on specific responses (Groth-Marnat, 1999). Such interviews can be modified depending on the particular situation and also allow the development of rapport and client-self-exploration (Groth-Marnat, 1999). However, although flexibility is one of the greatest inherent strengths of the clinical interview, it is also associated with the potential weakness of interviewer bias (i.e., the halo effect, confirmatory bias, the primacy

effect), which may negatively affect reliability and validity (Groth-Marnat, 1999). Therefore, both the advantages and the disadvantages of the various forms of interviewing must be weighed in relation to the goals and demands of the assessment situation when one is deciding which particular format (i.e., clinical or structured diagnostic) of interview to use.

The Clinical Interview and Depression. As previously noted, the clinical interview plays an important role in the assessment of depression, and Dozois and Dobson (2002) outline a number of basic considerations in interviewing depressed patients. It is crucial to ensure that interviewees are provided with information regarding what will be required of them throughout the assessment, and a clear rationale should also be provided. For example, Dozois and Dobson note that depressed people tend to be sensitive to being interrupted, so such specific issues should be addressed at the onset of the interview. Depressed people should be made to feel relaxed and should not be rushed through the interview, particularly given such symptoms of depression as psychomotor retardation. The experience of depression varies across individuals, so the interviewer may begin by asking the patient to describe the presenting complaints and particular experience with the disorder in his or her words. A tendency to exhibit negative biases on the part of depressed people may influence such reporting, however, so it is useful to check on the accuracy of the patient's report over the course of the interview.

It is important throughout the interview to attend to specific details of symptoms, and the primary areas requiring assessment reflect the major systems affected in major depression, including the affective, cognitive, behavioral, somatic, and social (Dozois & Dobson, 2002). For each symptom domain and for each specific symptom criterion, it is important to obtain a sense of severity, which can be accomplished through the use of quantitative measures and through qualitative descriptions provided by the patients. Individuals vary in the way they describe their symptoms, and the interviewer may have to translate the patient's idiosyncratic descriptions when assessing diagnostic criteria. It may also be useful to consult with significant others who may provide further information about more observable symptoms the person is reporting. As Dozois and Dobson point out, a detailed review of symptoms "not only helps in making appropriate diagnoses and treatment recommendations, it also conveys messages that the interviewer is interested in the patient and knowledgeable about the symptoms and difficulties that he or she is experiencing" (p. 273).

Consideration of both frequency and number of past depressive episodes is important for several reasons, including accurate diagnosis, and because such information is related to speed of recovery and risk of relapse (Dozois & Dobson, 2002). However, unintentional memory biases have been found to negatively affect the reporting of such information as age of first episode and past number of episodes (Dozois & Dobson, 2002). Therefore, Dozois and Dobson recommend a number of techniques, including ensuring that the interviewee is aware of the time period being assessed (e.g., the past 2 weeks when assessing MDD) and providing contextual cues when discussing past episodes (e.g., special occasions).

Assessment of the interviewee's history includes attending to a wide range of variables (Dozois & Dobson, 2002). Past psychiatric and medical conditions of both the interviewee and his or her family should be considered, along with current comorbid disorders, which may have important implications for diagnosis and treatment. Treatment history, which might include psychiatric hospitalization, psychotherapy, medications, electroconvulsive therapy, and self-help groups and products, should also be assessed because such information might suggest resources for change. Other important areas to assess include behavioral indices of depression, factors that may be maintaining the depression, the patient's level of motivation for change, and areas of strength, such as strong social support, which may be exploited in treatment.

Suicide assessment is an important feature of the assessment of depressed patients. Assessing suicide risk is difficult because of its low base rate, so in addition to being open and frank about suicidality, the clinician should ask about a number of potential risk factors (Dozois & Dobson, 2002). Risk factors that have been identified in the literature include hopelessness, impulsivity, substance abuse, a mental or physical disorder, and social isolation, and these should be kept in mind in addition to immediate suicide indicators such as a specific plan, timeframe, and available means (Dozois & Dobson, 2002). Psychometric

instruments such as the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974) may also assist in assessing risk, in addition to drawing on clinical experience and intuition. Dozois and Dobson recommend that, ultimately, the clinician must often conduct a "mental factor analysis" of risk factors, self-report scores, and the results of direct questioning in assessing suicide risk (see Meichenbaum, 2005, and Stolberg, Clark, & Bongar, 2002, for more thorough discussions of assessment of suicide risk in depression).

Interviewing for Therapy. Data from the assessment in general, and through interviewing procedures in particular, provide crucial information for case conceptualization and treatment planning. Although there is a range of basic areas of assessment in clinical interviewing of people with depression, the particular theoretical paradigm in which the interviewer is operating influences both the kinds of questions that are asked and the way the information obtained is interpreted (Barbour & Davison, 2004). The treatment of depression has been informed by identification and advancement of empirically supported treatments, with a number of specific interventions, including cognitive-behavioral therapy (CBT), behavior therapy, and interpersonal therapy, having a sufficient database to warrant being considered empirically supported (Chambless et al., 1998; Chambless & Ollendick, 2001). Whereas an interview taking place in the context of behavior therapy, for example, probably would involve a functional analysis of the specific conditions under which a behavior does or does not occur (Barbour & Davison, 2004), an interviewer working in the interpersonal therapy framework would attempt to identify major interpersonal problem areas and place the client's experience of depression in its interpersonal context (Weissman, Markowitz, & Klerman, 2000).

Interviewing for cognitive therapy (CT) or CBT also involves attending to particular issues. Widespread use of CBT-based interventions in treating depression is supported by a large body of evidence attesting to its efficacy and effectiveness. Aaron Beck's CT represents the best-established of the available CBT interventions (Hollon, Haman, & Brown, 2002) because CT has been shown to be effective in more randomized control trials than any other psychosocial intervention, and CT has been shown to be at least as effective in treating depression and more effective in preventing relapse than antidepressant medication (Persons, Davidson, & Tompkins, 2001). Some considerations in interviewing for CT will be examined briefly (cf. Beck, Rush, Shaw, & Emery, 1979).

As Beck et al. (1979) observe, therapy begins with the initial contact between the therapist and patient, and often this initial contact takes the form of the clinical interview. Some of the primary goals of the initial interview include the formation of the working relationship, which includes development of rapport; the gathering of important information, including the identification of target symptoms for intervention; and the use of specific cognitive techniques, which are aimed to produce at least some symptom relief. From the onset, the therapist works with the patient to establish a collaborative therapeutic relationship and to socialize the patient to therapy by using explicit and relevant examples to illustrate the cognitive model, including the link between negative thinking and unpleasant emotions. Providing a clear rationale for therapy and asking the patient for feedback is also important in the initial session, as is the identification of target symptoms. Behavioral or cognitive techniques are introduced, depending on presenting symptoms, with the goal of producing symptom relief, which further improves the therapeutic relationship and increases the patient's confidence in the efficacy of the therapy (see also Beck, 1995, for a further discussion of CT).

Beck et al. (1979) discuss several other considerations that are relevant in interviewing depressed patients. For example, it is important to recognize the validity of the negative ideas and beliefs held by the patient to himself or herself and to try to understand the basis of such beliefs rather than attempt to dispute them too early in the course of the interview or therapy in general. The level of structure and activity should also be adjusted as appropriate. For example, the therapist generally is more active early in therapy, including during the initial interview, and especially so with more severely depressed patients. The use of questioning is central to CT, not only as a means to gather information but also as a therapeutic tool in identifying, considering, and correcting negative cognitions and beliefs. Finally, eliciting feedback (e.g., about therapy, homework assignments, or the therapist) is particularly important with depressed patients, who may fear rejection or criticism from the therapist.

Interviewing Obstacles and Solutions

As indicated earlier, clinical interviewing with depressed patients can take various forms. There are areas that are typically assessed regardless of the theoretical orientation of the interviewer (e.g., presenting symptoms); however, the focus of the interview for therapy generally reflects the broader context of the particular treatment being implemented. Therefore, clinical interviewing plays a crucial role in case conceptualization and treatment planning.

Approaching the Assessment of Depression

Before examining the particular strategy of clinical interviewing and the depressive disorders, it is useful to consider the more general context of the assessment of depression. As Nezu et al. (2002) observe, a number of key issues guide the assessment process and selection of procedures, including the goals of the assessment, who is to be assessed, the value of a given assessment measure, and the source of the information provided. Each of these issues will be examined briefly, beginning with the goal of the assessment.

There are many different possible reasons or goals for the assessment of depression. These include screening, diagnosis and classification, description of symptoms, clinical hypothesis testing, treatment planning, prediction of behavior, and assessment of treatment outcome, and it is important to consider such particular goals when choosing assessment procedures and measures (Nezu et al., 2002). For example, measures used for screening purposes should display criterion-related validity and other characteristics such as sensitivity and specificity, whereas those used for diagnosis should be considered in terms of content validity and, if clinical judgment is involved, interrater reliability.

The question of who is being assessed is relevant to the appropriateness of the measure used (Nezu et al., 2002). Age, comorbid conditions, and ethnic and cultural background should all be taken into account because all these factors may influence the expression of depressive symptoms. When possible, measures developed specifically for use with certain populations with depression should be used, such as the Children's Depression Inventory (Kovacs, 1992), the Calgary Depression Scale for Schizophrenia (Addington, Addington, & Maticka-Tyndale, 1993), and the Vietnamese Depression Scale (Kinzie et al., 1982).

Nezu et al. (2002) stress consideration of the value of a given assessment tool, which is a function of both the likelihood that the chosen measure will provide information relevant to the goal of the assessment and the cost-benefit ratio of the use of a measure. The measure's psychometric properties, including the various facets of reliability and validity, should be examined, as should issues such as the time involved, practicality of administration, potential risks or ethical violations, and incremental validity. Ultimately, measures with strong psychometric properties and a positive benefit-to-cost ratio should be chosen.

The source of the information is another important consideration, where measures of depression can be categorized as either self-report or clinician rated (Nezu et al., 2002). Although self-report measures are brief, they are more susceptible to respondent bias, whereas clinician-rated measures may take longer but be more reliable. Therefore, a combination of both types of measures is generally recommended, in addition to a consideration of the four general issues raised by Nezu et al. (2002).

An abundance of measures of depression and depression-related constructs are available to researchers and clinicians. A recent volume by Nezu, Ronan, et al. (2000), for example, discusses more than 90 depression-related measurement tools. However, Nezu, Nezu, and Foster (2000, p. 17) point out that "although excellent assessment tools exist for many different clinical problems, the tools are only as good as the skill of the craftsperson who uses them," and much skill is needed in choosing which assessment measure to use for a given individual and purpose. Nezu, Nezu, et al. (2000) outline a 10-step set of heuristics to facilitate this decision-making process, which will be considered briefly here.

The first step involves determining the goal of the assessment, which may include screening, diagnosis, case formulation, treatment planning, and outcome evaluation. If the goal is to assess treatment outcome, for example, the selected measure should assess behaviors targeted by treatment, display good test-retest reliability in the absence of treatment, and be sufficiently sensitive to detect change. The second step is to adopt a system approach, which involves using multiple assessment measures and procedures to accomplish the various goals of the assessment

(i.e., a multimethod, system-oriented approach). The third step is to individualize assessment and identify obstacles (e.g., limited motivation on the part of the person being assessed or limited experience of the assessor), and the fourth step involves adapting the assessment to overcome obstacles, where the assessor might ask himself or herself, "What assessment procedures should I incorporate to maximize the chances of obtaining valid, reliable, and comprehensive information about this client for my particular assessment goal?" (Nezu, Nezu, et al., 2000, p. 21).

The fifth step involves generating a variety of assessment strategies for each focal area, which includes self-report inventories, interviews, and behavioral observation, and the sixth step involves generating multiple ideas for each strategy. The seventh step involves conducting a cost-benefit analysis, where the likelihood and value of outcomes is evaluated for each assessment goal and range of measurement alternatives. At the eighth step, the measures with the highest utility (those with the highest benefit-cost ratio) are selected, and at the ninth step, the selected procedures are implemented, which may entail adapting a particular measure for a specific situational context. Finally, the tenth step involves monitoring the effects and determining whether the assessment procedure has generated useful, valid, and reliable information.

Although such an involved approach to the selection of assessment approach may appear quite time-consuming, Nezu, Nezu, et al. (2000) point out that such a guided approach ultimately saves time and increases efficacy of assessment in both research and clinical situations. As reflected by the model proposed by Nezu, Nezu, et al., the importance of using multiple strategies in the assessment of depression cannot be overstated. Indeed, accurate assessment of depression entails use of multiple strategies, including structured and unstructured interviews, clinician ratings, and self-report inventories, ideally obtained from multiple perspectives, including the patient, significant others, and the clinician (Dozois & Dobson, 2002). Each of these assessment strategies has advantages and disadvantages that must be considered.

Structured interviews, such as the SCID-I (First et al., 1995, 1996) and the SADS (Endicott & Spitzer, 1978), offer a number of advantages related to assessment in general and depression in particular, including greater reliability than unstructured interviews and, in the case of the SCID and the SADS, strong reliability and validity in assessing mood disorders (Dozois & Dobson, 2002; Groth-Marnat, 1999). However, such interviews are lengthy and generally require extensive training to administer with adequate reliability (Dozois & Dobson, 2002).

Self-report measures and clinician rating scales offer a convenient means to assess symptoms and are particularly useful in identifying targets for treatment and assessing change over the course of therapy (Dozois & Dobson, 2002). A large number of self-report measures are available that exhibit strong psychometric properties and provide valuable information, such as the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996). However, self-report measures exhibit a number of general limitations, such as vulnerability to response bias and misinterpretation, and some are particularly relevant to the assessment of depression. For example, self-report measures are not appropriate for use with people with thought disorder or impaired reality testing or concentration (Dozois & Dobson, 2002). Such limitations necessitate the use of self-report measures in conjunction with other procedures rather than as the sole method.

Finally, clinician rating scales are a third commonly used assessment method, with the most common such measure being the HRSD (Hamilton, 1960, 1967). Clinician rating scales offer a number of distinct advantages, including providing a standardized format for clinicians to follow, allowing clinicians to follow up on inconsistent or incomplete responses, and providing information beyond that gained through self-report measures (Dozois & Dobson, 2002; Nezu, Ronan, et al., 2000). In terms of the latter advantage, self-report measures tend to provide more severe ratings of symptoms than clinician ratings, largely because of a lack of a normative database on the part of patients (Dozois & Dobson, 2002). Therefore, and as is the case with the assessment of depression in general, combining various procedures and measures is crucial for an accurate and complete assessment of depression.

The clinical interview is widely recognized as one of the most important tools for gathering information in both clinical and research situations (Barbour & Davison, 2004; Dozois & Dobson, 2004; Groth-Marnat, 1999). As evidenced by the preceding discussion, the assessment of depression should draw on multiple

methods and sources, and a number of considerations must be taken into account in their selection (Nezu, Ronan, et al., 2000; Nezu et al., 2002). It is important for the clinician to recognize consistent patterns of response across different types of measures of sources of information but also to recognize the possible importance of intermeasure inconsistency. With this broader context in place, the role of clinical interviewing in the assessment of depression in particular will now be addressed.

Case Illustration

Simone Walsh was a 40-year-old Caucasian woman who was referred by her family physician to a local mental health center because of ongoing concerns about her performance at work and apparent signs of depression, including crying at work. The psychologist who saw Simone at the center, Dr. Guillermo Hernandez, began the assessment by asking Simone to briefly describe the troubles she had been having at work or in other settings. Simone described a series of depression-related symptoms, including sad mood, loss of interest in many areas, self-denigrating thoughts, sleep disturbance (waking up in the night or early morning and difficulty returning to sleep), feeling slowed down, fatigue, and problems with concentration and thinking. She said that the onset of these problems had been about 6 months earlier, around the time that her husband of 14 years had suddenly advised her that he was leaving the relationship for another. Dr. Hernandez recognized that these symptoms met the *DSM-IV* criteria for major depressive episode, nonmelancholic subtype, but that Simone had not mentioned suicidal thoughts or behavior. On inquiry, Simone denied that she had any current thoughts in this direction, primarily because of the devastating effect it would have on her 5-year-old daughter.

Dr. Hernandez then inquired about Simone's history of depression. She responded by indicating that she had one similar episode in the past, when she was 23 years old, after she had left home and moved to a new city after finishing college. She reported feeling isolated and "frozen" for a period of 2 or so months at that time, a problem that eventually resolved as she became more engaged with activities and social relationships in her new setting. Further inquiry revealed no other apparent disorders. Simone did acknowledge the occasional use of alcohol to dull her senses (she also admitted to extensive marijuana use during college), and she indicated that she had been a shy child and socially anxious young adult, but these problems were not as great as in the past. Dr. Hernandez also questioned Simone about other legal or illegal drugs she might be taking that could simulate depression and about possible medical disorders, but she said that these considerations did not apply. Given this information, Dr. Hernandez revised his diagnostic impression to one of major depressive disorder, recurrent.

In order to further evaluate severity of Simone's adaptive functioning, Dr. Hernandez administered both the HRSD 17-item version and the BDI-II. The HRSD yielded a score of 25, which is in the moderate range of depression severity. The BDI-II score of 34 was seen as roughly comparable to the HRSD score and again placed Simone in the moderate range of severity for depressed patients. Of importance, item 9 on the BDI (suicidality) was rated 0, indicating a lack of active suicidal thinking, but item 2 (hopelessness) was 2, indicating a fairly strong endorsement of future pessimism. On inquiry, Simone admitted that she wondered whether her current problems would ever improve. The problems that she listed included isolation and loneliness, the lack of an intimate adult relationship, being overwhelmed as a mother at times (e.g., she said that she often managed to get what had to be done completed but that she "collapsed" once her daughter was in bed), poor work performance, and financial worries since her marital separation.

Dr. Hernandez, and the clinic in which he worked more generally, favored an evidence-based approach to the treatment of mental health problems. He had determined that cognitive-behavioral therapy was indicated for the problems Simone was presenting, and he shared a brief description of the model and his treatment recommendation with her. She generally agreed with the need for help, and she expressed some enthusiasm for the practical, problem-oriented strategy that Dr. Hernandez was offering. To begin this process, Dr. Hernandez elected to supplement the assessment information he already had with a behavioral assessment strategy. Specifically, he asked Simone to keep a daily diary of her activities, indicating for each hour the major task or event she was involved with (Beck

et al., 1979; Beck, 1995). As part of this record keeping, he also asked Simone to indicate whether she had any sense of mastery (success, completion), or pleasure associated with these events. This strategy provided a realistic sense of Simone's range of activities and her functional status.

In summary, Dr. Hernandez's assessment strategy was simple and clinically focused. Although he used a diagnostic interview, it was unstructured and not as systematic as alternatives, such as the SCID. He used two severity measures, one interviewer based and one self-report, and because the results of these two measures were approximately equal, they helped to reinforce the model of the patient's depression as being of moderate severity. Finally, Dr. Hernandez used a self-report instrument to collect functional behavioral information, which could be used both for planning new activities in CBT ans to index change in functional range and quality of activities over time. Dr. Hernandez was aware of other possible assessment targets, such as Simone's attitudes or attributional style, and the need to revisit the issues of hopelessness and suicidality over time. He was also mindful that although the patient had reported that she was (just) managing her parenting responsibilities and work performance, it might be necessary to obtain collateral and independent assessments in either or both of these areas if her depression did not respond to treatment or if her adaptive functioning seemed to be getting worse. With this information at hand, Dr. Hernandez concluded the assessment phase and initiated treatment.

Multicultural and Diversity Issues

Although depression may be viewed as a universal human condition, research interest in variation in the incidence, specific symptoms, meaning, and treatment of depression across ethnic or cultural groups has expanded significantly over the past decade (Gotlib & Hammen, 2002). Findings from such research, and increasing cultural diversity in both Canada and the United States, point to the need for clinicians to attend to individual differences when assessing depressive disorders.

For example, there are a number of recognized differences in the expression of particular symptoms of depression across cultures. Findings indicate that people from non-Western cultures (e.g., Filipino, Arab, Turkish, Japanese, Korean) are more likely to emphasize somatic symptoms of depression than depressed Westerners, with proposed reasons for this discrepancy including beliefs about the integration of mind and body, decreased emphasis on emotional expression, or stigma associated with mental illness among non-Western cultures (Gotlib & Hammen, 2002; Tsai & Chentsova-Dutton, 2002). Similar differences have also been found between particular ethnic groups. For example, whereas depressed African Americans have been found to report increased somatic symptoms, depressed European Americans have been found to be more likely to report such symptoms as suicidal ideation and guilt (Tsai & Chentsova-Dutton, 2002). Such differences in symptom expression clearly may complicate assessment and ultimately diagnosis of depressive disorders.

Use of structured diagnostic interviews among people from non-Western cultures or ethnic minorities is complicated by the fact that the diagnostic criteria underlying such interviews are derived from Western conceptions of psychopathology (e.g., the *DSM-IV-TR;* APA, 2000). As discussed earlier, significant variations in symptom expression across culture and ethnic groups may occur, as in the case of depressive disorders, and therefore it cannot be assumed that information obtained from assessment methods such as structured interviews will necessarily generalize across cultural and ethnic groups. There is evidence that structured diagnostic interviews may reduce the effects of cultural bias on psychiatric diagnosis (e.g., in the assessment of panic disorder); however, such interviews may also result in misdiagnosis of particular disorders for a number of reasons, not the least of which may be language barriers (Barbour & Davison, 2004). In conducting any form of psychological assessment, it is crucial to consider social and cultural factors that may affect symptoms and ultimately diagnosis, and clinicians must educate themselves if they are unfamiliar with the cultural or ethnic group to which the person they are assessing belongs (Barbour & Davison, 2004).

With publication of the *DSM-IV,* attempts were made to incorporate specific, culturally relevant information into the diagnostic nomenclature (APA, 1994). For example, a specific "Outline for Cultural Formulation," which includes consideration of such factors as the patient's cultural

identity and cultural explanations of the patient's illness, and a "Glossary of Culture-Bound Syndromes" appear in an appendix of the manual. Other models designed to increase attention given to cultural and other individual differences in diagnosis have also been proposed. Hays's (2001) ADDRESSING framework provides a heuristic for clinicians of specific individual difference factors (e.g., ethnicity, indigenous heritage, national origin, gender) that should be considered in conducting assessment and therapy with diverse populations.

In addition to a general consideration of issues of culture and ethnicity, there are a number of specific factors that the clinician should consider when conducting interviews with people of diverse backgrounds. Hays (2001) describes a range of differences in nonverbal communication, such as use of physical gestures, extent of direct eye contact, and use of silence, across cultural groups that the interviewer should attend to. For example, although direct eye contact is generally valued in Western culture, many non-Western cultures instead view indirect eye contact as both the norm and as a sign of respect toward those in authority. Depression itself can also influence a person's movements and mannerisms, including hand movements, eye contact, and rate of speech (Dozois & Dobson, 2002; Rehm, 1987; Schelde, 1998a, 1998b). Therefore, it is important that clinicians not only attend to cultural variations in nonverbal communication over the course of the interview but also consider the impact of both culture and depression on observed behavior.

Differential Diagnosis and Behavioral Assessment

Differential Diagnosis

The differential diagnosis of the depressive disorders is complicated by the fact that depressive symptoms are associated with a range of psychological and medical conditions and that depressive disorders often are comorbid with other disorders (Boland & Keller, 2002; Dozois & Dobson, 2002). However, the *DSM-IV-TR* (APA, 2000) provides explicit guidance in the differential diagnosis of major depressive episodes and the depressive disorders. Diagnostic criteria for a major depressive episode include that symptoms are not caused by a general medical condition or substance and are not better accounted for by bereavement. MDD is distinguished from a mood disorder due to a general medical condition and a substance-induced mood disorder, as determined by whether the mood disturbance is found to result from a general medical condition or a substance, respectively. After the death of a loved one, bereavement would be diagnosed unless symptoms persist for more than 2 months or include symptoms such as marked functional impairment, suicidal ideation, or psychomotor retardation.

MDD must also be distinguished from a number of other diagnoses (APA, 2000). In older adults, it is important to determine whether cognitive symptoms are caused by MDD or dementia, which is accomplished through a thorough medical evaluation and evaluation of symptom onset, course, and treatment response; for example, dementia typically is associated with a premorbid history of cognitive decline, whereas an abrupt cognitive decline is generally seen with the onset of MDD. MDD can be distinguished from a manic or mixed episode by the absence of manic symptoms. Both MDD and attention-deficit/hyperactivity disorder (ADHD) can involve symptoms of distractibility and low frustration tolerance, and caution should be used in diagnosing both in the case of children with ADHD if the primary mood disturbance is irritability. In the event that a psychosocial stressor precedes the onset of MDD, adjustment disorder with depressed mood may be the appropriate diagnosis if full MDD criteria are not met.

Diagnostic criteria for major depression include exclusionary criteria that the MDD is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified (APA, 2000). Schizoaffective disorder may be differentiated from major depression by its requiring a period of at least 2 weeks of delusions or hallucinations in the absence of prominent mood symptoms, and the *DSM-IV-TR* observes that although depressive symptoms may be present during psychotic disorders, they are often considered to be associated features of these disorders and do not warrant a separate diagnosis. However, if full criteria for MDD are met, the diagnosis of depressive disorder NOS may be made in addition to the diagnosis of schizophrenia, delusional disorder, or

psychotic disorder NOS. MDD must also be distinguished from dysthymic disorder, which is accomplished on the basis of severity, chronicity, and persistence. Dysthymic disorder requires the presence of depressive symptoms over a period of 2 years, compared with 2 weeks for MDD, and is generally associated with chronic, less severe symptoms that persist for many years. MDD must also be distinguished from a mood disorder caused by a general medical condition, substance-induced mood disorder, or dementia, as described in reference to MDD.

Finally, diagnostic criteria for dysthymic disorder stipulate that the mood disturbance is not better accounted for by MDD; that there has never been a manic, mixed, or hypomanic episode and that criteria are not met for cyclothymic disorder; that the disturbance does not occur exclusively during the course of a chronic psychotic disorder; and that the symptoms are not caused by a substance or general medical condition. Although dysthymic disorder and MDD share many symptoms, they do differ in terms of onset, course, and severity. Furthermore, both disorders may be diagnosed if no MDD was present for the first 2 years of the dysthymic disorder or if there has been a full remission of the MDD before the onset of dysthymic disorder (i.e., double depression). Accurate differential diagnosis and thorough assessment, including structured diagnostic interviews, increase the reliability of diagnosis and identification of comorbid conditions and are critical for case formulation and treatment planning (Dozois & Dobson, 2002).

Behavioral Assessment

As noted earlier, MDD involves a range of systems that affect functioning in a number of areas, including the affective, cognitive, behavioral, somatic, and social domains, many of which are amenable to behavioral assessment procedures (Dozois & Dobson, 2002). A number of the diagnostic criteria for MDD, such as depressed affect and psychomotor agitation or retardation, are directly observable (APA, 2000), and major theoretical and therapeutic models of the disorder, such as Beck's cognitive model (e.g., Beck et al., 1979; Clark et al., 1999), focus on the relationship between emotion, cognition, and behavior. Although an exhaustive examination of behavioral assessment of depression is beyond the scope of the present discussion, the role of behavioral assessment in the context of clinical interviewing will be discussed briefly (see Haynes & Heiby, 2004, and Haynes & O'Brien, 2000, for comprehensive examinations of behavioral assessment).

There are several behavioral indicators that the interviewer should attend to while interviewing depressed patients. Depression can affect a person's appearance, movements, and mannerisms (Dozois & Dobson, 2002). For example, research has found that depressed people exhibit less eye contact and hand movements and a lower rate of speech (Rehm, 1987). A number of these features, such as eye contact and speech rate, have also been found to improve as people recover. For example, Schelde (1998a, 1998b) has found depression to be characterized behaviorally by primarily a reduction in social interaction and secondarily by reduced self-occupation and body mobility. More specifically, behavioral markers of depression in this research included nonspecific gaze, withdrawal, and reduced mouth movements, and markers of recovery included social interest, social smile, and social initiative. Such findings have implications for interviewing depressed patients. For example, Schelde (1998b) observes that although depressed people may talk, their answers are brief and they tend not to display accompanying facial expressions and gestures. Such nonverbal communication can provide important information about the patient's current emotional state.

In addition to informal observation of behavioral symptoms and indicators of depression, the interview can also involve more formalized methods of behavioral assessment, such as a functional analysis of the patient's difficulties. "A functional analysis . . . aims to determine the conditions under which particular behaviors occur or do not occur, and whether they are followed by reinforcing or punishing events" (Barbour & Davidson, 2004, p. 185). Obtaining clear examples and definitions of any terms used by the depressed patient to describe his or her symptoms is crucial in order to operationally define the patient's difficulties, and the functional analysis can suggest hypotheses regarding causal factors of problem behaviors and indicate areas for intervention (Barbour & Davidson, 2004). For example, recent behavioral activation treatments for depression emphasize the use of functional analysis as a tool to examine the ideographic environmental contingencies that maintain depressed behavior, to

assess the specific needs and goals of the patient, and to target behavior that is likely to improve quality of life (Hopko, Lejuez, Ruggiero, & Eifert, 2003). Thus, results from the functional analysis play an important role in informing the therapy to follow.

Behavioral assessment also constitutes an important element of many behavioral and cognitive-behavioral interventions for depression (e.g., Beck, 1995; Hopko et al., 2003). For example, in CBT, behavioral interventions often are undertaken before cognitive ones because change in behavior is generally easier and may itself lead to more positive thoughts about certain situations (Dobson & Khatri, 2002). Among the more prominent behavioral techniques used in CBT are self-monitoring and activity scheduling, both of which entail repeated behavioral assessment on the part of the patient (DeRubeis, Tang, & Beck, 2001).

Self-monitoring involves having the patient record his or her activities and associated moods in a detailed manner (e.g., every hour) for a specified period of time, such as 1 week. Self-monitoring serves a number of functions, including informing both the therapist and patient of how much time is being devoted to certain activities, and provides a baseline to which future ratings can be compared (DeRubeis et al., 2001). Activity scheduling involves developing a schedule of activities that the patient found pleasurable from the self-monitoring exercise, activities that the patient enjoyed in the past but has been avoiding during the depression, or new activities that may be rewarding (DeRubeis et al., 2001). As part of the exercise, the therapist can have the patient test certain hypotheses, for example, by having the patient record predicted levels of enjoyment or mastery and compare them to actual ratings after completing the activities (Beck, 1995). Ongoing assessment over the course of therapy plays a number of important roles in terms of monitoring change over time, including allowing the therapist to identify any problems or areas for modification in treatment, and encouraging patients by providing clear evidence of progress (Dozois & Dobson, 2002).

In addition to the assessment of behavior, CBT interventions for depression also focus on assessing cognition. Although the therapist does attend to cognition in the initial interview, much of the formal assessment of the patient's thoughts and beliefs takes place as therapy progresses, with a central tool being the use of the Dysfunctional Thoughts Record (DTR; Beck, 1995). The DTR is a worksheet that the patient uses to record and respond to distorted cognitions and is a central technique through which cognitive restructuring is accomplished in CBT. Similar to other behavioral assessment techniques in terms of its requirement that the patient record situations in specific detail and on a regular basis, the DTR asks patients to record situations and the associated automatic thoughts, emotions, adaptive responses, and the outcome (i.e., in response to the adaptive response) (Beck, 1995). Like other behavioral assessment techniques, the DTR is reviewed regularly during therapy sessions. Furthermore, a range of self-report measures are available for the assessment of cognitive content and processes in depression, which may be useful therapeutically (see Blankstein & Segal, 2001, for further discussion).

Selection of Treatment Targets and Referral

As previously discussed, there are many different possible reasons for the assessment of depression (Nezu et al., 2002; Nezu, Nezu, et al., 2000). However, one of the most important goals is the development of a solid case conceptualization and treatment plan, which depends on information derived from the assessment such as appropriate diagnosis and an understanding of the presenting problems and their severity (Dobson & Dozois, 2002). Accurate diagnosis is important, for example, in determining what specific symptoms to target first in instances of depression comorbid with other disorders (Dobson & Dozois, 2002) and in selecting a particular intervention to use for a particular disorder, based on its level of empirical support (Chambless & Ollendick, 2001). Of course, implementation of an empirically supported treatment with a particular patient requires consideration of much more than diagnosis alone, and a thorough case conceptualization is crucial for treatment planning. A particularly relevant model of case conceptualization in the treatment of depression is that of Persons and colleagues (Persons & Davidson, 2001; Persons et al., 2001), which is based on Beck's cognitive theory of depression.

"A case formulation," as defined by Persons et al., "is an idiographic (individualized) theory

that explains a particular patient's symptoms and problems, serves as the basis for an individualized treatment plan, and guides the therapy process" (2001, p. 25). Persons et al. argue that evidence-based clinical practice requires that the clinician translate the nomothetic to the ideographic by tailoring empirically supported treatment protocols (e.g., CBT for depression) to the treatment of an individual patient in an evidence-based manner. This evidence-based formulation-driven approach to treatment relies heavily on data collected during the initial assessment, which leads to the case formulation that is based on hypotheses regarding possible mechanisms causing or maintaining problem behaviors, and the case formulation is in turn used to develop the treatment plan. Assessment continues over the course of treatment and is used to modify the treatment as necessary. Clinical decision making is guided by the empirical literature, and the therapist is guided by the case formulation rather than a list of interventions. Further more, the formulation and the treatment plan are based on a nomothetic formulation and protocol, respectively, with strong empirical support. Thus, treatment remains nomothetic in terms of drawing on an empirically supported intervention (e.g., CBT for depression) but is also idiographic in the way the protocol is implemented for the particular patient.

A cognitive-behavioral case formulation and treatment plan consist of a number of specific elements (Persons & Davidson, 2001; Persons et al., 2001). The "Identifying Information" section consists of demographic and background information (e.g., age, ethnicity, living situation) and is followed by the "Problem List," which is a comprehensive list of any problems the patient is experiencing in the symptoms, interpersonal, occupational, medical, financial, housing, legal, and leisure domains. Problems are further viewed in terms of Beck's three-component system of cognitive, behavioral, and mood symptoms of depression, which in turn leads to intervention suggestions. Though not strictly a component of case formulation, a "Diagnosis" section is included because of the utility of diagnosis in case formulation and treatment planning. For example, a diagnosis of depression implies certain schema about the self, world, and future and also suggests empirically supported nomothetic interventions.

The next section, "Working Hypothesis," consists of a number of subsections that are derived directly from Beck's theory of depression and may be modified depending on the particular cognitive-behavioral theory used (Persons et al., 2001). It is here that the nomothetic is translated to the ideographic. Persons et al. describe subheadings including "Schema," "Precipitating and Activating Situations," "Origins," and "Summary of the Working Hypothesis," which is described as the heart of the formulation and involves a description of how the particular patient learned particular schema that are now being activated by external events, in turn resulting in the identified symptoms and problems.

"Strengths and Assets," the next section of the formulation, involves noting patient strengths and assets (e.g., social skills, support network) that may be drawn on in designing interventions. The final section, which is based on the formulation, is the "Treatment Plan." This section includes a number of subsections specific to a cognitive-behavioral approach, including "Goals (Measures)," which involves collaboratively setting goals that are described in concrete terms and are assessed in terms of progress made over the course of therapy; "Interventions," where the specific interventions are related to the deficits described in working hypothesis, address problems from the problem list, and facilitate accomplishment of goals; and "Obstacles," where the therapist attempts to predict any difficulties that may arise in therapy in order to prevent or overcome them as needed.

Summary

Assessment procedures play a central role not only at the initial stage of the cognitive-behavioral case formulation, but also during implementation of the intervention derived from it. As evidenced from the preceding discussion, a cognitive-behavioral case formulation contains a great deal of information, which can be derived using a number of assessment strategies, including the initial clinical interview. As Persons et al. (2001) note, much of the required information can be assessed by simply asking the patient directly. Thus, a clinical interview conducted in the context of the cognitive-behavioral case formulation approach includes assessment of areas specific to this

model, such as information relevant to the problem list and working hypothesis (i.e., schema, activating situations, origins) and more general areas (e.g., depressive symptoms, behavioral assessment).

As Persons and colleagues (Persons & Davidson, 2001; Persons et al., 2001) acknowledge, there is little empirical support for the utility of the use of case formulation to guide intervention. However, the approach does rest on a foundation of empirically supported approaches as a guide for specific interventions, and Persons and Davidson recommend that therapists adopt one of the nomothetic formulations used in empirically supported therapies for the disorder being treated as a guide for the working hypothesis. Furthermore, a number of models of case conceptualization are available within the nomothetic cognitive-behavioral approach. However, as Nezu, Nezu, Peacock, and Girdwood (2004) observe, these variations share a number of important similarities, including an emphasis on the importance of individualized assessment in order to better understand the individual patient and the problems he or she is experiencing and similarities in the design of individual treatment protocols. Thus, models of case conceptualization such as that proposed by Persons and colleagues highlight the central role of assessment, including clinical interviewing in its various forms (i.e., structured diagnostic interviews and clinical interviews), not only in identifying areas of difficulty that a patient is experiencing but also in informing individualized and empirically based interventions to address those difficulties.

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11

BIPOLAR DISORDER

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DESCRIPTION OF THE DISORDER

Bipolar disorder is a serious psychiatric disorder characterized by extreme difficulties in social and occupational functioning (Mitchell, Slade, & Andrews, 2004). The disorder is projected to become the sixth leading medical cause of disability-adjusted life years worldwide by 2020 (Murray & Lopez, 1997). Fortunately, mood-stabilizing medications have been shown to reduce the risk of symptoms, hospitalizations, and even suicide (Angst, Angst, Gerber Werder, & Gamma, 2005; Baldessarini & Tondo, 2003; Goldberg, 2004). Recognition of this disorder is the first step toward providing effective care.

Despite the clear advantages of careful diagnosis, many mental health practitioners do not screen for this condition. For example, in one survey 79% of providers reported that they did not routinely screen for bipolar disorder (Brickman, LoPiccolo, & Johnson, 2002). Among people with bipolar disorder attending support groups, patients reported that it took them an average of more than 5 years to obtain the diagnosis of bipolar disorder (Lish, Dime Meenan, Whybrow, & Price, 1994). In a large community study, less than half of patients with bipolar disorder reported receiving treatment within the past year (Kessler, Rubinow, Holmes, Abelson, & Zhao, 1997). Sadly, treatment of depression without recognition of a history of mania can create substantial difficulties because antidepressant medications in the absence of mood-stabilizing medications have been found to trigger episodes of mania (Ghaemi, Lenox, & Baldessarini, 2001). Therefore, one vital public health goal is to increase recognition of this disorder by mental health practitioners.

The Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR;* APA, 2000) recognizes several forms of bipolar disorder, each defined on the basis of manic symptoms of varying duration and severity: bipolar I disorder, bipolar II disorder, cyclothymia, and bipolar disorder not otherwise specified (NOS). Bipolar I disorder is defined by one or more lifetime episodes of mania. According to *DSM-IV-TR,* a manic episode is defined by intense euphoric or irritable mood, accompanied by three associated symptoms (four if mood is irritable only). Associated symptoms can include decreased need for sleep, elevated self-esteem, distractibility, increased talkativeness, increased goal-directed activity, and excessive involvement in high-risk pleasurable activities (Table 11.1). To meet diagnostic criteria for mania, these symptoms must either create severe impairment for at least 1 week or be severe enough to necessitate hospitalization. The episode of mania can be accompanied by simultaneous symptoms of depression, in which case it is called a mixed episode. Despite the name *bipolar,* depression is not required for a diagnosis

of bipolar I disorder. Nonetheless, episodes of major depression are common for people with this disorder (see Table 11.1 for diagnostic criteria of depression).

Bipolar I disorder is the most severe form of the disorder, but a variety of milder forms of disorder have been defined, including bipolar II disorder, cyclothymia, and bipolar disorder NOS. Bipolar II disorder is defined by at least one lifetime hypomanic episode, along with episodes of major depression. Although hypomanic episodes are defined by the same symptoms as those used to define manic episodes, a hypomanic episode need only last 4 days and results in distinct changes in functioning rather than severe impairment. Cyclothymia is defined by frequent fluctuations between manic and depressive symptoms that do not meet the severity or duration criteria for mania or hypomania. The person must experience frequent mood fluctuations for at least 2 years (1 year in a child or adolescent). Finally, bipolar disorder NOS is defined by manic symptoms that do not meet either the frequency, duration, or severity criteria.

Table 11.1 ***DSM-IV*** **Criteria**

Manic Episode:

1. A period of 1 week or longer where mood is abnormally euphoric or irritable. (NOTE: The duration can be shorter than 1 week if mood changes result in hospitalization.)
2. Must have three or more symptoms (four if mood is irritable) during mood changes:
   - Elevated view of oneself
   - Feels rested despite decreased sleep
   - Pressured speech
   - Racing thoughts
   - Easily distracted
   - Increase in goal-directed behavior or agitation
   - Increased engagement in high-risk activities

Major Depressive Episode:

1. A period of 2 weeks or longer where individual is persistently depressed or anhedonic.
2. Must have five or more symptoms most of the day nearly every day during this period:
   - Depressed mood
   - Anhedonia
   - Significant increases/decreases in weight or appetite not due to dieting
   - Significant increases/decreases in sleep
   - Significant increases/decreases in motor activity
   - Fatigue
   - Lowered self-esteem
   - Concentration difficulties
   - Suicidal ideation

Bipolar I disorder and bipolar II disorder are both episodic: Symptoms can be absent for years at a time. Therefore, diagnosis rests on careful coverage of lifetime episodes, because even a 70-year-old person who last experienced a manic episode during childhood still qualifies for the diagnosis of bipolar disorder. Although some people go for a decade without symptoms, persistent subsyndromal symptoms of depression are normative (Judd et al., 2002). Moreover, even on adequate levels of lithium, most people experience further episodes within a 5-year period (Keller, Lavori, Kane, & Gelenberg, 1992).

Interviewing Strategies

A collaborative approach to the interview process helps set the tone for later treatment sessions. It may be useful to spend time initially setting expectations for the clinical interview. The clinician can explain the purpose of the interview (i.e., to gather information about the client to use for planning treatment) and can distinguish assessment from therapy goals. In addition, use of active listening skills (e.g., open questions, validating feelings, and reflective listening) can build rapport, which in turn can maximize patient disclosure.

Typically, a clinical interview should start with an assessment of the patient's presenting problems. A good interviewing strategy is to begin with an open-ended question (e.g. "What has brought you to see me?"). This allows the patient time to tell his or her story. The interviewer can then follow up with more specific questions to gather information about bipolar symptoms.

One of the difficult aspects of diagnosing bipolar disorder is that a clinician must be careful to capture manic and depressive symptoms. Although people with bipolar disorder are much more likely to seek treatment for depressive symptoms, epidemiological studies document that about 20–33% of people with bipolar disorder experience unipolar mania (cf. Karkowski & Kendler, 1997; Kessler et al., 1997). Longitudinal evidence suggests that many people initially reporting unipolar mania develop depressive episodes over a 15- to 20-year period (Solomon et al., 2003).

For each pole, areas to focus on include disruptions in mood, sleep, energy, behavior, cognition, and self-esteem. See Table 11.2 for a list of typical questions we use to begin to assess symptoms of depression and mania. It is advisable to start with less threatening questions with patients who are fearful or defensive. Generally speaking,

Table 11.2 Suggested Probes for Assessing Depression and Mania

Depression:

Have you ever had a period of 2 weeks or longer where you felt depressed most of the day, nearly every day?

Have you ever had a period of 2 weeks or longer where you the activities you usually enjoyed were less pleasurable?

During that time:
- How was your sleep?
- How was your energy?
- How did you feel about yourself?
- Did you feel lethargic or agitated?
- Did you have suicidal thoughts?
- How was your concentration?

Other signs of depression:
- Did life feel more difficult for you?
- Did you lose faith in yourself?
- Were you less social than usual?

Mania:

Have you ever had a period of 1 week or longer of where you felt happier than circumstances dictated most of the day, nearly every day?

Have you ever had a period of 1 week or longer of where you felt extremely irritable most of the day, nearly every day?

During that time:
- What was your energy like?
- How many hours per night were you sleeping? Did you feel rested or tired?
- Did you notice any changes in your behavior?
- Did you have any new or unusual ideas or goals? What were they?
- How did you feel about yourself? Were you more talkative than usual? Did others notice or comment on this?
- What was your concentration like?

Other possible signs of mania:
- Did you change your dress or appearance?
- Did you find that you got more accomplished?
- Did you find yourself more sexually desirable?
- Did life seem more exciting to you?
- Did people seem too slow?
- How was your confidence in yourself?

many patients are more open to discussing their depressive symptoms than their manic symptoms because depressive symptoms often are less stigmatizing. Within depression or mania probes, clinicians may first cover more objective symptoms, such as sleep patterns, concentration, or appetite before asking about the patient's mood. Recent evidence supports the idea that probing for increases in activity may be particularly helpful for identifying manic episodes (Akiskal & Benazzi, 2005).

A number of standardized instruments have been designed to capture the diagnosis of bipolar disorder (e.g., the Structured Clinical Interview for *DSM-IV;* First, Spitzer, Williams, & Gibbon, 1997; and the Schedule for Affective Disorders and Schizophrenia; Endicott & Spitzer, 1978) and the severity of symptoms (e.g., the Bech-Rafaelsen Mania Scale [BRMS]; Bech, 2002; Bech, Bolwig, Kramp, & Rafaelsen, 1979; and the Modified Hamilton Rating Scale for Depression [HAM-D]; Miller, Bishop, Norman, & Maddever,, 1985). The diagnostic interviews provide not only suggested probes but also thresholds for when to consider a symptom clinically significant.

In conducting any assessment of the severity of bipolar symptoms, clinicians should be aware that rates of completed suicide are about 12–15 times higher in those with bipolar disorder than in the general population (Angst, Stassen, Clayton, & Angst, 2002). After cardiovascular events, suicide is the most likely cause of death for people with bipolar I disorder (Angst et al., 2002). Rates of violence are also higher than in the general population (Corrigan & Watson, 2005). Therefore, it is important to assess for suicidal and homicidal risk. Asking specific questions about the presence and intensity of the patient's suicidal and homicidal thoughts, whether he or she has a specific plan and the means to carry it out, and the level of intent in carrying out a plan can help clarify the patient's risk of harm to self and others. Obtaining details on prior suicide attempts is also important.

The clinician should gather information about the patient's social and medical history. Given the highly heritable nature of bipolar disorder, family history of mood disorders should provide helpful information. Childhood events and traumas are also important to cover. An understanding of the patient's relationships within and outside of the family can help in treatment planning. The clinician should ask about the patient's medical history and substance use history because these are potential confounds in diagnosis of bipolar disorder.

Once the clinician has developed an understanding of the patient's symptoms, he or she should establish a timeline for their development. The clinician should inquire as to when the patient first noticed a change in his or her mood and when it reached a level that caused impairment. We find it helpful to use a lifechart (Denicoff et al., 1997) to capture the time course of episodes, antecedents, and consequences (Figure 11.1). Typically, we use one line of the lifechart to draw manic and depressive episodes,

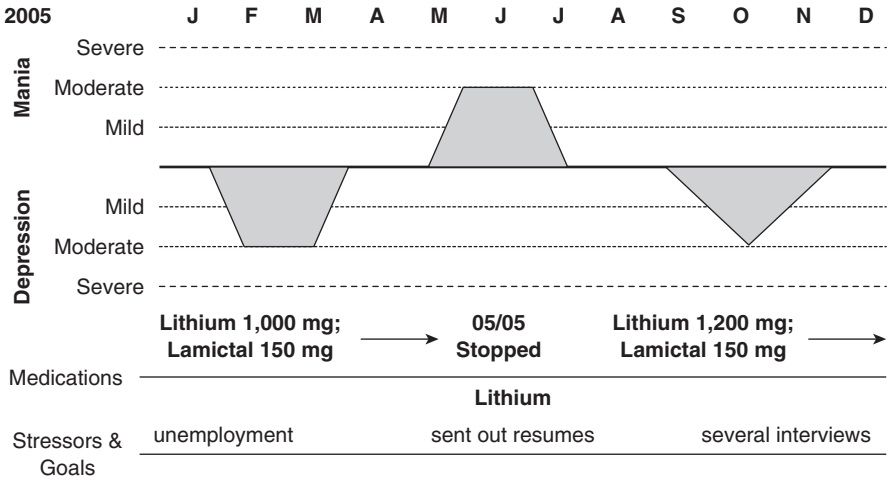

Figure 11.1 Example of a Lifechart

one for treatment, and one for life events. The interviewer can alternate his or her questioning to focus on events, mood changes, behavioral responses, and consequences to behavioral choices. Lifecharts can vary substantially in their level of detail. When interviewees have experienced more than six episodes, we often focus on understanding the pattern of symptoms over the past 2 years. When interviewees report few episodes, we draw the pattern for the entire life course. We often find it helpful to ask the patient to draw patterns as we watch or even to take the lifechart home and add to it during the week.

In drawing out the symptom line, we are interested in the severity of episodes but also the nature of prodromal periods because a better understanding of the rapidity of onset can help in planning strategies to prevent psychosocial problems as symptoms begin. We also use this as an opportunity to describe mixed episodes (periods of simultaneous depression and mania), which have been shown to be a predictor of poor treatment outcome (Kruger, Young, & Braunig, 2005). We cover subsyndromal symptoms, which can indicate a need for more intensive treatment with medication or psychotherapy.

We then use a second line to record treatment history, including medications, dosages, and periods of nonadherence. This often provides robust data about which medications have been effective and provides a concrete image for patients of the costs of nonadherence, which is all too common in this disorder (Basco & Rush, 1995; Keck, McElroy, Strakowski, & Stanton, 1996; Svarstad, Shireman, & Sweeney, 2001).

We use a third line to note major life events and changes. Much evidence supports major life events as a predictor of depression within bipolar disorder (Johnson & Fingerhut, 2004), and so careful questioning can often help capture events that preceded a bipolar episode. The interviewer should note stressful life events such as job changes, health problems, interpersonal losses, or financial difficulties. Bipolar disorder often takes quite a toll on a person's relationships, finances, and career, so it is important for interviewers to understand changes in these domains that unfold consequent to episodes. Although it is time-consuming, understanding the costs associated with this illness can help motivate patients for treatment.

One should consider the clinical interview as an initial step in the assessment of bipolar disorder. Ideally speaking, the clinician should monitor bipolar symptoms on an ongoing basis. This can be done in a diary format. The patient can monitor his or her sleep, mood, medication compliance, and use of alcohol and drugs on a daily basis.

Interviewing Obstacles and Solutions

Interviewing people with bipolar disorder can pose a number of challenges to the clinician. For example, symptoms of mania may interfere with the conversational flow of the interview. After discussing this issue, we turn to two particular issues that may lead patients to minimize their bipolar symptoms: poor insight and concerns about stigma.

Manic Symptoms and Conversational Flow

Patients who are experiencing current symptoms of mania may exhibit pressured speech. Beyond this, it is important to note that many clinical interviews place the interviewer in a dominant role, and a manic patient may deeply resent this type of exchange. Overly structured interviews, in which a patient has little room to decide when to elaborate on concerns, can be particularly frustrating for patients in this state. Therefore, it may be useful to give patients permission to ask questions or voice concerns during the interview or to provide some feedback about the order of topics to be covered. That is, we recommend finding small ways to restore some of the balance of power in allowing acutely manic patients opportunities to influence the interview process. Beyond this, we often find it helpful to note that we hope to cover a vast number of questions and to highlight that they will get chances to share other stories at the end of the interview. If a patient is acutely manic, breaking the interview up into smaller time periods can be helpful; it is often easier for patients to stay focused for brief periods of time.

Lack of Insight Into Symptoms

Insight into manic symptoms has been found to drop dramatically as people become manic (Dell'Osso et al., 2002). This is not surprising when one considers how cognition seems to shift with episode status. Bipolar patients may exhibit state-dependent changes in their ability to recognize or recall their symptoms. For instance, patients in

the midst of a manic episode may find it more difficult to remember details of their depressive history. Indeed, people who are experiencing acute mania often are poor at recognizing any signs of threat, much less their own dangerous warning signs. As an indicator of how profound such deficits can become, consider a study of facial affect recognition. Lembke and Ketter (2002) showed participants pictures of extremely intense emotional facial expressions and asked them to choose which emotion was being displayed. Although there is evidence that people with bipolar disorder are extremely sensitive to facial cues of negative affect during periods of remission (Harmer, Grayson, & Goodwin, 2002), people who were acutely manic were uniquely unable to recognize negative facial expressions. Imagine, then, how difficult it would be to evaluate complex interpersonal cues in a rich environment. Not surprisingly, during a manic episode, people can be oblivious to signs of distress or concern in others. They are also likely to be motivated to pursue their own personal goals, moving at lightning speed in a burst of confidence, such that people who provide negative feedback are ignored.

This presents quite a paradox for interviewers who would like to make a diagnosis of an acute manic episode. They can expect that many patients will not acknowledge concerns and do not want to hear negative feedback. Interviewers should keep feedback extremely behavioral and build consensus with a person step by step (e.g., first in regard to changes in concrete areas such as sleep, then in regard to activities, then in regard to romantic relationships) rather than attempting to quickly label a manic episode as such. That is, patients often can endorse concerns about not sleeping more readily than they can accept a full diagnosis of mania; we often work to facilitate good medical care for their difficulty sleeping.

As manic symptoms remit, insight often improves. Research also suggests that people develop better insight into illness as they age (Kleindienst, Engel, & Greil, 2005). Nonetheless, some patients have poor memories for the jumbled events of a manic episode, and others might not want to remember the events. We find that a calm, nonconfrontational stance can help promote enough rapport to facilitate discussion of these difficult experiences.

Given difficulties with insight and recall, family interviews can be helpful in piecing together details. Clinicians can maximize the reliability of their interviews by using multiple sources. If possible, clinicians should get patients' consent to interview loved ones who know the patient well and can report on his or her history. Clinicians are also advised to get permission to access the patients' past records of inpatient and outpatient medical and psychological treatment.

In one innovative study, researchers videotaped psychotic behavior at the time of hospital admission, and 6 weeks later they reviewed these tapes with patients (Davidoff, Forester, Ghaemi, & Bodkin, 1998). Although one can imagine that patients might have found these videos shocking, those who viewed the tapes sustained longer periods of time before rehospitalization than those who did not view such tapes. At times, family members may be able to provide a less shocking version of this sort of feedback to help patients understand the nature of symptoms that they may not fully remember.

Patient Concerns About Stigma

In keeping with a collaborative approach, clinicians may devote a portion of the interview to explaining the patient's diagnosis. Clinicians can use this time to understand the fears patients have about the disorder. Most patients find the process of diagnosis to be intensely stigmatizing. Self-blame can be reduced by honest discussion of the highly genetic basis of this disorder. Nonetheless, deep fears about the meaning of a bipolar diagnosis usually are not addressed just by the knowledge that this is a biologically driven disorder. Many clients have family members or friends with a history of bipolar disorder, and most have witnessed periods of untreated symptoms creating painful embarrassment and intense interpersonal rejections.

Our approach to stigma is to assume that people have views about what a diagnosis means and to ask about these views in detail before proceeding with diagnosis. Supportive psychoeducation can go a long way toward correcting some myths (e.g., bipolar disorder gets worse over time, people with bipolar disorder cannot work or must live in hospitals). In respect to some beliefs, we find it helpful to frame the purpose of diagnosis, which ultimately is to help in the process of treatment and regaining control. Written material can help challenge myths and fears. The National Institute of Mental Health

Web site provides free brochures with up-to-date information (http://www.nimh.nih.gov/healthinformation/bipolarmenu.cfm).

Some concerns about stigma are realistic: A recent survey suggests that most mental health consumers report stigma from family members, from employers, and even within their religious organizations (Wahl, 1999). Therefore, in exploring potential negative aspects of hearing a diagnosis, it is important for a clinician not to automatically dismiss fears and concerns. Rather, therapists can work with clients to minimize the negative consequences of the disorder for relationships, careers, and other important aspects of life.

Without overt discussion of these types of fears, the process of diagnosis can be overwhelming for many patients. For patients with severe mental illness, rates of suicide are particularly high in the first year after an initial diagnosis and hospitalization. Diagnosis, then, is a vulnerable time that requires delicate sensitivity to the best means of combating hopeless images of bipolar disorder.

Finally, we find it helpful to approach diagnosis as a process rather than a singular piece of feedback. Often, patients begin considering evidence that they have bipolar disorder only weeks into treatment, as they begin to develop more trust in the therapist. Over time, they gradually accept different facets of the disorder, perhaps beginning with an acknowledgment of certain symptoms and moving toward the understanding that symptoms could be of concern in the future. In one study, we found that acceptance of the need for treatment was multifaceted and included acknowledgment of previous and future symptoms, acceptance of the need for medications, difficulties letting go of positive aspects of mania such as energy and increased sociability, and willingness to tolerate the sometimes severe side effects of mood-stabilizing medications (Johnson & Fulford, under review).

Case Illustration

Although we have certainly met people who readily reviewed their symptoms and then easily accepted the diagnosis of bipolar disorder, this has been fairly rare in our experience. More commonly, a person who has not been previously diagnosed can find the interview difficult to complete: He or she may be vague about details, have trouble discussing concerns, or be unsure of the timing or severity of such concerns. In such cases, we often bring family members in for an interview. Often, it takes us several sessions to really help a patient integrate feedback from family members in a way that he or she finds useful and informative. Therefore, we have chosen a case illustration of a person who had difficulty recognizing signs of the disorder. To protect the identity of our client, we have changed several features of this story, at times incorporating details from more than one client to represent the general process of obtaining and sharing a diagnosis.

Stan was a 52-year-old married man who ran a small jewelry store. After hearing a community talk on bipolar disorder, Stan called to find out more about a treatment trial we were conducting, which included free psychotherapy. As part of that program, we screened Stan with the Structured Clinical Interview for *DSM-IV* (SCID) to determine whether he met diagnostic criteria for bipolar disorder.

In reviewing the events leading up to his interview, Stan reported that he and his wife separated in February, and shortly thereafter he was placed on a mood stabilizer. His wife accepted him back into the house on the condition that he continue to take medication for bipolar disorder. He stated that he had accepted his bipolar disorder and the need for treatment.

During the SCID, Stan endorsed a number of behaviors that were congruent with mania, but he denied that his behaviors were symptoms. For example, when asked about periods of irritability, he reported that he had suffered through two encounters with police in the past year over arguments. Although these seemed to be significant signs of irritability, Stan denied that anything was amiss with his condition during these incidents, stating that he had been unfairly treated by the police. Similarly, he described himself as 100% confident in his abilities but denied that he was experiencing any increase in self-esteem. His speech was pressured, but he stated that he was "always a talker." Although he endorsed sleeping only 4 hours per night, he stated that he had "always been a high-energy guy." Even though he described himself as diagnosed with bipolar disorder, Stan could not identify a single symptom that he saw as manic, nor could he identify a distinct time period of manic behavior. At the end

of the SCID, the interviewer was unable to state whether he met criteria for a manic episode, and we decided it was worth gaining his wife's perspective.

At a joint session the next week, Stan's wife gave a detailed overview of her concerns. She noted that Stan had always had more energy, more confidence, and less need for sleep than most people. For some time, these had seemed like distinctive strengths. Over the years, these characteristic behaviors sometimes became more intense, but not in a way that could be clearly characterized as episodic until February. In February, Stan began to demonstrate pressured speech and argumentativeness to an extent that friends expressed concerns to Stan's wife. She noted that during that time his sleep had diminished to a few hours per night, his spending had increased, and his driving had become more reckless. By her report, he met criteria for a manic episode in February. According to his wife, Stan began to calm down when mood-stabilizing medication was started. During the marital session, Stan was extremely distressed; with each symptom his wife described, Stan either denied the behavior or justified his reactions.

In many ways, the initial assessment with Stan was typical: At one level, he was able to acknowledge concerns about bipolar disorder. But he found the process of discussing these symptoms overwhelmingly difficult, he was unable to provide a clear image of any specific symptom, and he could not define the time course of any symptoms. At the same time, he showed a number of strengths: He presented as an intelligent and successful man who was motivated to engage in treatment and curious to learn more about bipolar disorder.

The therapist cautiously agreed to see Stan for treatment but let Stan know that psychotherapy would involve helping him learn to recognize symptoms of mania. Without the ability to label these symptoms, she warned Stan, efforts to learn to control these symptoms were not likely to go far. She agreed to begin by meeting with him and seeing whether they could jointly build a better sense of what the symptoms were and how to label them.

At the next session, Stan emphasized that he had already accepted that he had bipolar disorder and that he was taking medication, so he did not expect that this would ever be a problem again. Even as Stan denied any concerns about symptoms, he appeared to be experiencing some mild hypomanic symptoms: His speech was pressured, and his affect remained intense. Indeed, the therapist in the next office complained about the noise level because his voice was so loud. While providing reinforcement for his willingness to accept the diagnosis and the need for medications, the therapist began to discuss Stan's fears about what would happen if he were symptomatic. It seemed that Stan was concerned about how manic symptoms could threaten his marriage. Most important, though, he seemed to view symptoms in a black-and-white manner; he seemed to equate the idea of having one symptom with being "manic."

To combat Stan's fears about identifying symptoms, the therapist introduced the idea of manic "blips" as a common phenomenon in bipolar disorder. To reinforce the idea that manic symptoms could vary on a continuum, Stan and the therapist began to develop a personal checklist for him, which described different symptoms of mania and possible levels of severity. In using this scale, Stan was able to see that even though he had a couple mild symptoms, his symptoms were not at a full-blown level. This insight seemed to help him consider his symptoms more calmly. With these gains, Stan was in an excellent place to begin practicing mood management skills and monitoring their success.

Differential Diagnosis and Behavioral Assessment

Diagnosing bipolar disorder is difficult because of its overlap with a number of other psychological disorders. In one major community study, 100% of people with bipolar I disorder met criteria for a comorbid psychiatric condition (Kessler et al., 1997). In this section we discuss disorders that resemble bipolar disorder and suggestions for differential diagnosis.

Major Depressive Disorder

Most people with bipolar disorder experience episodes of depression, and they often seek treatment for depression without reporting their history of mania. Moreover, it can be difficult to differentiate major depressive episodes with prominent irritability from mixed episodes (APA, 2000). Both types of episodes are marked by

symptoms of irritability, sleep disturbance, and concentration difficulties. To qualify for a mixed episode, however, a person must meet criteria for both a manic episode and a major depressive episode nearly every day for at least 1 week.

Substance-Related Disorder and Mood Disorder Caused by a General Medical Condition

Diagnostic criteria for bipolar disorder specify that mood-related symptoms cannot be caused by the direct effects of a substance or a general medical condition. The most common substance involved in inducing manic episodes is antidepressant medication. Indeed, by one estimate, as many of 20% of people with bipolar spectrum disorder develop hypomanic or manic symptoms when treated with antidepressants alone (Ghaemi, Hsu, Soldani, & Goodwin, 2003). Current treatment guidelines suggest that antidepressant medications should be administered only in combination with a mood-stabilizing medication. Manic episodes that are triggered by antidepressant medication are diagnosed as substance-induced mood disorders.

Other substances that are particularly likely to trigger manic episodes include cocaine and stimulants. These substances directly increase the level of dopamine in the synaptic cleft and therefore may directly challenge the pathways involved in the genesis of manic episodes (Winters, Johnson, & Cuellar, under review).

Beyond these substances, intoxication or withdrawal from a broad range of substances often causes mood changes, impulsive or reckless behavior, and sleep disturbance. Medical conditions such as multiple sclerosis, stroke, and thyroid disease can also produce symptoms that mimic symptoms of mania or depression. It is therefore advisable to inquire as to whether the patient has had a recent physical exam.

Efforts to distinguish between a bipolar disorder and a substance-induced mood disorder are complicated by the fact that almost half of people with bipolar disorder abuse substances at some point during their lives (Brown, Suppes, Adinoff, & Thomas, 2001; Chengappa, Levine, Gershon, & Kupfer, 2000; Zarate & Tohen, 2001). It is therefore necessary to look at the temporal patterns between substance use and symptoms. It is sometimes necessary to defer a bipolar diagnosis until a sufficient period of detoxification has occurred.

Schizophrenia and Schizoaffective Disorder

Differentiating between bipolar disorder and psychotic disorders can be quite difficult in that mood disturbances often are linked with psychosis. Between one third and one half of patients with bipolar I disorder report psychotic symptoms (Judd et al., 2002; Lenzi, Rinaldi, Bianco, Balestri, & Marazziti, 1996), particularly during acute periods of mania (Black & Nasrallah, 1989). Psychotic symptoms tend to be present for less than 2 weeks per year (Judd et al., 2002).

If psychotic symptoms occur only during manic or depressive episodes, the patient would be diagnosed with bipolar disorder with psychotic features. When psychotic symptoms are more prominent, other diagnoses should be considered. Schizoaffective disorder is diagnosed when psychotic symptoms occur for 2 weeks or more outside the context of a mood episode. For schizophrenia, mood symptoms are brief relative to psychotic symptoms. Finally, a patient may be given dual diagnoses of schizophrenia and bipolar disorder if symptoms of both syndromes are present at a level that meets diagnostic criteria (APA, 2000).

Personality Disorders

Rates of comorbidity between personality disorders and bipolar disorder range from 33% to 50%, with particularly high rates when personality disorders are assessed during symptomatic periods (Ucok, Karaveli, Kundakci, & Yazici, 1998). Borderline personality disorder, histrionic personality disorder, and antisocial personality disorder, in particular, share symptoms with bipolar disorder. Patients with borderline personality disorder exhibit affective instability, impulsivity, and self-damaging behavior. Those with histrionic personality disorder can display seductive sexual behavior, rapidly shifting emotions, exaggerated expression of emotion, and self-dramatization. People with antisocial personality disorder have impulsive behavior, irritability, and antisocial behavior. Bipolar disorder can be distinguished from these personality disorders in that its symptoms are episodic and tied to mood changes. Therefore, it is important that clinicians examine the course of a patient's symptoms, specifically looking at mood patterns and their relationship to behavioral difficulties.

Generalized Anxiety Disorder

Restlessness, concentration difficulties, irritability, and sleep disturbance are characteristic of both generalized anxiety disorder (GAD) and bipolar disorder. However, the two disorders are easy to differentiate. In bipolar disorder, the aforementioned symptoms are related to episodic mood changes, whereas in GAD they are not. In addition, although people with GAD and bipolar disorder both have problems sleeping, bipolar patients feel rested despite their lack of sleep. According to the *DSM-IV* (APA, 2000), if a patient's GAD symptoms are confined to the course of a mood episode, he or she should be diagnosed with mood disorder and not GAD.

Multicultural and Diversity Issues

Intriguingly, rates of bipolar I disorder are about 1% across countries when studies are conducted using standardized interviews applied by similarly trained interviewers (Weissman, Bland, Joyce, & Newman, 1993). Some variability is apparent when studies have relied on different measures and training procedures for conducting diagnostic interviews, but such variability could reflect methodological differences (Noaghiul & Hibbeln, 2003). Nonetheless, rates of seafood consumption appear to explain some of the modest variability in rates of disorder across countries. That is, countries with higher rates of bipolar disorder tend to be those with low rates of seafood consumption (Noaghiul & Hilburn, 2003), consistent with the idea that omega-3 fatty acids are protective against mood disorders.

Little work has examined the course and outcome of bipolar disorder across different cultural groups. Similarly, little is known about how culture influences symptom expression. However, it is worth noting that in the United States, minority status has been tied to lower use of psychiatric treatment services (Wang et al., 2005). Therefore, sensitivity may be warranted in considering how culture influences attitudes and expectations about treatment.

Selection of Treatment Targets and Referral

The clinical interview should help set goals for treatment. This is best done within a collaborative framework. The patient should have input on what he or she would like to accomplish in therapy. The clinician helps the patient define goals that are specific, realistic, and measurable.

Medications are the bedrock of treatment for this disorder (Goldberg, 2004). The first medication that was found to be helpful in the treatment of manic symptoms was lithium, and to this day there is more evidence to support the efficacy of lithium than any other medication for bipolar disorder (see the APA Practice Guidelines, Hirschfeld et al., 2002). Beyond evidence from double-blind randomized trials that lithium reduces the severity of symptoms and the frequency of episodes (Prien, 1984), lithium is the first treatment shown to reduce suicidality (cf. Kessing, Sondergard, Kvist, & Andersen, 2005). Therefore, lithium is the first-line treatment.

Despite strong evidence for the efficacy of lithium, the side effects of lithium can be quite difficult to tolerate. About three quarters of people report side effects from lithium, which include excessive thirst, frequent urination, memory problems, tremor, weight gain, drowsiness, and diarrhea (Goodwin & Jamison, 1990). Antiseizure medications, such as valproate, have fewer side effects and have been shown to be effective mood-stabilizing agents in a series of trials.

Generally, mood-stabilizing medications have been found to be less effective in reducing depression symptoms than manic symptoms (Hlastala et al., 1997). To supplement mood-stabilizing medications, patients often are prescribed antipsychotic medications, antidepressants, and a range of other novel medication treatments (Rivas Vazquez, Johnson, Rey, Blais, & Rivas Vazquez, 2002). Antidepressants must be prescribed with caution, given the risks of inducing manic symptoms; current policy recommendations state that mood-stabilizing medications should be started before antidepressant medications are prescribed (Hirschfeld et al., 2002).

Although medications are the central treatment, there are several reasons that psychotherapy may be helpful as an adjunct to medication. Psychosocial interventions have been found to help improve adherence and decrease rates of hospitalization (Scott, 2004). Adherence is a particularly important goal in that in one major community survey, only 20% of people with bipolar disorder reported receiving outpatient treatment in the past year (Kessler et al., 1997). Even among those receiving outpatient treatment, as many as 75% have been found to experience

disruptions in consistent medication maintenance within a 1-year period (Unutzer, Simon, Pabiniak, Bond, & Katon, 2000). Many patients have great fear about taking medications, and it is important to assess and discuss these fears.

Psychosocial treatment may also be helpful in restoring aspects of a person's life that are damaged by this disorder; relationships, occupations, and finances each suffer a fairly dramatic toll with each episode. One third of people remain unemployed a full year after hospitalization for mania (Harrow, Goldberg, Grossman, & Meltzer, 1990). Because family conflict, life stress, social isolation, and negative cognitive styles clearly predict the course of the disorder (Johnson & Meyer, 2004), interventions designed to help reduce these potential triggers of symptoms are important (Johnson & Leahy, 2004). Indeed, cognitive, interpersonal, family, and group therapies have been found to reduce symptoms, particularly depressive symptoms, in a series of trials (Colom et al., 2003; Frank et al., 2005; Lam et al., 2003; Miklowitz, George, Richards, Simoneau, & Suddath, 2003).

Summary

Bipolar disorder can have serious consequences, making early detection and accurate diagnosis essential. A failure to screen for manic symptoms often leads to improper treatment, with severe implications for a patient's health and functioning.

We recommend a collaborative interviewing strategy beginning with the patient's presenting problem, followed by specific questions to capture both manic and depressive symptoms. It may be easier to begin with objective symptoms before moving into more difficult questions surrounding the patient's mood. Because high rates of suicide accompany this disorder, it is essential for clinicians to assess current and past suicidal ideation, plans, intent, and attempts. Instruments such as the SCID, HAM-D, and BRMS can be used to guide and provide structure to the clinical interview. Once manic and depressive symptoms have been identified, a lifechart is a useful tool to ascertain the time course of episodes, antecedents, and consequences. A comprehensive interview helps identify comorbid conditions and rule out other Axis I and Axis II disorders.

Interviewing a person with bipolar disorder may pose many challenges, and interviewers will need skill for dealing with potential problems such as pressured speech, poor insight, and concerns about stigma. Providing acutely manic patients with opportunities to influence the interview process, keeping feedback extremely behavioral, adopting a calm nonconfrontational stance, conducting family interviews, and understanding what a diagnosis means to the patient are strategies that can facilitate the diagnostic process. Concerns about stigma may particularly interfere with treatment seeking for some minorities. Sensitivity to the complexity of this disorder combined with an informed interviewing style can lay the groundwork for a collaborative treatment effort between clinician and patient. With accurate diagnosis, both medication and psychosocial treatments have much to offer for a person with bipolar disorder.

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SCHIZOPHRENIA

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DESCRIPTION OF THE DISORDER

Schizophrenia is a complex psychiatric illness characterized by many difficulties such as psychosis, apathy, social withdrawal, and disrupted functioning. It is considered to be the most severe and disabling of all adult psychiatric illnesses. The lifetime prevalence of schizophrenia in the general population is approximately 1% (Keith, Regier, & Rae, 1991). In general, the prevalence of schizophrenia is remarkably stable across a wide range of different demographic and environmental conditions, such as gender, race, religion, population density, and level of industrialization (Jablensky, 1989). However, schizophrenia is more common in some social circumstances, such as urban areas of industrialized countries (Peen & Dekker, 1997).

Because of its complexity, assessment of the disorder is necessarily broad based and involves various clinical interviews. In order to understand the wide scope of assessment, interviewing, and treatment, it is important to first review the diagnostic criteria and core psychopathology that define the illness and the common associated features, including comorbid disorders, that complicate the clinical picture.

Current classifications of schizophrenia are based primarily on the work of Kraepelin, who focused on the long-term deteriorating course of the illness (which he called dementia praecox), and Bleuler, who emphasized the core symptoms of the disorder as difficulties in thinking straight (lose associations), incongruous or flattened affect, loss of goal-directed behavior or ambivalence caused by conflicting impulses, and retreat into an inner world (autism, as coined by Eugene Bleuler). The two major classification systems, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM;* American Psychiatric Association, 1980, 1994) and the *International Classification of Diseases* (World Health Organization, 1992) both specify that the diagnosis of schizophrenia is based on the presence of specific symptoms, the absence of other symptoms, and psychosocial difficulties that persist over a significant period of time. Symptoms and impairments must be present in the absence of general medical or so-called organic conditions (e.g., substance abuse and neurological disorders such as Huntington disease) that could lead to a similar clinical presentation.

Core Symptoms and Impairments of Schizophrenia

For descriptive purposes, the core symptoms of schizophrenia are divided into three broad categories: positive, negative, and cognitive symptoms or impairments.

Positive symptoms are the *presence* of perceptual experiences, thoughts, and behaviors that are ordinarily absent in people without a psychiatric

illness. The typical positive symptoms are hallucinations (primarily hearing, but also feeling, seeing, tasting, or smelling in the absence of environmental stimuli), delusions (false or patently absurd beliefs that are not shared by others in the person's environment), and disorganization of thought and behavior (disconnected thoughts and strange or apparently purposeless behavior). Some positive symptoms are considered highly specific, such as first-rank symptoms (e.g., delusions of thought insertion or auditory hallucinations with a running commentary), and perhaps even pathognomonic (particularly affect, i.e., emotional expression, that is inappropriate to the content of the person's thoughts at that time). For many people with schizophrenia, positive symptoms fluctuate in their intensity over time and are episodic, with approximately 20–40% experiencing persistent positive symptoms (Curson, Patel, Liddle, & Barnes, 1988).

Negative symptoms are the opposite of positive symptoms in that they are defined by the *absence* of behaviors, cognitions, and emotions ordinarily present in people without psychiatric disorders. Common examples of negative symptoms include constricted or flat affect (diminished or absent expressiveness of facial expression, other body language or voice tone), anhedonia (loss of pleasure), anergia (loss of energy or initiative or ability to follow through on plans), and alogia (diminished amount or content of speech). All of these negative symptoms are common in schizophrenia, and they tend to be stable over time (Mueser, Bellack, Douglas, & Wade, 1991). Furthermore, negative symptoms have a pervasive impact on the ability of people with schizophrenia to engage and function socially and to sustain independent living (Pogue-Geile, 1989).

Cognitive impairments in schizophrenia include deficits in attention, memory, and executive functions (e.g., planning ahead, abstract thinking, and cognitive flexibility), and although in many cases they are stable, there is some evidence that they can worsen over time in late adulthood (Kurtz, 2005), particularly for a subgroup who have poor outcomes from early on. These impairments interfere with the person's ability to focus for sustained periods of time, which is highly related to functional disability, resulting in significant disruption to independent community living and work. Among the various cognitive impairments involved, there is evidence that social cognition is also impaired (Penn, Corrigan, & Racenstein, 1998) and that this impairment tends to be stable over time. This may result in poor social skills, leading to further problems in community integration.

Functional Disability and Handicap or Disadvantage

In addition to requiring presence of specific symptoms, modern diagnostic systems also require evidence of sustained functional disability (e.g., more than 6 months for *DSM-IV*) for the diagnosis of schizophrenia. Common difficulties in psychosocial functioning include problems fulfilling the roles of a worker, student, or homemaker, poor social relationships, and difficulties to care for oneself (e.g., disrupted grooming, hygiene, ability to cook, clean, do laundry, and attend to health care needs).

Although most people with schizophrenia indicate that competitive employment is a primary goal of theirs, a small minority (less than 15%) are actually working at any given time (Cook & Razzano, 2000; Drake et al., 1999). Problems in functioning contribute to difficulties in several other areas, resulting in handicap or disadvantage. The poor financial standing of many people with schizophrenia may cause them to reside in impoverished living conditions (e.g., in neighborhoods rife with substance abuse and crime) and to maintain poor dietary practices. Therefore, treatment for schizophrenia often entails substantial attention to the most common consequences of disrupted functioning in schizophrenia, such as unstable or unsafe housing, inadequate food and clothing (especially for homeless people), and neglected health problems.

Associated Features

Positive, negative, and cognitive symptoms and impairments and functional disability include the core characteristics of schizophrenia, there are additional associated problems. These include affective disorders such as postpsychotic depression (many times leading to suicide, which occurs in up to 10% of people with schizophrenia), anxiety disorders such as obsessive-compulsive and posttraumatic stress disorder, increased use of illicit drugs and alcohol, aggression (mainly if the person has previous aggression,

nonadherence, and substance use), limited insight into illness, and poor treatment adherence.

Interviewing Strategies

Development of more reliable criteria for schizophrenia in the *DSM-III* (American Psychiatric Association, 1980) was an extremely important development because until then the reliability of the diagnosis was low (Matarazzo, 1983). The main advantage of structured interviews is that they provide a standardized approach for gathering information, which reduces the variability of the assessment. Among the most important contributions to increased reliability were the development and use of interviewing strategies. Another advantage is that it provides guidelines for determining whether a specific symptom exists. On the downside, in order to fully benefit from the advantages of structured interviews, a fair amount of training and persistence are needed.

A comprehensive assessment interview should commence with evaluation of basic characteristics of the disorder, followed by frequently associated features and common comorbid diagnoses. In the following section we focus on interviewing strategies for assessing these areas.

Specific Domains of Assessment

A wide range of assessment instruments, divided primarily into self-report and interview-based instruments, has been developed to evaluate the severity of psychiatric symptoms. The Structured Clinical Interview for *DSM-IV* (SCID; First, Spitzer, Gibbon, & Williams, 1996) is the most widely used diagnostic assessment instrument for research studies of people with psychiatric disabilities in the United States. Psychiatric rating scales, based on semistructured interviews, have also been developed to provide a useful, reliable measure of the wide range of psychiatric symptoms commonly present in people with a psychiatric disability. These scales typically contain between 1 and 50 specifically defined items, each rated on a severity scale of five to seven points. Some interview-based scales have been developed to measure the full range of psychiatric symptoms, such as the Brief Psychiatric Rating Scale (BPRS; Lukoff, Nuechterlein, & Ventura, 1986) and the Positive and Negative Syndrome Scale (Kay, Opler, & Fiszbein, 1987), whereas other interview-based scales have been designed to tap specific dimensions, such as the Scale for the Assessment of Negative Symptoms (Andreasen, 1984) and the Hamilton Depression Rating Scale (Hamilton, 1960). The same classification holds true for self-report scales.

Interview-based psychiatric rating scales typically include a combination of symptoms elicited through direct questioning and symptoms observed in the course of the interview, as well as symptoms elicited by a collateral history taking (from caregivers and clinical documentation). For example, on the BPRS, depression is rated by asking questions such as "What has your mood been lately?" and "Have you been feeling down?" Mannerisms and posturing, on the other hand, are rated based on the behavioral observations of the interviewer. Psychiatric symptom scores can be either added up to get an overall index of symptom severity based on a rating scale or summarized in subscale scores corresponding to symptom dimensions such as negative, positive, and comorbid (affective and other) symptoms.

Positive and Negative Symptoms and Cognitive Impairments

Mental health professionals may use a variety of methods to assess positive and negative symptoms and cognitive impairments, including personal observation, interviews with collaterals, tasks, and use of standardized scales— clinician rated as well as self-report—designed to measure one type of symptom or all symptoms. The most widely used instruments include the BPRS (Lukoff et al., 1986; Overall & Gorham, 1962), the Scale for the Assessment of Negative Symptoms (SANS; Andreasen, 1982), the Scale for the Assessment of Positive Symptoms (SAPS; Andreasen, 1984), and the Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987), all of which are designed to be administered as semistructured clinical interviews. The BPRS was developed as a general measure of severe psychopathology in psychiatric disorders and includes items relevant to positive, negative, disorganization, and mood symptoms (Mueser, Curran, & McHugo, 1997). The SANS was developed to measure the negative symptoms of schizophrenia, and factor analyses indicate three correlated clusters of symptoms: apathy-anhedonia, blunted or flattened affect, and alogia-inattention (Sayers, Curran, & Mueser, 1996). The SAPS was developed to assess

the positive symptoms of schizophrenia, including hallucinations, delusions, bizarre behavior, and disorganized thought. The PANSS incorporates all the 18 items of the original BPRS and includes additional items tapping negative symptoms, cognitive impairments, and comorbid symptoms. Cognitive impairments can be assessed by a wide variety of instruments, mainly addressing working memory, attention or vigilance, verbal learning and memory, visual learning and memory, speed of processing, reasoning and problem solving, and social cognition (Bilder, 2006).

Role Functioning

Role functioning is the extent to which a person is able to meet the expectations of socially defined roles, such as employee, student, parent, or spouse. People with schizophrenia often have difficulty securing and sustaining competitive employment and therefore supporting themselves. The effects of schizophrenia on work productivity have been documented extensively (Marwaha & Johnson, 2004). People typically have difficulty getting jobs, working the number of hours required by many jobs, and keeping jobs.

Schizophrenia can also affect school performance because of the early age of onset, often leading patients to prematurely terminate educational attainment (Kessler, Foster, Saunders, & Stang, 1995). Dropping out of school early is problematic for many patients for a variety of reasons, including feelings of failure and lower levels of education, which are also a disadvantage when they are trying to enter the workforce (Mueser, Salyers, & Mueser, 2001).

In terms of assessment, work-related problems can be evaluated by obtaining information such as the type of job a person has, the wages and benefits paid, the number of hours worked, and satisfaction with the job. Work history information may be similarly obtained, such as prior jobs the person has had, the longest duration of competitive employment, wages and hours worked at the last competitive job, and reasons for job termination. This information is readily obtained through a direct interview with the patient and others.

Some structured interviews of social functioning also contain questions about work performance, such as the Social Adjustment Scale-II (Schooler, Hogarty, & Weissman, 1979). Observational measures of the quality of vocational functioning have also been developed, such as the Work Behavior Inventory (Lysaker, Bell, Bryson, & Zito, 1993). Observational measures such as these generally rely on another person who can complete the measure, such as the employer. Therefore, these measures are limited to vocational settings in which the patient has disclosed his or her disability to the employer or in which all the workers have a disability.

Independent Living and Self-Care Skills

Self-care skills involve the behaviors or activities of daily living (ADLs) necessary to maintain one's health, to present in a socially appropriate manner, and to meet one's basic living needs. Common self-care skills include personal hygiene and grooming, dental care, and self-managing illnesses such as diabetes. Independent living skills are known as instrumental ADLs (I-ADLs), or skills necessary for living on one's own, such as the ability to use public transportation, budget money and pay bills, do laundry, cook, and maintain one's apartment safely.

One of the best-validated instruments for assessing these skills is the Independent Living Skills Survey (Wallace, Liberman, Tauber, & Wallace, 2000). This measure includes both a client and a staff (or significant other) version and assesses a wide range of specific behaviors related to self-care and independent living. Many other instruments for measuring community functioning also tap some independent living skills, such as the Social and Adaptive Functions Evaluation (Harvey et al., 1997) and the Multnomah Community Ability Scale (Barker, Barron, & McFarlane, 1994).

Assessing Associated Features

Because schizophrenia usually affects many aspects of the person's life, it is essential to assess also the common associated features of the illness mentioned earlier, which include affective and anxiety disorders, substance abuse, lack of insight, and nonadherence.

Affective and Anxiety Disorders. People with schizophrenia disproportionately suffer from a lack of positive feelings (anhedonia) and high levels of negative affect, particularly depression, anxiety, and hostility (Blanchard & Panzarella,

1998; Glynn, 1998). Therefore, mood and level of anxiety are clearly important domains to assess in formulating a treatment plan, particularly given evidence that negative affect is associated with a poorer clinical course in people with schizophrenia (Blanchard & Panzarella, 1998).

Several instruments can be used to assess mood and anxiety, including the Beck Depression Inventory (BDI; Beck & Beck, 1972) and the Spielberger State-Trait Anxiety Scale (STAI; Spielberger, Gorsuch, & Lushene, 1970). The BDI and STAI, both of which are self-report tools, also have the advantage of being empirically validated and may be repeated frequently to monitor depression and anxiety throughout the course of treatment. A schizophrenia-specific instrument with good psychometric properties that was generated specifically for depression in schizophrenia is the Calgary Depression Scale for Schizophrenia (Addington, Addington, & Schissel, 1990). Posttraumatic stress disorder (PTSD) can be screened for by the PTSD Checklist (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996), which is a self-report measure that requires respondents to rate the degree to which they experience each of the 17 PTSD symptoms identified in the *DSM-IV* in relation to a prespecified traumatic event.

Substance Abuse. Given the high prevalence of substance abuse in schizophrenia, a comprehensive assessment should explore active substance use, both past and present. One such instrument, the Dartmouth Assessment of Lifestyle Instrument (DALI; Rosenberg et al., 1998), is an interviewer-administered scale that may be completed in approximately 6 minutes and was designed as a brief screen for detecting substance use disorder in people with severe mental illness, including schizophrenia. Items on the DALI address patterns of substance use, loss of control, consequences of use, dependence in terms of physiological syndromes, and subjective distress.

Even if substance use is denied, some measure of caution should be maintained, particularly for young, single men with lower-than-average levels of education, given that these men have the highest rates of substance use comorbidity (Mueser et al., 2000). If substance use is suspected, random urine drug screens and interviews with close informants may be conducted to test for current or recent substance use. People who acknowledge a substance use history should be monitored closely because of the chronic, relapsing nature of substance use disorders.

Poor Treatment Adherence. Studies have demonstrated that up to 55% of people with schizophrenia have significant difficulty following treatment recommendations, including taking medications as prescribed (Fenton, Blyler, & Heinssen, 1997). Poor treatment adherence is associated with increased symptom levels and functional disability and higher rates of relapse and rehospitalization. A more thorough assessment of adherence to medication regimens should include evaluation of barriers to adherence, including unpleasant side effects, complexity of medication regimens, cognitive impairment, poor insight or awareness of illness and of the need for treatment, poor alliance with mental health care providers, insufficient supervision during administration, family beliefs about illness or medications, mental status or current symptoms (e.g., paranoia about medications), and perceived benefit of medications (Cramer & Rosenheck, 1999; Kemp, Hayward, Applewaite, Everitt, & David, 1996; Weiden et al., 1994). Standardized scales designed to evaluate treatment adherence and attitudes toward medications may help identify targets for intervention. One such measure is the Rating of Medication Influences (ROMI) scale (Weiden et al., 1994). Other instruments include the Drug Attitudes Inventory (Hogan, Awad, & Eastwood, 1983), a self-report measure of willingness to take medications, and the Neuroleptic Dysphoria Scale (Van Putten & May, 1978), designed for use with acutely psychotic people.

Interviewing Obstacles and Solutions

Psychiatric diagnosis uses generic clinical assessment skills, such as combining open-ended and close-ended questions, as well as specialized skills that are needed to overcome obstacles associated with the psychiatric impairments. In this section we discuss such common obstacles, and proposed solutions to them, focusing on people with schizophrenia.

Obstacle 1: Preinterview Baggage

Obstacle: Some of the obstacles may begin even before the interviewee has attended the interview or met the interviewers. These may be related to the interviewee's feelings, expectations, and concerns, perhaps based on past experience. For instance, even before coming to the interview the interviewee may feel threatened, expect to be harshly judged and criticized, and be concerned about the possible consequences of the interview. Such preinterview feelings may manifest themselves in a range of different ways. For example, an interviewee who is feeling threatened may be very guarded or may be aggressive as a response to his or her perceived threat. Similarly, an interviewee who expects to be judged harshly may be hesitant at best or, worse, reluctant and oppositional to reveal anything and may even be hostile and antagonistic toward the interviewer. Finally, an interviewee who is concerned with the consequences of the interview might be busy trying to guess how he or she might best respond to questions asked by the interviewer, which would seriously threaten the validity of the information elicited.

Solution: Because the effectiveness and quality of all interviews depend on rapport, a starting point for the interviewer meeting an interviewee with the aforementioned concerns would be to develop empathy and understanding of the potential origins of the interviewee's baggage. This may include recognizing that the interviewee may have been in several clinical settings and situations that he or she perceived as threatening (e.g., being interviewed at a teaching hospital in front a group of trainees who were all strangers), was indeed judged harshly (e.g., for discontinuing medication against medical advice or using substances), or suffered from negatively perceived consequences of previous interviews (e.g., forced interventions or involuntarily hospitalization). In addition, the interviewer may use his or her clinical skills to help the interviewee feel more comfortable by expressing concern and empathy and greeting the interviewee and his or her story in a nonjudgmental manner. It is often useful in such cases to focus on the interviewee's immediate emotions and needs and address the discomfort that he or she might be feeling ("I have a sense that you are not feeling very comfortable. I was wondering whether you might be willing to share how you are feeling right now."). In addition to addressing the interpersonal context, there are several practical ways in which the interviewer can help the interviewee feel more at ease. Examples include introducing himself or herself and describing what to expect in terms of the format of the interview (its nature, rationale, and length) and what will follow in a clear and detailed manner. The interviewee should then be invited to ask questions and express any concerns, which should be addressed before proceeding. Forming a collaborative atmosphere in which the interviewee actively participates in an interview rather than being a passive subject is important. In addition, respecting the interviewee's style and pacing oneself to better match the interviewee's pace gradually increases the interviewee's trust and participation. Finally, when the interviewee is uncomfortable, it is particularly useful to start the interview with a warmup phase that includes easy-to-answer, factual questions to help the interviewee become more at ease. As the interviewee feels more comfortable, follow-up questions can be particularly helpful to gather more information about particular areas of significance.

Obstacle 2: Lack of Insight Into Illness

Obstacle: Because the interview usually takes place in a clinical setting (outpatient clinic or hospital), a typical early question is "What brought you here?" or "How did you come to be in the hospital?" This question is meant to provide a neutral stimulus to encourage the interviewee to reveal the sequence of events that preceded current treatment and to help obtain an overview of the present episode. One potential obstacle is that the interviewee may lack insight into the behaviors, experiences, or beliefs that characterize the current episode and preceded current interventions or hospitalization. The interviewee may deny having a problem altogether ("I do not know, everything was just fine."), believe that a problem led to being treated but that the problem was not his or hers ("They [family] wanted me taken away because they needed the room in the house."), or believe that he or she has a problem but that it is not a mental problem ("I was feeling weak and they wanted to do some tests on me"). These cases, reflecting various degrees and styles of lack of insight,

which is common among people with schizophrenia, present a potential obstacle for the interviewer seeking to obtain an overview of the current episode and psychiatric history.

Solution: Although it may be frustrating for the interviewer, it is not useful to be confrontational or repeat the question with the hope that the interviewee will eventually "gain insight." It is important instead to acknowledge the potential value in the information collected rather than get angry or anxious about failing to elicit the desired information. Information collected from an interviewee who seems to have limited insight into his or her condition may be of value for several reasons. First, discrepancies between the perceptions of interviewees and mental health providers may not always indicate lack of insight (Roe, Lereya, & Fennig, 2001). Second, even if the interviewee clearly lacks insight, it is clinically useful to explore and understand how different events are perceived and experienced by the interviewee (Roe & Kravetz, 2003). In addition, in some cases lack of insight may serve as a defense from the threat to self posed by the illness and its social and personal meaning (Roe & Davidson, 2005). Therefore, acknowledging the clinical value of the interviewee's report, even if it is not consistent with that of the interviewer, may help the interviewer convey genuine respect for the interviewee's views rather than become inpatient, angry, or confrontational regarding the interviewee's "lack of insight."

Obstacle 3: The Guarded and the Suggestible Interviewee

Obstacle: The validity of the information collected may be seriously compromised in the extreme cases of the particularly guarded or suggestible interviewee. At one extreme, the guarded interviewee may not reveal much information, particularly in relation to symptoms. Because clinical assessment in psychiatry depends to a great degree on self-report, interviews with guarded interviewees may create the false impression that the person experiences fewer symptoms than he or she actually does. At the other extreme is the suggestible interviewee, who is easily influenced by the interviewer's questions and comes to believe that he or she has experienced any symptom he or she is asked about and therefore might be assessed as being more symptomatic than he or she really is. Regardless of which of the two extremes a person is at, the information collected through the interview may not accurately reflect the person's condition.

Solution: There are several possible solutions to these problems. First, the interviewer can be explicit about the value of eliciting the most valid information and its importance in helping to generate the most beneficial and tailored treatment plan. Second, the interviewer can gently test whether the interviewee understood the questions. Third, once he or she identifies such a tendency, the interviewer should be particularly careful with leading questions that imply to the interviewee what the "right" answer is (which would motivate the guarded interviewee to deny the symptom and the suggestible interviewee to become convinced he or she has it). Finally, it is important that the interviewer use his or her judgment and clinical skills and evaluate whether other sources (including observations within the interview) are consistent with the interviewee's self report.

Obstacle 4: Assessing Symptoms

Obstacle: Many obstacles to collecting reliable information during an interview are intensified when one is trying to elicit information about symptoms. As already discussed, interviewees often deny having symptoms altogether, are reluctant to discuss these experiences, or are highly suggestible and easily convinced that they have many of the symptoms asked about. All of these obstacles make it particularly difficult to achieve the primary goal of a diagnostic interview: to assess interviewees' symptoms in a reliable manner. The inherent difficulty is that because of the absence of laboratory test markers and indicators, psychiatric diagnosis depends heavily on self-report, which is subject to many distortions.

Solution: Ironically, the interview's inherent limitations are also its strength because the complex process and data it reveals can facilitate the generation of diagnostic hypotheses. For instance, by evaluating the content and logical flow of the interviewee's verbalization, the interviewer may be able to learn about the presence of symptoms such as hallucinations and thought disorganization (e.g., loose associations, circumstantiality, and thought blocking). Although delusions may be readily assessed at times because of the interviewee's preoccupation with the theme or idea, at other times more

engagement in lengthier discussions is needed before the interviewee begins to reveal much about these delusional ideas. In addition, observations of the interviewee's behavior and affective expressivity during the interview can detect symptoms such as constricted or inappropriate affect. Finally, the interviewer may ask himself or herself whether he or she is losing track of the point the interviewee is trying to make, which can serve as a useful cue to consider different symptoms such as tangential speech or derailing.

Obstacle 5: Symptoms Getting in the Way

Obstacle: The core symptoms of the disorder can make interviewing a person with schizophrenia difficult. Examples include the interviewee actively hallucinating, being delusional, displaying disorganized thought or behavior, or presenting with severe negative symptoms, cognitive impairments, or comorbid symptoms such as anxiety. Common effects of these symptoms and impairments are distraction of the interviewee, which disrupts the flow of the interview, and poor collaboration on his or her part.

Solution: There are various ways to address such disruptions. One way is to break up the interview into smaller parts in order to accommodate the person's attention span. This can involve taking more frequent rest breaks or conducting the interview over a few days. This approach can also be used within the interview by breaking questions down into smaller ones so that the interviewee can more easily retain and process the questions. Finally, it is often useful to identify incentives for the person to participate as fully as possible in the interview, both explaining the benefits of the interview, providing token rewards (e.g., refreshment breaks), and linking participation in the assessment to helping the person achieve some other personally desired goal.

Obstacle 6: The Importance of Context

Obstacle: Another obstacle is a lack of sufficient information on personal or cultural context within which the diagnostic information could be meaningfully understood. This can occur in transcultural situations if the interviewer is not versed in the interviewee's language and culture. It can also occur if insufficient time is allocated to the interview. Finally, it can also occur if there is lack of trust on the part of the interviewee, be it because of paranoia, a traumatic history with the health care system, unsatisfactory communication skills on the part of the interviewer, or other factors.

Solution: To understand the personal context it is useful to explore how symptoms relate to various domains of a person's life. To gather such information it is important that the interviewer ask about a range of other contexts, including work, living, leisure, and social relationships, to try to identify the often complex mutual influences between these contexts and symptoms. Another imperative aspect of the context is its longitudinal course (e.g., time of onset of the first psychotic episode), which would affect the developmental abilities of the interviewee (e.g., educational level and interpersonal experiences). Also, the interviewer should be sensitive to paranoia or a traumatic history on the part of the interviewee that may disrupt the interview, and use appropriate communication skills to build trust (e.g., fully disclosing the possible risks and expected benefits of the interview; giving the interviewee as much control as possible over the interview by asking open-ended questions and inviting the person to tell his or her life story; and using empathic verbalizations). Last but not least is the cultural and spiritual context. Because the interviewer functions as a yardstick to some degree in evaluating the interviewee's beliefs, it is imperative that the clinician be familiar with the interviewee's general and health beliefs in relation to those of the culture to which he or she belongs. The next section discusses cultural considerations in greater depth.

Case Illustration With Dialogue

Arthur, a 24-year-old bachelor who lives with his widowed mother, is referred by his family doctor for a psychiatric consultation because of prolonged social withdrawal. The family doctor provides information that Arthur was diagnosed with a first and only psychotic episode when he was 17. He was treated then for a couple of months with an antipsychotic medication that resolved his psychosis, after which he discontinued the medication, and since then he has not received psychiatric care. Because Arthur wants to be seen in consultation without his mother, the mother sends a letter to the consultant suggesting that Arthur was always somewhat withdrawn but

that since his psychotic episode he has completely isolated himself, confining his life to watching TV, eating, and sleeping, and that he does not share his thoughts with her. The following are parts of the consultation interview, focusing on some of the aforementioned obstacles and solutions.

Interviewer: Hello, Arthur. My name is Dr. Paul Brown, and I am a psychiatrist. You can call me by my first or last name, whatever you feel most comfortable with. Please have a seat. . . . Do you know why your family doctor referred you to me?

Arthur: First I want to know what my mother wrote in the letter she sent you [obstacle number 1].

I: That's fair enough because your mother did not indicate that you should not know what she wrote in the letter. As I understand from your family doctor, you wanted to see me alone, without your mother. Therefore, she thought it would be helpful for me to know how she sees how you have been doing, considering that you live with her and that she has known you since you were born. Does that make sense?

A: I guess. So what did she write in the letter?

I: Actually, not a lot. Mainly that in the last few years you have been keeping to yourself, staying at home and making do with TV, eating, and sleeping. That also seems to be the reason for your family doctor referring you to me. What do you think about that?

A: She's always on my case, and now she has managed to bring the Doc into the loop. I have just not decided what I want to do in my life, so I am waiting it out.

I: It is very important for me to hear your perspective on what has been going on in your life. That is my purpose for this meeting, so that I can give you my impression of what's been going on in your life and whether there is anything that could be helpful to you. Is that okay? And would you have another purpose for this meeting?

A: My purpose was to know what my mother wrote to you in the letter. I know that now, so we can go on talking. Who knows, maybe you can help me understand why I am stuck.

I: In order to try to do that, I would need to ask you questions. The meeting will probably take around an hour or so. If you need a break, let me know, and we will do that. Can we start?

A: Sure.

I: Let's start with some basic facts. How old are you. . . .

I: You have told me that your relationship with the TV has become that of a love-hate one, because sometimes it is your friend and sometimes it is not. You seemed a bit reluctant to go into more detail [obstacle number 3]. Would you be comfortable to explain it to me, so I can understand what's going on in your life better?

A: You'll laugh at me.

I: I promise you I take you very seriously.

A: Sure?

I: My job is to help people, whatever they are experiencing. The more I know what you are experiencing, the more I can help you.

A: Okay. Sometimes the TV sends me messages. . . .

I: I notice that during our talk once in a while you seem to lose your thread of thought, so that I had to repeat some of my questions [obstacle number 5]. Did you notice that?

A: I am not used to talking so much, so maybe I am tired.

I: Do you lose your thread of thought at home?

A: Maybe.

I: There are many reasons why that could happen, and one of the things I can help out with is to find out how much of that is happening, and if so why. For that, I would need you to answer a few questions and to follow

a few instructions. This will only take a few minutes. Can we do that now?

A: Go ahead.

I: This is called the Folstein Mini–Mental Status Examination. It is not about passing or failing, but rather gives both of us information on things like your concentration and memory. The first question is, what is the date today?

Multicultural and Diversity Issues

Understanding different cultural beliefs, values, and social structures can have important implications for the diagnosis of schizophrenia and its assessment. Ethnic groups may differ in their willingness to report symptoms, as illustrated by one study that reported that African American interviewees were less likely to report symptoms than Hispanics or non-Hispanic Whites (Skilbeck, Acosta, Yamamoto, & Evans, 1984). In addition, many other studies have found that African Americans are more likely to be diagnosed with schizophrenia than other ethnic groups (Adams, Dworkin, & Rosenberg, 1984). Knowledge of cultural norms is critical in avoiding the possible misinterpretation of culturally bound beliefs and practices when arriving at a diagnosis. Several studies have shown that ethnic differences in diagnosis vary as a function of both the interviewee's and the interviewer's ethnicity (Loring & Powell, 1988). Of note, misdiagnosis of affective disorders such as schizophrenia is the most common problem with the diagnosis of ethnic minorities in the United States (Jones, Gray, & Parsons, 1981, 1983).

Differential Diagnosis and Behavioral Assessment

Differential Diagnosis

The symptoms of schizophrenia overlap with those of many other psychiatric disorders, and therefore the presence of other syndromes should be assessed and ruled out before the diagnosis of schizophrenia can be made.

Schizoaffective and mood disorders are commonly confused with schizophrenia because they are mistakenly thought to simply assume the presence of both psychotic and affective symptoms (particularly in bipolar and psychotic depression types). But it is not the predominance of the psychotic versus the affective component that determines the diagnosis but rather the timing of the psychotic and affective symptoms. If psychotic symptoms always overlap with affective symptoms, the person is diagnosed with an affective disorder, whereas if psychotic symptoms are present in the absence of an affective syndrome, the person meets criteria for either schizoaffective disorder or schizophrenia. The distinction between schizophrenia and schizoaffective disorder is even more difficult because judgment must be made as to whether the affective symptoms have been present for a substantial part of the person's illness.

Although the differential diagnosis between schizophrenia and schizoaffective disorder is difficult, the clinical implications of this distinction may be less important than that between the affective disorders and either schizophrenia or schizoaffective disorder. Some research on family history and treatment response suggests that schizophrenia and schizoaffective disorder may be similar disorders and may respond to the similar interventions (Levinson & Mowry, 1991). Therefore, the information provided in this chapter on schizophrenia may also pertain to schizoaffective disorder, and the differential diagnosis between the two disorders may not be of major importance from a clinical perspective, particularly with recent research showing that some second-generation antipsychotic medications have not only antipsychotic properties but also mood-stabilizing properties (Citrome, Goldberg, & Stahl, 2005).

Recent research (Mueser, Goodman et al., 1998; Mueser et al., 2002) reveals high rates of exposure to trauma and PTSD comorbidity among people with severe mental illness such as schizophrenia. These findings and the overlap in symptom presentation make it a highly relevant disorder in schizophrenia assessment. Dissociative or reexperiencing symptoms such as trauma-related auditory phenomena and flashbacks may be mistakenly interpreted as schizophrenia (Sautter et al., 1999).

Substance use disorder, such as alcohol dependence or drug abuse, can be either a differential diagnosis to schizophrenia or a comorbid disorder. With respect to differential diagnosis, substance use disorders can interfere with a clinician's

ability to diagnose schizophrenia and can lead to misdiagnosis if the substance use is covert (Kranzler et al., 1995). Psychoactive substances, such as alcohol, marijuana, cocaine, and amphetamines, can produce symptoms and dysfunction that mimic those found in schizophrenia, such as hallucinations, delusions, and social withdrawal (Schuckit, 1989). The most critical recommendations for diagnosing substance abuse in schizophrenia include the following: Maintain a high index of suspicion of substance abuse, especially if a interviewee has a past history of substance abuse; use multiple assessment techniques, including self-report instruments, interviews with interviewees, clinician reports, reports of significant others, and biological assays; and be alert to signs that may be subtle indicators of presence of a substance use disorder, such as unexplained symptom relapses, increased familial conflict, money management problems, and depression or suicidality. Once a substance use disorder has been diagnosed, integrated treatment that addresses both the schizophrenia and the substance use disorder is necessary to achieve a favorable clinical outcome (Mueser, Noordsy, Drake, & Fox, 2003).

Many general medical disorders, such as hyperthyroidism, and cognitive disorders, such as dementia of various types, can present with schizophrenia-like symptoms. Also, in many of these disorders the cognitive impairments are similar, such as in some cases of head injury. Therefore, distinguishing schizophrenia from these disorders may be difficult, particularly when past history is not conclusive (e.g., when a first psychotic episode started after head injury). Moreover, the impact of comorbidity (e.g., whether head injury that occurred after the onset of schizophrenia is contributing to symptom severity and cognitive impairment) may be very difficult to determine because the natural course of schizophrenia in itself is not a uniform one. Still, a thorough medical and psychiatric history is helpful in this respect, as are laboratory tests (e.g., blood tests for hormones and many other factors, brain imaging such as computed tomography and magnetic resonance imaging) to rule out or support general medical and cognitive disorders.

Behavioral Assessment

Schizophrenia is sometimes associated with disruptive behaviors, particularly when it is refractory to treatment (Brenner et al., 1990). Of most concern are behaviors that result in physical risk to the person with schizophrenia or to others, such as suicidality and aggression, respectively. These are more common in people with schizophrenia than in the general population, particularly in subgroups such as young men with schizophrenia (for depression) and nonadherent substance-abusing people with schizophrenia (for aggression). Although predicting risk and dangerous behavior is difficult, there are measures that attempt to do that, some with more success than others. Suicidality in general has been somewhat predicted by scales such as the Scale for Suicide Ideation (SSI; Beck, Kovacs, & Weissman, 1979). More recently, a schizophrenia-specific measure to assess suicidality has been developed, based on the SSI (Alphs et al., 2004). Both measures involve a structured interview. Aggression in general has been measured and predicted by many scales. In the context of severe mental illness, a scale developed to predict aggression in interviewees settings is the Broset Violence Checklist (Almvik & Woods, 1998; Almvik, Woods, & Rasmussen, 2000), which is based on clinician's observations. In the context of schizophrenia, scales such as the Violent Risk Appraisal Guide and the historical part of the risk assessment device HCR-20 have been used with moderate success to predict future violence in known offenders (Tengstrom, 2001).

Selection of Treatment Targets and Referral

Considering the variability in symptoms, associated features, and comorbid diagnoses in schizophrenia, it is important that treatment for people with schizophrenia be individually tailored. A comprehensive assessment can help provide the information needed to identify specific disabilities that will serve as targets for change, which should be based on the interviewee's identified goals as much as possible (Anthony, Cohen, Farkas, & Gagne, 2002). This section describes treatment related to three broad areas that can be assessed using the interviewing strategies discussed earlier: symptoms, functioning, and quality of life. Although this division is somewhat arbitrary, because the three areas interact with one another, it provides a useful framework.

Symptom Target Interventions

Medication and Adherence Interventions. Antipsychotic medications are the most powerful single intervention to reduce symptoms and prevent relapses. They are most effective in their impact on positive symptoms and to a lesser degree on negative symptoms and cognitive impairments. Since the 1990s, various atypical or second-generation antipsychotics have been developed and have largely replaced the first-generation antipsychotics, which had more side effects, particularly more neurological side effects (admittedly, the second-generation antipsychotics demonstrate other disturbing side effects, such as hyperlipidemia and possibly diabetes mellitus). Of note, clozapine, which was discovered before the 1990s but has atypical properties, is widely agreed to be the treatment of choice for refractory schizophrenia (Gaebel, Weinmann, Sartorius, Rutz, & McIntyre, 2005). One of the most puzzling yet consistent findings is that despite evidence supporting the effectiveness of psychiatric medication (Thornley & Adams, 1998), only about half of people diagnosed with a severe mental illness and prescribed psychotropic medications use their medication as prescribed (Weiden & Olfson, 1995). A range of interventions have been developed to address this very challenge. Boczkowski, Zeichner, and DeSanto (1985) describe an example of the psychoeducational approach, in which individual medication regimens are carefully reviewed and written materials with information about the medications are provided. Similarly, behavioral tailoring interventions (e.g., Boczkowski et al., 1985; Cramer & Rosenheck, 1999) focus on helping interviewees develop specific cues that incorporate taking their medication with routine aspects of their daily activities. Finally, Kemp et al. (1996) describe compliance therapy, based on the principles of motivational interviewing (Miller & Rollnick, 2002), psychoeducation, and cognitive-behavioral techniques. This intervention provides information about the benefits and side effects of medications, highlights discrepancies between interviewees' actions, beliefs, and desires, emphasizes the value of staying well, and encourages self-efficacy with respect to taking medication.

Illness Management Interventions. There is growing recognition that the interviewee can take an active role in his or her own illness management (Mueser et al., 2002). Examples of treatment components that can enhance illness management include monitoring early signs of symptoms and relapse, developing plans in advance to deal with possible situations of worsening of symptoms, and developing coping skills to address stress.

Cognitive-Behavioral Therapy. Cognitive-behavioral therapy for psychosis conceptualizes delusions and hallucinations as distorted perceptions and beliefs that are resistant to disconfirmation but may be altered by reviewing objective evidence and encouraging consideration of alternative perspectives or adaptively coping with the psychotic symptoms. There are different variants of cognitive-behavioral therapy for psychosis, some restorative (i.e., attempting to reduce or eliminate the psychosis) and others compensatory (i.e., attempting to cope adaptively with the psychosis) (Rathod & Turkington, 2005). For example, it can aim to develop a collaborative relationship with the interviewee and to examine the conditions in which symptoms occur and then to consider alternative, more adaptive interpretations of reality. Therapists may begin to gently encourage interviewees to explore the evidence supporting psychotic beliefs, first targeting those that were identified as least firmly held. Although structured and systematic cognitive-behavioral therapy for psychosis is a new intervention, the data available to date support its effectiveness (Zimmermann, Favrod, Trieu, & Pomini, 2005).

Cognitive Remediation and Rehabilitation. Until recently, it was commonly argued that the cognitive impairments accompanying schizophrenia are irreversible and that not much can be done to improve on that. Lately, both psychopharmacological and psychosocial research suggests that some cognitive impairments can be reversed or compensated for. This is particularly important because cognitive impairments predict dysfunction, perhaps more than any other symptom or impairment in schizophrenia (Green, Kern, Braff, & Mintz, 2000). The second-generation antipsychotics may improve some cognitive functions in schizophrenia, although there are contradictory reports, and they do not seem to eliminate cognitive deficits (Rund & Borg, 1999). Cognitive training, also called cognitive remediation and cognitive rehabilitation, demonstrates an even more robust effect, restoring some cognitive functions, such as sustained attention, and

compensating for others, such as disrupted short-term memory (Twamley, Jeste, & Bellack, 2003). However, the broader impact of cognitive rehabilitation on functioning remains less clear.

Functioning

Social and Independent Living Skills Training. Many people with schizophrenia report experiencing difficulty behaving appropriately or feeling comfortable in social situations, which often leads to social withdrawal and dysfunction. Over the past three decades, treatment for schizophrenia has encouraged active teaching methods such as didactic instruction, modeling, behavioral rehearsal, corrective feedback, role play, contingent social reinforcement, and homework. Several manualized skill training modules have been developed by various clinical academic centers, such as the Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation at the University of California at Los Angeles. These modules have been empirically validated and used in several countries around the world (Liberman et al., 1998). Symptom self-management, recreation for leisure, medication self-management, community reentry, job seeking, workplace fundamentals, basic conversation skills, and friendship and dating skills are among the modules that are available, all of which use the same teaching techniques, including didactic instruction, role play, problem solving, homework, and in vivo behavioral rehearsal. These modules have been demonstrated to be effective in promoting significant learning of social and independent living skills in people with schizophrenia (Liberman et al., 1998) and, given their user-friendly nature, may be administered by a broad array of mental health professionals. Research on social skill training indicates that it is an effective and useful modality for improving adaptive social and role functioning (Bellack, 2004).

Family Interventions. The theoretical rationale for including family counseling derives from research suggesting that people living in families with high expressed emotion—that is, overt attitudes indicating criticism, dissatisfaction, hostility, and overinvolvement—were more vulnerable to relapse and rehospitalization (Budd & Hughes, 1997). Family intervention therefore was designed to teach more adaptive, less stressful family communication skills and problem solving through instruction and modeling of appropriate skills by a therapist. Over the past 20 years, several types of family intervention for schizophrenia have been developed. Common components that are offered in varying amounts include education about the illness, practical and emotional support, and skill development in communication, problem solving, and crisis management (Dixon, Adams, & Lucksted, 2000). Most successful family intervention programs are offered for a long period of time (more than 6 months) by mental health professionals involved in interviewees' treatment. Research has demonstrated that family interventions may help lower relapse rates (Pitschel-Walz, Leucht, Bäuml, Kissling, & Engel, 2001).

Integrated Dual-Diagnosis Treatment. Historically, treatment for people dually diagnosed with schizophrenia and a substance use disorder was either sequential or parallel (Drake & Mueser, 2000). Research has found that integrated psychiatry and addiction programs that engage such dually diagnosed patients in treatment for at least 1 year produce greater improvement in substance use outcomes (Drake, Mueser, Brunette, & McHugo, 2004). Several different programs based on the integrated approach have been developed. Their primary goal is to include an awareness of the implications of the substance use disorder into all aspects of the mental health treatment program. The most effective integrated treatment models are comprehensive in that they target not only the substance use but also the multitude of other behaviors and life circumstances, such as living environment and social networks, that may be maintaining it. Family involvement is based on the important role relatives can play in giving support and helping interviewees move forward on the road to recovery by developing motivation to address their dual disorders and use self-management strategies. For many interviewees, both disorders are persistent, and therefore their treatment usually entails a long-term approach (Mueser et al., 2003).

Vocational Rehabilitation. Given the potential benefits of work in terms of increasing activity, socialization, financial status, self-esteem, community tenure, and self-reported quality of life, stable employment should be included as a treatment goal if the interviewee expresses an interest in it. Past vocational approaches such as sheltered

employment have been largely displaced by more independence-enhancing vocational approaches, such as supported employment. The Individual Placement and Support (IPS) model, which is perhaps the contemporary paradigm of supported employment, is based on the "place-train" approach to vocational rehabilitation. IPS is characterized by rapid attainment of competitive jobs in the community, the provision of support and training as needed after work has commenced, and attention to interviewee preferences in terms of the type of job sought and the nature of support provided (Becker & Drake, 1994). To ensure integration of vocational rehabilitation and clinical treatment, in the IPS model the employment specialist performs all vocational support functions (i.e., assessment, job search, and support) while working as an integral member of the interviewee's clinical treatment team. Controlled research on the IPS model has shown that it dramatically increases rates of employment compared to traditional train-place models or day treatment programs with adjunctive vocational rehabilitation (Bond, 2004; Drake et al., 1999).

Assertive Community Treatment and Case Management. People with schizophrenia who need assistance with several aspects of daily functioning such as work, housing, transportation, medication management, and money management may need aid from a variety of social service agencies. The growing appreciation of the complexity of coordinating the various services has led to the development of various case management models, including assertive community treatment (ACT; Stein & Santos, 1998). ACT is provided by a team of mental health professionals, including psychiatrists, nurses, social workers, occupational therapists, recreational therapists, case managers, and peer support workers, who work at the same facility. Because most mental health services are delivered directly by the ACT team members and not brokered to other providers, both coordination and continuity of care are greatly facilitated. Case loads are shared across clinicians so that one person is not solely responsible for coordinating the care of a particular group of clients, and ACT teams generally have low client to clinician or case manager ratios (e.g., 10:1 rather than the 30:1 of clinical case management). This allows more time to be spent assisting each client. ACT teams typically offer 24-hour (7 days a week) coverage and provide most services in the community. Other case management models are less intensive, providing coordination of services with or without direct clinical care (Bond, Drake, Mueser, & Latimer, 2001; Mueser, Bond, Drake, & Resnick, 1998).

ACT addresses several of the problem domains that may be identified in a comprehensive assessment of functioning and often serves as a critical foundation for other treatment approaches intended to target those impairments and dysfunctions. For example, case managers are in an excellent position to monitor problems such as poor adherence with prescribed medications and substance use. Assistance with practical needs of daily living such as housing, transportation, and shopping undoubtedly helps clients maintain stable living arrangements and reduces stress, which is related to reduced time spent in hospitals and perhaps greater subjective quality of life (Mueser et al., 1998). Case managers also reduce stress by helping interviewees navigate the complexities of general medical services and social service agencies. Finally, assuming a positive working relationship, case managers may be able to convince reluctant interviewees to participate in useful treatment such as skill training, family work, or cognitive-behavioral therapy, and may be instrumental in encouraging competitive employment. Because of the higher intensity of services on ACT teams and their emphasis on outreach into the community, ACT services usually are reserved for a subgroup of people with schizophrenia who have difficulty managing their illness through the usual array of community mental health services and have histories of either frequent psychiatric hospitalizations or extremely impaired psychosocial functioning.

Quality of Life

Quality of life is narrowly defined as the person's subjective well-being in various domains of life. It is assessed in health care by many instruments, and there are now some measures of quality of life in the context of schizophrenia, such as the Quality of Life Interview (Lehman, Kernan, & Postrado, 1995) and the Wisconsin quality of life Index (Becker, Diamond, & Sainfort, 1993), which is unusual in that it has three versions: a self-report one, a clinician-rated one, and a family report one. Quality of life is indirectly affected by many factors, including the aforementioned interventions. It is also directly affected by some

interventions. One such intervention is supportive psychotherapy, which may use person-centered, psychodynamic, and other techniques (Penn, Mueser, Tarrier, Gloege, & Serrano, 2004). Probably the most systematic approach to date to supportive psychotherapy is the psychodynamic approach (Winston, Rosenthal, & Pinsker, 2004). Importantly, it is different from exploratory psychotherapy, which is the more traditional type of psychodynamic psychotherapy, in that supportive psychotherapy generally attempts to avoid provoking anxiety in the client. Other interventions that affect quality of life directly are wellness enhancement, using more holistic approaches such as relaxation and facilitating and supporting spirituality. Finally, self-help positively affects quality of life, be it participation in a clubhouse, peer support, or other self-help initiatives.

SUMMARY

Schizophrenia is a severe, long-term, multifaceted and heterogeneous psychiatric disorder characterized by disruption in social functioning, in the ability to work, and in self-care skills and by the core symptoms of positive symptoms (hallucinations, delusions, disorganization), negative symptoms (alogia, apathy), and cognitive impairments (in attention, memory, and executive functions). Schizophrenia can be reliably diagnosed with structured clinical interviews, with particular attention paid to differential diagnosis and to commonly associated problems, such as substance use and posttraumatic stress disorder, which often complicate the clinical picture. Assessment for treatment and rehabilitation planning is a complex process that involves delving into a wide range of domains of impairment and functioning. Effective assessment is crucial to identifying the most important treatment and rehabilitation goals and to prioritize pursuit of those goals.

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13

PANIC AND AGORAPHOBIA

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DESCRIPTION OF THE DISORDER

Panic disorder (PD) is an anxiety disorder that affects approximately 2% to 3% of the adult population at any point in time and is associated with poor physical health outcomes and high rates of health care use (Greenberg et al., 1999). According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV;* American Psychiatric Association [APA], 1994), the essential feature of PD is the presence of recurrent, unexpected panic attacks along with significant panic-related worry. Panic-related worry can take a number of different forms including persistent fears and concerns about having additional panic attacks (e.g., "Will I have another panic attack today?" "If I drive on the highway will I panic?"), worry about the possible implications or consequences of the panic attacks (e.g., "If I panic, I'll be incapacitated [die, faint, etc.]."), or a significant behavioral change related to the attacks (e.g., phobic avoidance due to fears of panicking). Importantly, these panic attacks cannot arise solely from the direct physical effects of a substance (e.g., caffeine intoxication) or from a medical condition (e.g., hyperthyroidism). Finally, the panic attacks cannot be caused by some other mental disorder (e.g., social anxiety disorder, obsessive-compulsive disorder).

Because panic attacks are central to PD, a bit more clarification about their nature is needed. Panic attacks involve an abrupt convergence (i.e., usually within a few minutes) of a number of autonomic and cognitive symptoms and typically result in intense fear or distress. According to the *DSM-IV* (APA, 1994), at least four symptoms must occur simultaneously for the panic attack to be considered a full-symptom panic attack. These symptoms include heart palpitations and chest pain, lightheadedness, nausea, flush or chill, shortness of breath, tingling sweating, feelings of unreality, and shaking. The subjective or cognitive symptoms include feelings of terror, fear of dying, and feeling out of control.

It is worth noting that significant heterogeneity exists in panic attacks, both across individuals and within an individual. In recent years, much attention has been devoted to elucidating the nature and phenomenology of panic attacks (Barlow, Brown, & Craske, 1994). In turn, such research not only has confirmed speculation that panic attacks are ubiquitous in clinical and nonclinical populations but has also resulted in increased recognition that panic attacks are not unidimensional with respect to clinical presentation. Rather, panic attacks are now viewed as heterogeneous in terms of their phenomenology, and interindividual heterogeneity regarding the experience of panic itself (i.e., across subjective, physiological, and behavioral domains) appears to be the rule clinically, not the exception.

In the past decade, several typologies have been developed to more fully account for the apparent heterogeneity in the phenomenon of panic (Klein & Klein, 1989; Ley, 1992; Whittal, Goetsch, & Eifert, 1996). The latest panic typology within the *DSM-IV* (APA, 1994) underscores the heterogeneity of panic symptoms by organizing panic in a polythetic fashion such that a panic attack may consist of physical (e.g., numbness, palpitations) or cognitive (e.g., fear of dying) symptom domains. The *DSM-IV* adopted a new panic attack typology that removed the diagnosis of panic attacks from the PD diagnostic section, where it had been in the *DSM-III-R.* The *DSM-IV* now allows recognition of three types of panic: unexpected, situationally bound, and situationally disposed. An unexpected (spontaneous, uncued) panic attack is defined as one that is not associated with a situational trigger (i.e., it occurs out of the blue). Because the *DSM-IV* requires that panic is recurrent, this would imply that at least two unexpected panic attacks are required for the diagnosis, but of course most people with PD experience much more. People with PD often have situationally predisposed panic attacks (i.e., those more likely to occur on, but not invariably associated with, exposure to a situational trigger). Situationally bound attacks (e.g., those that occur almost invariably and immediately on exposure to a situational trigger) can also occur in PD but are less common.

It is clear, then, that patients with PD typically present with a mixture of different types of panic attacks. It is also notable that although spontaneous or unexpected panic attacks often are characteristic of panic at the onset of PD, patients are more likely to establish links between panic and various situations over time, such that situationally disposed or bound panic becomes more common over the course of the disorder. The current empirical literature has not yet fully explored the importance of understanding the particular individual differences in panic, but some studies suggest that differences in panic may be consequential (Schmidt, Forsyth, Santiago, & Trakowski, 2002).

Finally, the frequency and severity of the panic attacks vary widely. For example, some people have moderately frequent attacks (e.g., once a week) that occur regularly for months at a time. Others report short bursts of more frequent attacks (e.g., daily for a week) separated by weeks or months without any attacks or with less frequent attacks (e.g., two each month) over many years. Limited-symptom attacks (i.e., attacks that are identical to "full" panic attacks except that the sudden fear or anxiety is accompanied by fewer than 4 of the 13 panic symptoms) are also very common in people with PD.

People with PD display characteristic concerns about the implications or consequences of the panic attacks. Some fear that the attacks indicate the presence of an undiagnosed, life-threatening illness (e.g., cardiac diseases, seizure disorder). Despite repeated medical testing and reassurance, they may remain frightened and unconvinced that they do not have a life-threatening illness. Others fear that the panic attacks are an indication that they are "going crazy" or losing control or are emotionally weak. We consider these specific concerns to be a key element in the assessment of patients because they will help direct cognitive behavioral treatment. Many people with recurrent panic attacks significantly change their behavior (e.g., quit a job, stop driving) in response to the attacks. Concerns about the next attack, or its implications, often are associated with development of avoidant behavior that may meet criteria for agoraphobia, in which case PD with agoraphobia is diagnosed.

Classification of PD and agoraphobia within the *DSM* has undergone significant changes over time and continues to be controversial (Cerny, Himadi, & Barlow, 1984). In particular, the *DSM* has substantially changed its description of the relationship between PD and agoraphobia. Marks (1970) originally suggested that agoraphobia was a phobic disorder arising from fears of public places that may or may not occur with panic attacks. Consistent with Marks's contentions, the *DSM-III* (APA, 1980) classified agoraphobia as a phobic disorder that could occur with or without panic attacks, whereas PD was considered to be a separate class of anxiety disorders called anxiety states or anxiety neuroses. Over time, however, as researchers increasingly recognized that agoraphobia often is a consequence of panic attacks, the *DSM* has reversed the relationship between these conditions such that in the *DSM-III-R* (APA, 1987) and *DSM-IV* (APA, 1994), agoraphobia is typically considered secondary to PD. Therefore, agoraphobic behaviors are now more commonly conceptualized as panic-related

sequelae (Frances et al., 1993; Goldstein & Chambless, 1978; McNally, 1994).

This important change in nosology raises questions about the nature of agoraphobia. In the rare cases of agoraphobia without a history of panic attacks (Kearney et al., 1997; Lewinsohn, Zinbarg, Seeley, Lewinsohn, & Sack, 1997), agoraphobia is an autonomous diagnostic entity. These appear to be instances of people developing the classic fear and avoidance of crowds or open spaces without a history of panic (Hayward, Killen, & Taylor, 2003; Marks, 1987). The central criteria for this diagnosis include meeting diagnostic criteria for agoraphobia and failing to meet diagnostic criteria for PD.

In the majority of cases when an agoraphobia diagnosis is used, however, this diagnosis is not an independent diagnostic entity but it is simply a specifier attached to a PD diagnosis. Agoraphobia is used to indicate the severity of phobic avoidance behaviors exhibited by patients with PD. In these cases, the patient meets diagnostic criteria for PD along with the same criteria for agoraphobia specified in agoraphobia without history of PD. We suggest that this leads to the potential for confusion in the diagnostic system because *agoraphobia* is used as both a diagnostic entity (agoraphobia without history of PD) and a specifier (i.e., considered in cases of PD).

Many of the symptoms seen in panic attacks and PD are similar to those experienced in acute medical crisis (e.g., a heart attack), and many people seek immediate medical attention only to be told that their problems are psychological, not medical. Indeed, many people with PD have had repeated medical tests and have sought several "second opinions" because it is difficult to believe that one can experience such intense symptoms and not have a medical illness. On the other hand, certain medical conditions are associated with panic and may mimic panic symptoms.

The relationship between PD and nonpsychiatric medical illness is complex. It appears that nonpsychiatric medical conditions can contribute to the development of PD (Kahn, Drusin, & Klein, 1987; Raj, Corvea, & Dagon, 1993) or exacerbate PD symptoms (McCue & McCue, 1984). In addition, increasing evidence suggests that PD can contribute to the development of physical conditions or exacerbate existing physical conditions (Karajgi, Rifkin, Doddi, & Kolli, 1990; Kawachi et al., 1994). For example, longitudinal evaluation of PD indicates a higher risk for a number of medical conditions (e.g., hypertension, migraine headaches, ulcer, thyroid disease) than in other anxiety conditions and the general population (Rogers et al., 1994). Therefore, careful screening for medical conditions is critical in evaluating for PD.

Interviewing Strategies

Interviewing strategies for PD should focus on the acquisition of pertinent information that will guide the clinician in making an accurate diagnosis. This information includes the presence and severity of the various symptom domains that constitute PD. This information is obviously useful, if not critical to developing the most efficacious treatment plan. In the context of treatment, clinicians are encouraged to develop interviewing strategies to evaluate treatment progress. In this section we focus the assessment on a number of symptom domains and also provide a guide for various interview and self-report measures that can assist in these assessments (see Antony, Orsillo, & Roemer, 2001).

Table 13.1 presents a list of interviewing and assessment strategies that are organized by symptom domain, with measures recommended to assess each domain. It is useful to dismantle PD across a number of domains that define the disorder as a means to describe the condition, document recovery from the disorder, and identify possible obstacles (e.g., depression) that can influence treatment response. In the case of PD, it is helpful to consider partial versus complete recovery. Partial recovery involves some symptomatic remission of the typical symptoms such as panic attacks or phobic avoidance. However, we define complete recovery more broadly and discuss this with every patient. In this conservative definition, complete recovery from PD involves four key dimensions: no more panic attacks, no more panic-related worry, no use of safety aids, and normal levels of anxiety sensitivity. The rationale for this conservative definition is that sometimes patients are infrequently panicking and may have limited avoidance behaviors. However, if they continue to show panic-related worry or anxiety sensitivity, they are at much greater risk for relapse. Similarly, the continued use of safety aids may mask the level of recovery. Therefore, we recommend that clinicians and patients show good awareness of these dimensions, starting with the

initial assessment. It is helpful to keep these dimensions in mind in organizing the initial and ongoing assessment of patients.

Diagnosis

Obtaining an accurate diagnosis obviously is one of the central aims of the initial assessment. The use of structured interviews produces more reliable diagnostic inferences than diagnostic decisions made without the use of standardized instruments (Grove & Meehl, 1996). Unless the clinician is very familiar with *DSM-IV* criteria (APA, 1994), we recommend the use of comprehensive structured clinical interviews such as the Structured Clinical Interview for *DSM-IV* (SCID-IV; First, Spitzer, Gibbon, & Williams, 1994) or the Anxiety Disorders Interview Schedule for *DSM-IV:* Lifetime (ADIS-IV; DiNardo, Brown, & Barlow, 1994). The SCID-IV and the ADIS-IV can be used at intake to rule out differential diagnoses and assess for comorbidity. Both interviews are excellent, although the ADIS provides more specific data about the condition apart from *DSM* criteria.

Assessment of PD should also include strategies to rule out medical conditions that mimic or exacerbate panic attacks (Barlow, 2002; Taylor,

Table 13.1 Domains to Include in Interviewing Strategies Aimed at Assessing Panic Disorder

Domain	*Assessment Tool*
Diagnosis	• SCID-IV or ADIS-IV • Medical evaluation
Panic attacks	• SCID-IV or ADIS-VI • PDSS
Anxious apprehension	• The Fear Questionnaire • PDSS • Scale 1 of the PAI
Safety aids	• Safety Aid Identification Form • Mobility Inventory
Anxiety sensitivity	• Anxiety Sensitivity • Body Sensations Questionnaire • Body Vigilance Scale
Comorbidity	• SCID-IV or ADIS-IV • Beck Depression Inventory–II • Social Interaction Anxiety Scale
Suicidality	• SCID-IV or ADIS-IV • Beck Scale for Suicide Ideation • Suicidal Ideation Scale
Core threat cognitions	• Agoraphobic Cognitions Scale • Scale 2 of the PAI
Self-efficacy in coping with panic	• Scale 3 of the PAI
General levels of anxiety	• Beck Anxiety Inventory • State-Trait Anxiety Inventory
Quality of life	• Global Assessment of Functioning • Sheehan Disability Scale • Quality of Life Inventory

NOTES: ADIS-IV = Anxiety Disorders Interview Schedule for *DSM-IV*: Lifetime; PAI = Panic Attack Inventory; PDSS = Panic Disorder Severity Scale; SCID-IV = Structured Clinical Interview for *DSM-IV*.

2000). Medical conditions that may resemble panic include endocrine disorders (e.g., hyperthyroidism, hypoglycemia), cardiovascular disorders (hypertension, congestive heart failure), respiratory disorders (e.g., asthma), neurological disorders (e.g., seizure disorders), and substance-induced panic as the result of substance withdrawal (e.g., alcohol, marijuana) or substance ingestion (e.g., caffeine, cocaine, amphetamines). We find that incorporating an interview or self-report instrument that asks about these conditions is very useful, but often referral to a physician is needed if the patient has not received a recent medical evaluation.

Treatment Targets

After diagnosis of PD has been established, it is recommended that the clinician gather information that will aid in the development of a treatment plan and provide baseline information that can be used to compare subsequent assessments in an effort to monitor treatment progress. Effective assessment of PD should include the assessment of six primary components: panic attacks, anxious apprehension or fear of panic, safety aids, anxiety sensitivity (fear associated with bodily sensations), comorbidity, and suicidality. Other domains that are useful to evaluate include core threat cognitions, self-efficacy in coping with panic, general levels of anxiety, and overall disability. Unless otherwise noted, these 10 areas should be assessed at intake and every 2 to 3 weeks throughout treatment to monitor treatment progress.

Panic Attacks. To understand the nature of panic attacks, it is important to assess the frequency, severity, and type (e.g., nocturnal, situationally bound) of panic experienced by the patient. At intake, panic attack characteristics can be assessed through clinical interview such as the SCID-IV and ADIS-IV. Additionally, panic attack severity can be assessed using a clinician-administered scale such as the PD Severity Scale (PDSS; Shear et al., 1997). The PDSS can be used to assess seven components of panic attacks during the past month. In fact, the PDSS provides a very useful and brief measure of functioning and symptom severity. In the ideal situation, panic attacks can be monitored using a prospective self-monitoring approach (e.g., the Texas Panic Attack Record Form) that reduces overreporting bias (Margraf, Taylor, Ehlers, Roth, & Agras, 1987). To accomplish this, forms are provided to the patient to complete each time he or she experiences a panic attack and turn in at the next therapy session.

Anxious Apprehension. Relative to panic per se, anxious apprehension—the level of worry a patient has about panicking—is more critical to creating impairment and disability. Many people experience panic, but few go on to experience PD. The distinction between these two groups has to do with whether someone develops anxious apprehension. The PDSS and the Fear Questionnaire (Marks & Mathews, 1979) and scale 1 of the Panic Attack Inventory (PAI; Telch, Brouillard, Telch, Agras, & Taylor, 1989) are examples of measures of anxious apprehension.

Safety Aids. Safety aids are actions the patient uses to provide temporary relief from anxiety and panic. There are true and false safety aids. True safety aids protect people from actual danger. However, false safety aids are behaviors used to cope with or prevent anxiety in situations in which there is no actual threat. Safety aids perpetuate anxiety because they prevent the patient from activating and challenging thinking errors that maintain anxious reactivity. There are five broad categories of safety aids: avoidance of bodily sensations, avoidance of situations, companions, medication and other substances, and idiosyncratic safety rituals.

Once the clinician has educated the patient about safety aids, the patient's particular safety aids can be identified either in session with the clinician's assistance or as homework. The PDSS also provides a measure of some important safety aids such as avoidance of situations and avoidance of sensations. Of course, the most common type of safety aid is phobic avoidance. Agoraphobic avoidance can be assessed with the Mobility Inventory (Chambless, Caputo, Jasin, Gracely, & Williams, 1985), a self-report measure consisting of 26 different situations that are typically the subject of agoraphobic avoidance. The patient rates degree of avoidance when alone and when accompanied, providing useful information on the safety aids of avoidance and use of companions.

Anxiety Sensitivity. Anxiety sensitivity refers to individual differences in the fear of arousal

symptoms. Theoretical models suggest that fear of anxious arousal is a dispositional tendency that will lead to the development and maintenance of panic attacks (Maller & Reiss, 1992; Reiss & McNally, 1985). Moreover, treatment outcome research has shown that changes in anxiety sensitivity account for treatment response in cognitive-behavioral therapy (CBT; Smits, Powers, Cho, & Telch, 2004). It is therefore recommended to monitor anxiety sensitivity on a regular basis. The Anxiety Sensitivity Index (Peterson & Reiss, 1993) is the most widely used measure of anxiety sensitivity. Other measures to consider are the Body Sensations Questionnaire (Chambless, Caputo, Bright, & Gallagher, 1984), which asks patients to rate the extent to which they fear specific arousal-related bodily sensations. In addition, the Body Vigilance Scale (Schmidt, Lerew, & Trakowski, 1997) can be used to monitor conscious attention to internal cues.

Comorbidity. PD often co-occurs with other Axis I conditions, including other anxiety disorders and depression (Kessler, Chiu, Demler, & Walters, 2005). Because of this, and because panic attacks occur across a wide range of conditions, differential diagnosis can be challenging in PD. This is another reason we recommend the use of a comprehensive clinical interview such as the SCID-IV and the ADIS-IV. When comorbidity exists, it is often critical to ascertain the primary diagnosis. In many cases, PD appears to create secondary mood and anxiety problems. Treatment outcome data suggest that successful treatment of PD often leads to significant remission of co-occurring mood or anxiety disorder symptoms. However, there are many instances in which Axis I conditions are independent and may not be affected by the PD intervention. Also, there are instances in which these comorbid conditions may worsen during treatment.

Use of some substances is associated with panic symptoms. For example, panic attacks are associated with cannabis use (Zvolensky et al., 2006) and cigarette smoking (Zvolensky, Schmidt, & Stewart, 2003). In addition, PD is also highly comorbid with particular substance use disorders including alcohol use disorders (Kessler et al., 1997) and cannabis use disorders (Zvolensky et al., 2006). As noted earlier, in cases of patients presenting with panic and a history of substance use, it is important to determine whether the panic symptoms persist in the absence of substance use and withdrawal to determine whether a diagnosis of PD is warranted. Furthermore, the assessment of substance use among people with PD is necessary to determine whether the patient engages in problematic substance use behaviors that could undermine treatment in at least two ways: Anxiolytic substances may interfere with activation of fear structure, and the patient may attribute successful completion of exposure exercises to the substance use rather than to newly acquired skills.

Suicidality. People with PD experience significantly greater levels of suicidal ideation and significantly more suicide attempts than people with other psychiatric conditions (Weissman, Klerman, Markowitz, & Ouellette, 1989). Furthermore, several anxiety-related variables are associated with suicidal ideation among people with PD after depression, including overall anxiety symptoms, level of anticipatory anxiety, avoidance of bodily sensations, vigilance toward bodily perturbations, and fear of cognitive incapacitation, is controlled for (Schmidt, Woolaway-Bickel, & Bates, 2001). It is therefore important to perform regular suicide assessments with patients with PD. It is recommended that the clinician interview the patient at intake and periodically throughout treatment on suicidal ideation and regularly administer self-report measures of suicidality, such as Beck Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979) or the Suicidal Ideation Scale (Rudd, 1989).

Core Threat Cognitions. Core threat cognitions are unrealistic beliefs attached to the patient's alarm reaction. In the case of PD, core threat cognitions typically are concerned with one of three domains: physical threat, social threat (i.e., embarrassment), and loss of control. Evaluation of these domains is useful for the cognitive therapy component of the treatment and can be helpful in designing other types of interventions (e.g., interoceptive exposure). Intensity of various core threat cognitions can be assessed using self-report measures such as the Agoraphobic Cognitions Scale (Hoffart, Friis, & Martinsen, 1992) and scale 2 of the PAI (Telch et al., 1989).

Self-Efficacy in Coping With Panic. Increases in problem-focused coping appear to be related to outcome among patients with PD (Hino, Takeuchi, & Yamanouchi, 2002). Self-efficacy in

coping with panic therefore can be used to provide a good gauge of the patient's perceived mastery of skills acquired over the course of treatment. Furthermore, poor panic-specific coping (compared with poor coping skills generally) is associated with increased panic responding (Schmidt, Eggleston, Trakowski, & Smith, 2005). This dimension can be assessed using scale 3 of the PAI (Telch et al., 1989). The PAI-3 can be used to specify persistent problem areas that warrant further treatment. Evaluating self-efficacy can also be particularly useful near termination to ensure that the patient feels confident in using newly acquired skills.

General Levels of Anxiety. It is sometimes useful to assess levels of overall subjective anxiety to provide an assessment of the general level of subjective distress. Two widely used measures are the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) and the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). One advantage of the BAI is that it takes less time to complete than the STAI. If the STAI is used, it is recommended that both the state and trait measures be administered at intake. However, in most cases only the state measure would be regularly readministered to monitor treatment progress.

Quality of Life. Given that PD is associated with marked impairment across several domains of functioning (Simon et al., 2002), it may be useful to assess the patient's level of overall functional impairment. This can be done with clinician ratings such as the Global Assessment of Functioning (APA, 1994) or self-report scales of functional impairment including the Sheehan Disability Scale (Sheehan, 1983).

Interviewing Obstacles and Solutions

When interviewing patients with PD, it is important to be aware of certain obstacles that could lead interviewers astray when it comes to diagnostic decision making, selection of treatment strategy, and selection of treatment targets. This section outlines difficulties commonly encountered in each of these three areas, their potential impact on diagnosis and treatment, and possible solutions.

Obstacles in Diagnostic Decision Making

We have established that diagnostic accuracy is a fundamental feature of the interviewing process. In fact, subsequent enterprises such as treatment, monitoring or measurement, and referral all hinge on the correct identification of the primary diagnostic entity. Therefore, the interviewer should be keenly aware of certain key features of PD that may influence the accuracy of the diagnosis.

When it comes to diagnostic errors, the interviewer must contend with one of two possibilities: false positives and false negatives. In the case of PD, false-positive errors may occur when various medical morbidities are mistaken for PD. White and Barlow (2002) outlined specific medical conditions that include panic-like symptoms such as endocrine disorders (e.g., hypothyroidism, hypoglycemia), cardiovascular disorders (e.g., mitral valve prolapse, cardiac arrhythmia, hypertension), respiratory disorders (e.g., asthma), and neurological disorders (e.g., multiple sclerosis). Each of these medical conditions creates symptoms that may mimic the physiological symptoms of panic attacks and therefore should be ruled out.

False-positive decisions carry with them their own set of risks, and another consideration is the possibility of false negatives. In PD, false negatives are more likely to occur when the chief presenting problem is not panic but rather a medical complaint. This is an issue of central importance, given that many panic patients first appear in a primary care setting. For example, Katon, Vitaliano, Anderson, Jones, and Russo (1987) found that 35% of patients in a primary care setting had diagnosable PD.

To minimize false-negative errors, interviewers should assess whether the physiological events are accompanied by subjective fear and whether the panic-like symptoms occur in the absence of real danger (i.e., they are not responses to a specific environmental stressor). If the patient reports excessive, unexpected fear, this would be consistent with a PD diagnosis instead of or perhaps in addition to the primary medical complaint.

Although a majority of people with PD report excessive fear in association with panic attacks, it is crucially important to note that a proportion of panic patients will not report fear in association with panic episodes. In the case of

nonfearful PD (NFPD), patients typically experience a small number of somatic symptoms (particularly chest pain; Beck, Berisford, Taegtmeyer, & Bennett, 1990). However, there is a marked absence of affective and cognitive symptoms. Many of these cases present in various medical clinics. One way to distinguish NFPD from genuine cardiovascular conditions is by determining whether behavioral changes followed the onset of symptoms. The *DSM-IV* field trial found that among nonfearful panickers, significant behavioral changes developed after symptom onset. Therefore, it may be particularly informative to conduct a behavioral assessment in cases such as these.

Obstacles Influencing the Selection of Treatment Strategies

A variety of empirically validated treatments for PD are available. Pharmacological and psychological therapies are efficacious in reducing acute anxiety symptoms associated with PD. When making treatment recommendations, the interviewer should be generally aware of specific conditions that may be problematic for a particular treatment modality.

Interoceptive exposure is one of the front-line treatments for PD (Schmidt & Trakowski, 2004). In this approach, the feared sensations are provoked in a controlled setting, with the expectation that habituation will gradually extinguish the fear response. However, several diagnosis-specific and nonspecific obstacles could interfere with this particular treatment. For instance, a nonspecific obstacle to such an approach includes things such as age, whereby older or infirm patients may suffer adverse health consequences in response to prolonged exposure. Ethical considerations may limit panic provocation in younger patients. In instances such as these, the interviewer may want to focus on cognitive therapy, which in isolation has been shown to produce significant relief from panic symptoms (Clark, 1986). On the other hand, sometimes patients may have difficulty understanding the cognitive aspects of the condition. In these cases, and with children, it is helpful to adopt a more behavioral intervention strategy that focuses on exposure.

Pharmacological treatments for PD have received wide empirical support. Most psychopharmacological treatments for PD are safe and non–habit forming. However, one important consideration when one is making a recommendation for pharmacological treatment is whether the patient has a history of substance abuse or dependence. Benzodiazepines in particular carry a specific risk for tolerance, abuse, and dependence (Shader & Greenblatt, 1993). Therefore, the interviewer should carefully consider the risk associated with benzodiazepines when making treatment recommendations, particularly with patients who have a history of substance use problems.

Obstacles Influencing the Selection of Treatment Targets

Often the interviewer must identify specific areas on which subsequent treatment will focus. Generally speaking, once a diagnosis is established, this information provides a reasonable amount of guidance as to the specific symptoms to be treated. However, because PD symptoms are heterogeneous, the particular symptoms and response patterns vary greatly from patient to patient. Therefore, it is important for the interviewer to have a grasp not only of likely treatment targets but also of obstacles that could interfere with their detection or successful resolution.

In the treatment of PD, therapy typically focuses on two target areas: cognitive symptoms and behavioral symptoms. Cognitive symptoms include the patient's thoughts and beliefs about the catastrophic nature of panic episodes. Behavioral symptoms can include such things as agoraphobic avoidance of certain people or locations, safety behaviors meant to increase a feeling of subjective security, and interoceptive avoidance, which involves the avoidance of specific activities that could elicit panic-like sensations (e.g., exercise).

In terms of cognitive symptoms, a fairly extensive body of literature suggests that a majority of patients with PD experience catastrophic cognitions during panic attacks (Ottaviani & Beck, 1987; Salkovskis & Clark, 1990; Westling & Öst, 1993). On the other hand, there are patients with PD who do not report catastrophic ideation. When there is no clear recognition of catastrophic ideation, certain elements of treatment (e.g., cognitive therapy) may not be feasible. Another obstacle that may interfere with the

identification of these symptoms is the significant variability in *types* of panic-related cognitions. For instance, factor analytic studies support existence of three major types of catastrophic cognitions that occur in the context of panic attacks: physical collapse, mental collapse, and social collapse (Chambless et al., 1984; Telch et al., 1989). Furthermore, the relative primacy of each area may vary widely from patient to patient (i.e., some people may endorse fears of fainting, whereas others may fear primarily public embarrassment due to overt symptoms of panic). Therefore, the interviewer should identify which of these areas is primary because research suggests that the manipulation of so-called hot cognitions will have a direct impact on the likelihood of successful treatment (Hicks et al., 2005; Keijsers, Hoogduin, & Schapp, 1994).

Behavioral symptoms of PD are also heterogeneous. Similar to the problems the interviewer may encounter in the realm of cognitive symptoms, the subtlety and variety of behavioral symptoms may complicate their identification. Therefore, it is important to be aware of the various types of behavioral symptoms, which will inform subsequent treatment recommendations. Principal among the behavioral symptoms of PD is interoceptive avoidance. Given that many patients with PD demonstrate sensitivity to and fear of bodily perturbations, it stands to reason that the person will take steps to avoid situations in which they are evoked. For instance, exercise, certain foods or drinks (especially caffeinated beverages), and even sexual relations may all be avoided in an attempt to elude physiological hyperarousal. The interviewer should take a careful inventory of situations and behaviors that evoke feared physiological sensations. Such a list should then be folded into treatment recommendations because exposure sessions should focus on the very situations in which the patient is likely to encounter aversive interoceptive experience.

Another subtle but problematic type of behavioral symptom is a safety behavior (i.e., safety aid). These are actions designed to bolster subjective feelings of safety or security in situations that normally cause the patient distress. For example, patients with PD may travel to certain places only if they have a "safe person" with them, or they may carry "safety" objects, such as a cane, water bottle, lucky charm, or pill bottles. The array of potential safety cues and behaviors is virtually limitless (Salkovskis, Clark, & Gelder, 1996). The key point is that safety is falsely attributed to the presence of the person or trinket (rather than the innocuous nature of the situation), which therefore diminishes the effectiveness of exposure. Therefore, the interviewer should assess idiosyncratic habits that the patient may use to deal with situations that would typically result in a panic attack. Furthermore, these should also be outlined in treatment recommendations so that they may be eliminated before exposure work.

Case Illustration With Dialogue

The following case is adapted from a history of a patient who is fairly typical of those with severe PD with agoraphobia in terms of onset, symptoms, and course. In this particular case, the patient has a prior diagnosis of PD, but the key questions are very similar in cases after there is a clear acknowledgment of panic. Interviews often begin with the patients providing a concise history of their panic.

Therapist: So you have been diagnosed with panic disorder. Give me a brief history by telling me when it first began, how it has run its course, and the ups and downs, and then let me know how it is affecting you currently.

Patient: I am really embarrassed to tell you what panic disorder has done to my life because I feel like a neurotic mess. My first attack happened 10 years ago at the airport where I was picking up my husband. I hadn't had much sleep that week because both my daughter and son had been sick, and my husband was out of town. I was late for the plane, and I'm nervous being in airports and flying in general. I had taken a new route and had gotten lost. I was feeling generally disoriented I think from the lack of sleep and just nerves in general. I went to the gate, and it was the wrong gate, and that made me feel a little mixed up. It turns out that my husband had told me the wrong flight number. But I'm thinking, "Am I a little bit crazy here?" and then I started to run as fast as I could to the airline desk to find out what the right gate was.

When I started to run I got very, very lightheaded. I thought I was going to pass out right there in the airport, and

I didn't know if I could get myself out of this. There was a cop standing there, and I told him that I might pass out, and I gave him my name and phone number. Well, that got him very excited. He asked if he should call the medics, and I said I don't know, I might be okay. He went ahead and called the medics, so they came, and that actually made me more nervous.

T: So at this point, were you actually having a panic attack?

P: Not yet, but when the medics came, they put this thing on my finger to measure the oxygen in your blood, and it came out with a reading of *no oxygen.* The medics totally freaked out, and it was like they all had panic attacks at that point. And they were shouting, "Get the oxygen!" and I'm like, "Oh my God." So now it's getting worse, and at this point I would say it was a panic attack. It was horrible. They brought in a stretcher and oxygen. I mean, here I am in the middle of the airport with this whole hook-up, and they're scurrying around like I'm about to die. This didn't help my anxiety much. They put me in the ambulance, and then they started putting the pulse thing on themselves, and they couldn't get readings either. I kept saying, "But I'm breathing." So anyway, once I found out that the equipment was malfunctioning, everyone felt much better, and I felt much better.

T: Wow, so at the time you were having some scary thoughts like "I'm about to pass out" or "I'm not getting enough oxygen." Were there other scary thoughts you were having at the time? . . . [Note that in this case the patient has already reported at least one threatening thought. Often, patients will simply say they had a panic attack and that it was terrible but will not provide information about the specific nature of their ideation. When that is the case, asking something like "I understand you were panicking, but what was so frightening?" or "What sorts of scary thoughts were you having when you were panicking?" is helpful. This provides the interviewer with critical information about what we sometimes call core threats, or ideas that are sufficient to provoke panic in anyone who believes them. Sometimes this process is confusing to patients, and it is also helpful to say, "You've said that you were panicking, but you didn't always have that term—*panic attack.* Think back to when you hadn't ever heard of a panic attack; what did you think was happening?" You might also say, "If I were to insert the thought 'I'm having a panic attack' into someone's head, how would that make them feel? It probably wouldn't make any sense unless they knew what a panic attack was. I'm trying to get at the meaning of a panic attack for you."]

T: That is an excellent account of how things got started. Now tell me about how panic developed over time.

P: Then about 2 weeks after that, I had another panic attack where I was in a department store and everything looked real bright, and I started feeling like "Oh my gosh, is something happening again?" and sort of lightheaded. Then I experienced something that I hadn't before, which I guess is called derealization, it seems like you're dreaming what's happening, things didn't seem real. To me, this was even more frightening than feeling like I was going to pass out because I thought now I'm losing my mind.

T: Did having panic attacks affect your behavior?

P: In addition to going to the emergency room about five times early on, my limitations increased over time. I was afraid to eat alone for fear that I might choke and die, and my kids would be alone in the house. I couldn't go out by myself unless it was right outside my condo, my own block. My husband and other family members have had to accompany me everywhere. I used to have daily attacks, but now I don't really. I tried a bunch of different medications, including Xanax and Prozac, but I couldn't stand how they made me feel in general, even though they made me feel less anxious.

T: Tell me more specifically about how your panic and fears of panic are affecting you right now.

P: I have basically stopped going out of the house most of the time. I use the excuse that I'm staying home with the kids, but that isn't really working anymore. My son is now a teenager, and he complains that I embarrass him by never going to school functions or his soccer games. I can't even go shopping with my daughter for school clothes. My husband has tried to be supportive, but dealing with a panic person can be a real chore. He had to drive me here today. I feel like a total mess. I alternate between feeling guilty, humiliated, and depressed and feeling really angry at this stupid disorder.

T: Most people that are as debilitated by panic as you are often will feel depressed; after all, your life has been really disrupted. Tell me more about your depression.

This is followed by an assessment of mood in this patient, including suicidal ideation and intent.

Multicultural and Diversity Issues

To date, most research on PD and other types of anxiety psychopathology has been conducted in the United States. However, psychological science must pursue information on issues pertaining to anxiety-related psychopathology across diverse populations. Such research activities benefit underserved populations and they permit the refinement of contemporary perspectives of anxiety and other types of psychopathology.

One central question is whether the condition we recognize as PD in North America is universally recognized or whether the *DSM-IV* (APA, 1994) notion of PD, which originates from medical doctrine that emphasizes biological commonality over cultural diversity, fails to adequately capture cross-cultural diversity. The empirical literature appears to suggest that *DSM* panic attacks and PD can be reliably diagnosed in other countries. For example, the Upjohn Cross-National Panic Study found that PD could be reliably diagnosed in Europe, Australia, and Central and South America, with symptom profiles being remarkably consistent across countries (Amering & Katschnig, 1990). However, as McNally (1994) points out, the Upjohn study did not establish the cross-*cultural* validity of PD because of the substantial level of cultural similarity across the participating countries. To better establish cross-cultural validity, PD must be evaluated in less Westernized countries.

In fact, there have been several reports evaluating PD in African countries. In a study of Ugandan villages, Orley and Wing (1979) describe the existence of spontaneous panic attacks. Otakpor (1987) provides an account of several patients that appeared to have PD and were successfully treated with antidepressants. Also, *DSM-III* (Hollifield, Katon, Spain, & Pule, 1990) and *DSM-III-R* versions of PD have been diagnosed in Africa (Bertschy, 1992). There is also one report evaluating panic attacks in Iran (Nazemi et al., 2003). This report generally supports the idea of cross-cultural similarity of panic and PD among Iranian students. This literature obviously is fairly limited, but it is consistent with the idea that panic and PD are somewhat culturally universal.

On the other hand, there are also indications that PD is substantially affected by culture. For example, studies in India suggest different frequencies in certain panic attack symptoms and a much higher percentage of patients receiving an agoraphobia diagnosis (Neerakal & Srinivasan, 2003). Moreover, the sex ratio among those with agoraphobia is completely the opposite of that found in the United States. For example, Raguram and Bhide (1985) found that almost 85% of their agoraphobia patients were men. The explanation provided for these cross-cultural differences is that phobic avoidance would be difficult to detect in Indian women because many are forbidden to leave the home or can leave only when accompanied by a man.

There are also several instances of so-called culturally bound variants of panic and PD. In these cases, some of which are listed in the *DSM-IV* as culture-bound variants, the condition is similar to the Western diagnosis but differs in some substantive way. Kayak-angst (Amering & Katschnig, 1990) is a condition that resembles PD but is seen exclusively in male Eskimos. Kayak-angst involves feelings of terror, disorientation, and fear of drowning while kayaking far off shore. These attacks occur only at sea and dissipate once the person is back on shore. Koro describes a panic-like state surrounding fears that the penis is retracting into the body and occurs fairly exclusively in China and Chinese communities (Rubin, 1982). Sore-neck syndrome has been described as

culture-bound variant of PD that occurs among Khmer refugees. Sore-neck syndrome involves fears that wind and blood pressure may cause blood vessels in the neck to burst, includes many symptoms of panic, and is highly comorbid with a PD diagnosis (Hinton, Um, & Ba, 2001).

One of the better-studied culture-bound syndromes that relates to PD is a condition called *ataques de nervios,* which translates to "attacks of nerves." As noted in the *DSM-IV-TR* (APA, 2000), *ataques de nervios* is an experience of distress characterized by a general sense of being out of control. The most common symptoms include uncontrollable shouting, attacks of crying, trembling, and heat in the chest rising into the head. Dissociative symptoms, suicidal gestures, and seizure or fainting episodes are observed in some episodes of *ataques de nervios* but not others. This syndrome is reported to occur typically after a distressing event such as an interpersonal conflict or the death of a loved one (Guarnaccia, DeLaCancela, & Carrillo, 1989). *Ataques de nervios* appear to have high prevalence rates in Hispanic countries (Guarnaccia, Canino, Rubio-Stipec, & Bravo, 1993) and high rates of comorbidity with a number of anxiety disorders including PD but also posttraumatic stress disorder and generalized anxiety disorder (Guarnaccia et al., 1993; Lewis-Fernández, Garrido-Castillo, et al., 2002). There have also been a number of studies demonstrating *ataques de nervios* among Hispanic samples in the United States (Salmán et al., 1998; Weingartner, Robison, Fogel, & Gruman, 2002).

With a similar presentation to panic attacks, several studies have evaluated the congruence between panic attacks and *ataques de nervios.* To date, this work has concluded that despite overlap, these are two distinct conditions that can both occur in the same person (Lewis-Fernández, Guarnaccia, et al., 2002; Liebowitz et al., 1994). Several symptoms have been reported to differentiate the two disorders; *ataques de nervios* are proposed to include fewer unprovoked episodes, more dissociative symptoms, and a slower crescendo than panic attacks (Lewis-Fernández, Garrido-Castillo, et al., 2002).

There is a wide range of perspectives on the impact of culture on the development of mental illness, including PD. A traditional psychiatric perspective indicates that biological forces determine the presence and the core aspects of the disorder, whereas cultural factors may affect the expression of the condition. For example, an underlying panic process may account for the emergence of panic in different cultures that will manifest itself as panic attacks, koro, or kayak-angst depending on cultural forces. On the other hand, Kleinman (1988) suggests that what is overlooked by this perspective is that the illness that emerges from a biological diathesis may be just as important as the underlying biological disease process. In other words, the interaction of culture with biological disposition may create important patterns in onset, course, treatment response, and so forth. For instance, among Cambodian refugees, orthostatic changes appear to be particularly provocative of panic attacks (Hinton, Pollack, Pich, Fama, & Barlow, 2005). Thus, cultural variables can be critical determinants of panic and PD.

Differential Diagnosis and Behavioral Assessment

PD often can be mistaken for other psychiatric and nonpsychiatric disorders. We have already indicated the common problem of distinguishing PD from medical morbidities. In this section, we approach the issue of differential diagnosis between PD and other anxiety disorders, with a focus on behavioral assessment techniques.

Because patients with PD often suffer from social, physical, and occupational disability and suffer from mild to moderate levels of anxiety, it can sometimes be quite difficult to distinguish PD from other anxiety disorders (which generally share the same features). In particular, social anxiety disorder (SAD) and generalized anxiety disorder (GAD) should be ruled out because they can sometimes contain episodes of intense anxiety and panic attacks. Typically, this is accomplished by identifying the circumstances under which the patient becomes anxious and the content of the anxious apprehension. In the case of SAD, anxiety episodes typically occur exclusively in the context of social situations, whereas in PD, panic attacks also occur in nonsocial situations. However, some patients with PD have fears about social consequences that result from panic attacks. The basic issue to be considered is whether the patient has fears of panic per se. If this is the case, then PD is indicated. In the case of GAD, patients may also experience panic attacks along with excessive

worry in any number of contexts. Once again, the critical issue is whether there is substantial worry about panic per se rather than worry about certain things that may or may not result in panic attacks.

In addition to evaluation of the central fear of panic, several laboratory and behavioral tests are available that can be used to distinguish PD from other anxiety disorders. These laboratory indices, sometimes called biological challenge tests, have a long history in PD. Biological psychiatrists began to use challenge tests, where the patient is exposed to a biological substance, to evaluate the purported neurobiology of PD. Challenge agents include norepinephrine, cholecystokinin, isoproterenol, caffeine, lactate, and high doses of carbon dioxide. Psychologists have also used challenges to understand cognitive parameters that affect fearful responding. A behavioral extension of the challenge task would include interoceptive assessment (Schmidt & Trakowski, 1994). This assessment involves the intentional generation of physical sensations through various exercises such as spinning or running in place. Both biological challenges and interoceptive exercises often create anxiety and even panic in patients with PD.

Although there are not clear data regarding how other anxiety patients respond to challenges or interoceptive exercises, it would be very unusual for a patient with PD to report no or little anxiety during these exercises (Schmidt & Trakowski, 1994). Therefore, challenge or interoceptive assessment can help to rule out PD when there is little or no fear. However, a positive fear response to these assessments does not rule out other anxiety conditions.

Selection of Treatment Targets and Referral

The information collected during assessment interviews is vital to the determination of treatment targets and referral. Because we have already outlined symptom targets, this section of the chapter outlines the current research findings on treatment type, including combined (psychosocial plus pharmacological) treatment for PD.

Psychosocial Treatments

Several psychosocial treatments have been found to be efficacious in PD treatment, including in vivo exposure (Mathews, Gelder, & Johnston, 1981), cognitive therapy (Beck & Emery, 1985; Clark, 1986), and CBT (Barlow, Craske, Cerny, & Klosko, 1989; Telch et al., 1993). CBT is generally considered the treatment of choice for PD (Otto & Deveney, 2005). Historically, the practice of encouraging patients to repeatedly confront situations that produce intense fear and avoidance (i.e., in vivo exposure) has been the hallmark of behavioral treatments for agoraphobia and panic. The newer CBT protocols derived from this framework focus on correcting the patient's hypersensitivity to bodily sensations and the misinterpretation of these sensations as signaling immediate threat. The main components of treatment typically include education, training in cognitive reappraisal (i.e., cognitive restructuring), repeated exposure to bodily sensations connected to the fear response (i.e., interoceptive exposure), and repeated exposure to external situations that trigger a fear response (i.e., in vivo exposure).

When the newer CBT protocols are used, the question arises as to the selection of treatment targets and the sequencing of treatment. Exposure treatments can vary widely in their execution. For instance, exposure can be administered in a gradual, hierarchical fashion or in a more intensive manner, be therapist directed or patient directed, and involve in vivo or interoceptive exposure. The choice of treatment strategy should be guided by the information collected during intake and depends on the types of situations feared by the particular patient and individual differences in areas such as the patient's level of avoidance and anxiety sensitivity. Unfortunately, there is no clear empirical evidence to guide such choices.

There are some circumstances under which treatment may deviate from traditional CBT protocols for PD. For example, if the suicide assessment reveals that the patient is presenting with a high level of suicide-related dangerousness, treatment should begin with crisis management (see Rudd, Joiner, & Rajab, 2001). Additionally, it may be the case that a patient's comorbid conditions interfere with treatment delivery. Patients with comorbid mood disorders may demonstrate a decreased interest or motivation to engage in difficult exposure tasks without the assistance of psychopharmacological or psychosocial treatments targeting depressive symptoms. Similarly, patients with comorbid substance use disorders may benefit from brief motivational interviewing

(see Miller & Rollnick, 2002) to increase motivation to change problematic substance use behaviors before engaging in treatment for PD.

Pharmacotherapy

In addition to psychosocial treatments, several classes of medication have been efficacious in ameliorating panic-related symptoms in a number of double-blind placebo-controlled trials. Antidepressants, particularly selective serotonin reuptake inhibitors, have become the medication of choice in PD treatment, reducing symptoms without causing the withdrawal and dependency that can occur with benzodiazepines. A recent meta-analysis concluded that selective serotonin reuptake inhibitors and tricyclic antidepressants are equally efficacious, although there may be a higher dropout rate among patients who use tricyclics (Bakker, van Balkom, & Spinhoven, 2002).

Combined Psychopharmacological and Psychosocial Treatments

Use of combined treatment approaches, in which the administration of medication is coupled with psychosocial intervention, is a common method for most mental disorders (see Sammons & Schmidt, 2001, for a review). For instance, Pincus et al. (1999) found that nearly 90% of patients of psychiatrists were receiving medication and that 55.4% of outpatients received both medication and psychotherapy. Use of combined treatment approaches is particularly evident in the treatment of PD. One possible explanation for the high rate of combined treatments in clinical practice is that mental health professionals may regard this approach as the most effective mode of intervention.

Common rationales for combining psychosocial and pharmacological treatments include treatment specificity, facilitation of psychosocial treatment with pharmacotherapy, and facilitation of pharmacotherapy with psychosocial treatment (see Telch & Lucas, 1994). The treatment specificity line of reasoning relies on the assumption that drug and psychological treatments affect different facets of a disorder. For example, medication could be used to affect neurobiological features of the disorder, whereas psychosocial interventions may address behavioral aspects. In comparison, the psychosocial facilitation argument suggests that the primary mode of treatment should be psychological, but the adjunctive use of medication may be indicated in some cases.

Unfortunately, despite the intuitive appeal of combined treatments for PD, there is little research to support the assumption that combined treatment approaches are superior to singular interventions (see Sammons & Schmidt, 2001). The few studies that have reported long-term efficacy indicate that the preliminary benefits of combined treatment are lost during follow-up and that in some cases combined treatment may yield poorer long-term outcome. For example, Barlow, Gorman, Shear, and Woods (2000) found that although combined imipramine plus CBT resulted in better outcome at posttreatment and postmaintenance, CBT alone predicted the best outcome at 6-month follow-up. The addition of imipramine to CBT appeared to reduce the long-term efficacy of CBT. Furthermore, CBT did not mitigate relapse after medication discontinuation.

Summary

In summary, although the literature suggests that combined treatments may promote some short-term beneficial effects, combined treatments appear to lose their advantage in the long term and in some cases may have deleterious effects. On the other hand, it is worth considering the possibility that these medication trials typically must be discontinued at the end of treatment. The length of medication treatment may not be sufficient in these cases to produce the desired neurobiological changes. Therefore, long-term benefits of combined treatments may be underestimated. Furthermore, although it is somewhat surprising that combined treatments are not more efficacious for people with PD, a variety of factors may contribute to the lack of clear advantages, including the way in which the treatment approach is explained (or not explained) to the patient, a tendency to overrely on medication (or under rely on cognitive-behavioral skills), and misattribution of gains. Further work is needed to clarify these important issues.

Practical Recommendations for Treating PD

What do the data suggest for clinicians? For both unmedicated and medicated patients,

tentative treatment algorithms can be derived based on the current research findings. When an unmedicated patient presents for treatment, it appears to be most conservative to start with a trial of CBT without pharmacological intervention because the data suggest that the singular effects of CBT will be highly effective for the majority of patients. Yet there are several instances in which CBT should be immediately combined with pharmacological intervention. For example, a PD patient with co-occurring severe depression may not be capable of undertaking a CBT trial and should be considered for a combination of CBT with antidepressant medication.

As for medicated patients, data do not indicate that the addition of CBT will yield positive benefits. However, there are some instances when the clinician may want to consider CBT for medicated patients. For example, CBT has been shown to be effective for medicated patients who do not respond to pharmacotherapy (Otto, Pollack, Penava, & Zucker, 1999). Similarly, CBT often is useful if medication discontinuation is a treatment goal because CBT can be helpful in discontinuing antidepressants and benzodiazepines (Schmidt, Woolaway-Bickel, Trakowski, Santiago, & Vasey, 2002; Whittal, Otto, & Hong, 2001).

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14

SPECIFIC PHOBIA

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DESCRIPTION OF THE DISORDER

Specific phobias, formerly called simple phobias in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (*DSM-III-R;* American Psychiatric Association [APA], 1987), are characterized by extreme fear and avoidance of a particular object or situation. This response is persistent and irrational and may be provoked merely by the anticipation of the situation. The phobic person experiences the fear nearly every time the phobic stimulus is encountered. To warrant a diagnosis, symptoms must cause significant impairment in functioning or be the source of significant distress. In adults, the person must also recognize that the fear is excessive or unreasonable. For example, blood-injection-injury (BII) phobic people fear and avoid medical and health care situations (e.g., doctors, hospitals, medical appointments). They report worrying about whether the phobia would prevent them from obtaining essential medical procedures or from taking their children for medical checkups (Öst, 1989; Öst, Hellström, & Kåver, 1992; Thyer, Himle, & Curtis, 1985).

Types

The *DSM-IV* identifies five types of specific phobias: animal type (e.g., spiders, snakes, dogs, mice), natural environment type (e.g., heights, storms, water), BII type, situational type (e.g., airplanes, elevators, enclosed places, driving), and other type (e.g., vomiting, choking, or contracting an illness). Animal and height phobias are the most common (Bourdon et al., 1988; Curtis, Magee, Eaton, Wittchen, & Kessler, 1998).

Specific phobias are currently split into different types based on arguments that the types are characterized by distinct ages of onset, gender prevalence rates, comorbidity patterns, physiological responses, and apprehension foci (see Antony & Swinson, 2000, and Barlow, 2002, for brief reviews). For example, there is evidence that fainting in response to phobic stimuli is specific to BII phobia (Öst, 1992) and that the onset of animal and BII phobias is generally earlier than situational and height phobias (Barlow, 2002). Claustrophobics are more fearful of bodily sensations than snake and spider phobics (Craske & Sipsas, 1992), and such fears appear to contribute to their fear and avoidance of enclosed spaces (Smitherman, Hammel, & McGlynn, 2003). Furthermore, there is emerging evidence that differences in interoceptive fears between the phobias may have treatment implications. Craske, Mohlman, Yi, Glover, and Valeri (1995) report that cognitive treatment targeting misinterpretation of bodily sensations was effective for claustrophobia but not snake and spider phobia. However, Antony, Brown, and Barlow (1997a) argue that assigning phobias to types is problematic for a number of reasons, including problems in research on the types and unclear

guidelines for distinguishing them (e.g., whether dentist phobia is a form of BII phobia).

Epidemiology

In the United States, lifetime prevalence rates are approximately 11% for specific phobias (Eaton, Dryman, & Weissman, 1991; Kessler et al., 1994). However, internationally, lower rates typically are reported (Barlow, 2002), and exact rates are unclear because of variability in sampling, populations, and assessment techniques.

The median age of onset for specific phobia is approximately 15 (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996). However, the typical age of onset appears to vary by phobia type, with animal and BII phobias beginning in childhood and situational and height phobias beginning in adolescence or adulthood (Barlow, 2002). There is some evidence that subclinical fear typically begins years before the onset of clinical phobias (Antony et al., 1997a), suggesting the utility of early assessment and interventions.

Etiology

The two-factor theory proposed by Mowrer (1939, 1947) forms a foundation for many current theories regarding fear acquisition. The theory posits acquisition through classical conditioning, in which a previously neutral stimulus is paired with an aversive stimulus, perhaps during a traumatic experience. For instance, a person might develop a flying phobia after being on an airplane that had engine trouble and needed to make an emergency landing. The two-factor theory further posits symptom maintenance via operant conditioning. By avoiding or escaping from encounters with the feared stimulus, phobic people can reduce their anxiety, which is negatively reinforcing and increases the likelihood of future avoidance. Furthermore, theorists have added that avoidance prevents habituation and the disconfirmation of negative beliefs about the phobic stimulus.

Over the years there has been some support for the two-factor theory. In several samples conditioning experiences appear to have a role in the onset of the majority of claustrophobia and dental phobia cases and to a lesser extent in animal and blood phobias (Öst, 1987). However, one major criticism of the theory is that a large subset of people can't recall a direct conditioning experience preceding phobia onset (Rachman, 1990). Naturalistic examinations of nonclinical populations also reveal that direct conditioning experiences fail to account for all subthreshold fears (Kleinknecht, 1982; Vernon & Berenbaum, 2004).

Rachman (1976, 1977) provides an expanded model of phobia acquisition to account for onset caused by vicarious acquisition and information transmission or instruction. In vicarious conditioning, a person might witness someone else's traumatic experience or witness someone behaving fearfully, as when parents model fear of dogs to their children. This has been observed in laboratory rhesus monkeys that learned to fear snakes after observing their parents behave fearfully with toy and live snakes (Mineka, Davidson, Cook, & Keir, 1984). In addition, in acquisition through information or instruction a person could develop a phobia after hearing about plane crashes on the news or being consistently warned by parents about the dangers of flying.

Although some studies provide support for these acquisition pathways (McNally & Steketee, 1985; Menzies & Clarke, 1993; Merckelbach, Arntz, & de Jong, 1991; Merckelbach & Muris, 1997), others do not report the expected group differences in frequency of acquisition experiences between phobic and nonphobic people (Di Nardo et al., 1988; Graham & Gaffan, 1997; Menzies & Clarke, 1995a; Poulton, Davies, Menzies, Langley, & Silva, 1998; Poulton, Menzies, Craske, Langley, & Silva, 1999). The three pathways do not appear to explain all phobias, nor does the model explain why some people do not develop phobias despite numerous acquisition experiences (see Antony & Barlow, 1997, for discussion).

In addition, Menzies and Clarke (1995b) have attempted to explain phobias that seem to occur in the absence of conditioning experiences, theorizing a fourth acquisition pathway. They propose that evolutionarily relevant stimuli (e.g., animals, heights, water) may not require a conditioning experience in order for a phobia to develop, whereas evolutionarily neutral situations (e.g., doctors, dentists, flying) may require such acquisition pathways. There is some support for this notion (Harris & Menzies, 1996; Menzies & Harris, 1997). For a full discussion, see the February 2002 special issue of *Behaviour Research and Therapy.*

Although acquisition and maintenance theories of phobia typically have been fear-based, Davey and colleagues (Davey, 1992; Davey, Forster, & Mayhew, 1993; Matchett & Davey,

1991) propose a disease avoidance model of animal phobia focusing on the potential contribution of disgust. Simply put, the model suggests that it was evolutionarily adaptive for humans to avoid, via disgust, animals deemed dirty, contaminated, or diseased. Support for the disease avoidance model suggests that disgust may play an important role in several types of specific phobia.

Disgust

Until recently fear has been the primary focus of phobia research, but disgust is emerging as an important area of study in its own right. Fear and disgust are both thought to be avoidance-motivated emotions, and in addition to the copious evidence of behavioral avoidance of frightening objects there is emerging evidence of avoidance of a range of disgusting objects (Rozin, Haidt, McCauley, Dunlop, & Ashmore, 1999; Woody & Tolin, 2002). Disgust and behavioral avoidance have often been indirectly examined in the specific phobias via phobics' interactions with contaminated items. For example, it has been found that spider phobics are less likely than nonphobics to eat, or report a willingness to eat, snacks over which a spider had walked (de Jong, Andrea, & Muris, 1997; Mulkens, de Jong, & Merckelbach, 1996). Disgust also appears to contribute more directly to spider avoidance (Woody, McLean, & Klassen, 2005), although not all studies have reported disgust-motivated avoidance behavior in animal phobic people (Klieger & Siejak, 1997; Vernon & Berenbaum, 2002), perhaps because of differences in contamination risk between the approach and avoidance tasks used. The relationship between disgust and avoidance has not yet been clarified.

In general, there is evidence documenting disgust responses to spiders and BII stimuli, particularly among phobic people. Disgust responses have been demonstrated via self-report during exposure to pictures of spiders (Tolin, Lohr, Sawchuk, & Lee, 1997) and during in vivo exposure to a spider (Vernon & Berenbaum, 2002; Woody & Tolin, 2002). Facial electromyelograms consistent with disgust have been found during guided imagery involving a spider (de Jong, Peters, & Vanderhallen, 2002), and facial expressions of disgust have been noted in response to a live spider (Vernon & Berenbaum, 2002). Although both spider phobic and nonphobic control groups report disgust in response to spiders, spider phobic people commonly report significantly stronger disgust to spiders and to disgust stimuli than do nonphobic controls, regardless of the form of the stimulus and the assessment method used (de Jong & Muris, 2002; de Jong et al., 2002; Sawchuk, Lohr, Tolin, Lee, & Kleinknecht, 2000; Sawchuk, Lohr, Westendorf, Meunier, & Tolin, 2002; Tolin et al., 1997; Vernon & Berenbaum, 2002; Woody & Tolin, 2002). Similarly, disgust appears to play an important role in BII phobia (Sawchuk et al., 2000, 2002; Tolin et al., 1997; Tolin, Sawchuk, & Lee, 1999).

Interviewing Strategies

Selecting an Interview Format

Diagnostic interviews vary in the extent to which they are structured and standardized. At one extreme, structured interviews have precisely worded questions to be given in a certain order and include a decision tree for the interviewer to follow. Sections, or modules, typically begin with a broad screening question, which if answered affirmatively leads the interviewer to ask a series of specified follow-up questions. If the screening question or a certain number of follow-up questions are answered negatively, the interviewer is directed to go on to the next module. Structured interviews do not permit the interviewer to vary the phrasing or order of questions or add topics or questions. Their rigid structure is designed for interviewers with little clinical experience or for computer administration, both of which seem to be related to a loss of diagnostic accuracy (Antony, Downie, & Swinson, 1988; Komiti et al., 2001; Ross, Swinson, Larkin, & Doumani, 1994).

At the other end of the continuum are unstructured interviews, which are idiosyncratically conducted by expert clinicians. The interviewer generates all questions and follow-up questions. Although unstructured interviews address the disadvantages of structured interviews, including flexibility and time efficiency, they are not without drawbacks. When clinicians produce interview topics and questions without external aid or prompting, there is the possibility that important areas of inquiry will be skipped or forgotten. In fact, when diagnostic disagreements have been examined, a large number of them appear to be related to interviewer variability (see Blanchard & Brown, 1998, for a review).

Semistructured interviews offer a compromise between the strengths and weaknesses of the

structured and unstructured interviews. For this reason, they are quite popular with researchers and practitioners alike. They are designed for use by trained clinicians and provide a standardized set of basic interviewing questions but allow changes in question order or the addition of follow-up questions. Semistructured interviews also leave final diagnostic decisions to the judgment of the interviewer. For this reason, they are not appropriate for administration by lay interviewers. However, when semistructured interviews are conducted by properly trained clinicians they can have reasonably strong interrater reliability. They typically take 1–4 hours to administer. Examples of semistructured interviews including specific phobia modules are the Structured Clinical Interview for the *DSM-IV* (SCID-IV; First, Spitzer, Gibbon, & Williams, 1996, 1997) and the Anxiety Disorders Interview Schedule for *DSM-IV* (ADIS-IV; Brown, Di Nardo, & Barlow, 1994; Di Nardo, Brown, & Barlow, 1994). The ADIS was designed specifically to target the anxiety disorders and therefore is quite comprehensive in its coverage not only of anxiety disorder diagnostic criteria but also of information regarding etiology and course. However, the ADIS is less comprehensive in its coverage of other Axis I disorders and does not address Axis II disorders, so supplementing it with additional assessments may be necessary. On the other hand, the SCID includes modules concerning a broad range of Axis I and II disorders but is less detailed regarding anxiety disorders. A thorough comparison of the ADIS and the SCID can be found in Antony and Swinson (2000).

Interviewers may want to consider whether a structured, semistructured, or unstructured interview format is most appropriate for their goals, schedule, and setting. This judgment should take into consideration the psychometric properties of the instrument, the population for which it was designed, how ratings are made (e.g., categorical symptom ratings are made on the SCID, dimensional ratings are made on the ADIS), the degree of necessary training and experience of the interviewer, and whether computerized versions are available.

Basic Areas of Assessment

Regardless of the type and format of interview used, a number of basic areas of assessment for specific phobias should be covered. These include current symptoms, level of distress and impairment, the influence of environmental factors, the presence of other symptoms and disorders, symptom history, and psychosocial, developmental, and treatment history.

First, clients should be encouraged to provide a detailed description of the presenting complaint in their own words. If the assessment is being conducted in a research setting in which specific phobias have been solicited, phobic fear and avoidance are more likely to be the presenting complaint. However, it is quite uncommon for clients to present for treatment of a single specific phobia. In most clinical settings clients may identify other problems initially. For instance, in the case study presented in this chapter a client who self-identified as suffering from posttraumatic stress disorder (PTSD) after a motor vehicle accident was determined to have driving phobia. Similarly, cases abound in which clients present with seeming specific phobia symptoms but eventually receive a different diagnosis, such as panic disorder with agoraphobia (PDA) or obsessive-compulsive disorder (OCD). Furthermore, multiple disorders may be present.

Specific phobias commonly occur in the presence of other Axis I disorders, particularly anxiety and mood disorders. It is important to determine whether phobic symptoms are better accounted for by another disorder. Furthermore, even in the case of an independently existing specific phobia, it is important to decide whether specific phobia is the principal diagnosis (associated with the most distress and impairment). Such determinations can be made after a careful assessment of the onset and course of symptoms, as well as levels of distress and impairment. It will also be useful to consider whether treatment for one disorder is likely to exacerbate the other. For example, it is not uncommon for stressful exposure treatments to exacerbate a preexisting substance use problem, suggesting that the substance use problem may need to be brought under control first or at a minimum monitored during anxiety treatment. Furthermore, the clinician should also address any substance use (e.g., caffeine, amphetamines) that may contribute to anxiety.

The client's initial description of the problem is likely to include aspects that may suggest several possible diagnoses. A systematic assessment of the client's signs and symptoms, including behavioral, cognitive, somatic, and emotional, will help to clear this up. Behaviorally, escape and avoidance symptoms are most common. A person with a height phobia may describe needing to

leave a balcony because of anxiety, whereas a snake phobic may report running away from snakes. Furthermore, phobic people may avoid situations involving the potential for exposure. For example, dog phobics might change their jogging route to avoid a yard that contains a dog or turn down dinner at the home of a friend with a dog.

Along with such avoidance, phobic people often report cognitions that include unrealistically negative beliefs about the phobic object or one's response to it. Clients might describe irrationally negative thoughts about the phobic object's characteristics, such as the assumption that spiders or snakes will feel slimy or that birds will attack because they sense the client's fear. To assess such cognitions, the clinician may ask the client for predictions, querying, "If you were to encounter a dog unexpectedly, what do you think would happen?"

Examining the contribution of ongoing cognitive processes may also be useful. Processing biases for threat-relevant information have been widely found in the anxiety disorders (see Mathews & MacLeod, 1994, and Williams, Mathews, & MacLeod, 1996, for reviews) and are presumed to contribute to their maintenance. People with anxiety disorders, high trait anxiety, or induced anxious mood typically display attentional and interpretive biases for threat-relevant stimuli. Phobic fear and anxiety seem to direct attention toward potentially threatening stimuli and encourage threatening interpretations of ambiguous information (Becker & Rinck, 2004). For instance, when anxious people hear part of a phrase about "Little Susie's growth" they are more likely to make a threatening interpretation, assuming cancerous growth rather than normal developmental growth. A large number of experimental paradigms have been developed to test for such biases.

Because phobic people interpret phobic situations as highly threatening, it is not surprising that somatic symptoms typically are present. The evaluator should explore the presence of the physical sensations associated with fear, including elevated heart rate, trembling or shaking, tingling, dizziness, sweating, and chest pain. In fact, it is not uncommon for people with severe specific phobia to have situationally bound panic attacks in response to their phobic situation (Craske, 1991). Another subset of phobic people experiences situationally predisposed panic attacks, in which the attack does not occur upon every exposure to the situation but is more likely. Physiological monitoring, particularly during a behavioral assessment, can provide additional useful information in this area (Alpers, Wilhelm, & Roth, 2005; Cacioppo, Berntson, & Andersen, 1991; Hugdahl, 1988; Turpin, 1990). Given findings regarding the role of disgust in BII and animal phobias, physical responses such as nausea and vomiting should also be assessed, as should heart rate deceleration, which has been noted during disgust responses (Levenson, 1992). Assessors should also remain alert for a potential drop in heart rate, blood pressure, and muscle tone among BII phobic people because up to 70% report a history of fainting upon exposure to BII stimuli (Öst, 1992), suggesting the need for assessment of this area and, if present, appropriate measures before exposure treatment.

Information about cognitions and physical sensations provides indirect information regarding emotional responses, but the interviewer will also want to ask clients to describe and rate the intensity of various emotional responses. When the interview is combined with a behavioral assessment, the client's emotion ratings before, during, and after exposure to the phobic stimulus should be collected. Again, disgust should be explicitly assessed in cases of BII and animal phobia. Facial expressions, body posture, and vocal tone should be attended to. Disgust facial expressions typically include a raised upper lip and wrinkled nose, whereas raised eyebrows and a tense mouth indicate fear (Ekman, 1982; Ekman & Friesen, 1975).

When assessing for specific phobia signs and symptoms, it is important to determine whether they cause clinically significant impairment. In extreme cases the impairment is obvious, as when a spider phobic woman does not leave her house at night for fear of being unable to see and avoid spiders. In many cases, however, the impairment is questionable and the interviewer needs to probe the degree to which symptoms interfere with role responsibilities, job advancement, relationships, and daily activities. If the client is unable to provide examples of impairment or estimate the frequency or degree of interference, imaginary scenarios may be helpful. For example, the interviewer could ask whether the client could tolerate phobic exposure in order to get to a very important meeting on time (e.g., walking by a dog in an enclosed yard or taking an underpass with a

spiderweb rather than walking the long way around). To warrant a diagnosis of specific phobia, clients must experience functional impairment or significant distress resulting from their fear or avoidance. This is the criterion that clients most often fail to meet. For instance, although a modest number of people fear and avoid spiders, they may feel that it is normal and justified and therefore are not distressed by it. Similarly, those living in areas where the phobic object is not common or for those suffering from only mild aversion may not experience impairment.

Once the clinician has a good understanding of the client's symptoms, knowledge of the influence of environmental factors is also important. There are likely to be certain contexts that increase or decrease the level of distress caused by the phobic stimulus. A snake phobic might find a snake extremely distressing when loose in his yard, strongly distressing during a hike, and only moderately distressing in a glass aquarium at a zoo. A person with a fear of flying probably will find flying in a small commuter airplane on a stormy day much more upsetting than flying on a large jet airliner during good weather. The contextual factors that serve as safety signals and are reassuring can be as important as those that are distressing. For example, a young woman with insect phobia reported little insect fear when her mother, an entomologist, was present and could tell her which were poisonous. Such information about environmental factors can aid in planning treatment and constructing an exposure hierarchy so that clients are exposed to the majority of their fear-provoking triggers and gradually give up the use of safety signals.

In addition to a detailed description of the client's current symptom presentation, information should also be obtained about symptom history, incorporating acquisition, maintenance, and remission factors. Information should be collected regarding symptom onset, including situational factors such as etiology (e.g., vicarious learning), and personality factors such as emotional trait proneness (e.g., high trait anxiety or disgust sensitivity). Symptom course, including factors that may have contributed to exacerbation or remission, should also be investigated. For instance, naturalistic examinations have noted the role of increased factual knowledge and unexpected positive experiences with the stimulus in the remission of spider distress (Kleinknecht, 1982; Vernon & Berenbaum, 2004).

As in all psychological assessments, psychosocial, developmental, and treatment history and current situation should be addressed. What have the client's childhood, family, school, work, and dating experiences generally been? What are the client's current family situation, level of social support, and financial status? What are the client's skills, resources, deficits, and limitations? The clinician will also want to learn whether the client has previously sought psychological treatment and, if so, when, for what, and with whom, and what aspects of treatment were helpful or harmful. A release should also be obtained for previous psychological records and reports and any testing results, and permission should be sought to speak with former service providers.

The presence of Axis II disorders and medical, neurological, and cognitive conditions should also be assessed. The influence of Axis II disorders on symptom presentation and treatment should be considered. Ideally, the client will also be referred for a thorough medical examination because specific physical conditions may mimic or exacerbate anxiety, including endocrine, respiratory, and cardiovascular disorders. It may also be the case that the client has a condition that will limit or preclude certain treatment tasks. For example, a height phobic suffering from inner ear and balance problems or from a seizure disorder cannot safely complete in vivo exposure exercises involving precarious heights.

Interviewing Obstacles and Solutions

A number of interviewing obstacles are common in assessment of phobic anxiety and avoidance. For instance, in several situations and for different reasons, clients may not fully or adequately describe their symptoms. In some cases, clients may not appear to meet the diagnostic criterion requiring distress about their symptoms or recognition of the excessive or irrational nature of their fears. In most of these cases, a thorough, detailed, and careful follow-up is the solution.

It is not uncommon for clients to underestimate the scope of their difficulties. One particularly salient area in which underestimation occurs is in identification of avoidance behaviors. Naturally, clients are most likely to identify and report obvious avoidance, such as avoiding driving over bridges or looking out windows of tall

buildings for a height phobia. They are often less aware of subtle avoidance, including being overly careful or needing excessive reassurance, such as needing someone to be nearby in order to climb a few steps on a ladder. Similarly, running away from spiders may be an obvious form of avoidance, whereas avoiding hiking or camping may be less noticeable because situations with the potential for exposure are avoided altogether. Furthermore, such activities may occur at a low base rate, making their avoidance less noticeable. It is often useful to have a list of situations and activities commonly avoided rather than relying on clients to list all their avoidance behaviors.

On the extreme end, avoidance can become a natural part of the routines of some clients. These people have adapted so well to their fears that avoidance may simply be habit, without the need for conscious thought or planning. In such cases it is not unusual for clients to deny having any fear and to be unaware of most of their avoidance behaviors. Because of their successful avoidance they may not have experienced fear recently. In such cases, a thought experiment with the client imagining contact and careful probing regarding cognitions can be useful.

In other cases, despite describing a full complement of phobic fear and avoidance symptoms, clients may not appear to qualify for a diagnosis because they initially deny distress regarding their symptoms and refute the idea that their reactions are excessive or unreasonable. In some sense it is not surprising that anxious clients would take this stance. Anxious people often overestimate the probability and valence of negative outcomes. For example, spider phobic people are more likely to make unrealistically negative attributions about spiders than nonphobic people (Riskind, Moore, & Bowley, 1995) and make higher probability estimates of being bitten and having the bite be harmful (Jones, Whitmont, & Menzies, 1996). Similarly, height phobics overestimate the likelihood of falling and being hurt in the fall (Menzies & Clarke, 1995b). Phobic people may also overrate the severity or uncontrollability of their own response to the phobic situation, such as a height phobic worrying about losing control and jumping off a high bridge (Antony et al., 1997a).

Given the perceptual and cognitive biases of anxious people, it is not surprising and is actually quite understandable that they see their responses as justifiable. Although there is some debate about the advisability of a diagnostic requirement of distress or insight regarding phobic symptoms (Jones & Menzies, 2000), sometimes careful questioning can reveal that the client does fit the criterion despite initial indications to the contrary. In some cases, clients do have distress or awareness about the excessiveness of their reactions but feel defensive, pressured, or misunderstood. In dealing with such clients it is important to validate the reality of their fear experience and make it clear that treatment will proceed at their pace. Clients who are not particularly psychologically minded may simply lack awareness of the impact of their symptoms. In such cases, prompting the client to be self-reflective with a series of questions may be useful ("Do you react more strongly to the stimulus than your friends and family?" "Do people who are close to you view your fear, disgust, and avoidance as excessive?" "If I waved a magic wand and took your reaction away, how might your life be changed?"). In the end, if clients are seeking treatment, learning about them may be more important than whether this criterion is ultimately met.

Case Illustration With Dialogue

To illustrate some key assessment issues described in this chapter, the following case is described. The client, Jenny, is a 32-year-old Caucasian woman who responded to a newspaper advertisement for a stress and anxiety clinic housed in a psychology department outpatient training clinic. Jenny is upper middle class, recently finished a graduate program, and works as a teacher. She has been married for several years. She and her husband moved to a small town one and a half years ago for Jenny to begin her teaching position. Jenny's husband is a consultant who works from home and travels fairly regularly. Jenny reports being happy with her work and relationships but is troubled by fear and avoidance of driving. Public transportation is not available in her town, and driving is a necessary part of daily life.

After a brief intake interview and explanation of clinic policies, Jenny was referred to the stress and anxiety clinic, and the SCID-IV interview was administered. The following excerpts have been adapted from an assessment interview that occurred over the course of multiple sessions.

Therapist: What brings you in to the clinic today?

Jenny: Well, something has to change. My husband is tired of driving me around, and he isn't always in town. He said I have to get back to driving.

T: So you have stopped driving?

J: Well, just cut back is more like it. I still drive when I need to, but I refuse to drive on the highway, and I try not to drive at night. It hasn't been that much of a problem until recently because I live really close to work. I just walk in to work, and if it is raining or something one of the girls gives me a lift home. But my husband has needed to travel a lot for work recently, and I didn't want to take him to the airport. His friend got sick and couldn't drive him at the last minute, and I refused. We got in a big fight. He started pointing out all the places I don't drive to and how there are friends and family I can't visit and how I couldn't pick up supplies last week and how much he has to do to try to take over.

T: I see, so you used to do more driving than you do now?

J: Yes, I used to be a really big driver, road trips and that kind of thing. Now I just don't enjoy driving any more; it makes me too anxious.

The client's initial description of her driving fear and avoidance symptoms could be part of a range of possible disorders. For instance, if her symptoms are caused by a fear of having panic attacks while driving and being unable to escape, she may have PDA. If her fear and avoidance are part of a stress reaction including reexperiencing, numbing, and hyperarousal after a traumatic automobile accident, then she may have PTSD. If her anxiety about driving is prompted by an obsessive concern that she has hit someone and a compulsive need to check that she has not done so, she may have OCD. If her fear and avoidance are circumscribed, then she may have a specific phobia, situational type. To make a distinction the interviewer needs more information about her symptoms and their onset.

Therapist: What prompted this change, Jenny?

Jenny: I got in a car crash about 8 months ago. I was driving. It was really scary. We were on the highway. My husband and I were in a big fight, and I told him he was clearly too angry to drive. Perfect, huh? How ironic. I told him I was calmer, so I should drive. So I was driving along and I went to change the radio station. When I looked up, we were about to hit this big truck that was right next to us. I swerved, and the next thing I knew we were upside down in the ditch.

T: Wow, how scary!

J: I know. I still remember the smell of the dirt. I was hanging upside down, and I could smell the dirt and grass, and the windshield was broken. I remember feeling kind of floaty, and then I wondered whether I was injured. I really couldn't tell, you know?

T: Uh huh. You were in shock?

J: Yes, I had to look down and check myself out to make sure I was all right. And I noticed I had broken my watch, and I was upset because my husband had given it to me. And then I remembered that he was in the car with me, and I had this moment of feeling like I swallowed my heart. But I looked over and he was okay. I mean, mostly okay. He had a cut on his head, and there was a little bit of blood, but he could look at me and talk to me and everything.

T: Good, good, so you were both basically okay?

J: Yeah, I guess you could say that. But boy, was I freaked out.

T: I bet.

J: I still feel horribly guilty about that, that my first thought was about myself. I mean, what kind of a person must I be to have completely forgotten that he was in the car? I haven't admitted that to him, that I was only concerned with myself first. I feel terrible. I could have killed my husband.

At this point, the client appears to be describing typical peritraumatic responses, including extreme fear and horror and possible dissociation (feeling "floaty" is a term that may indicate depersonalization), and a posttraumatic emotional response of shame and guilt. Because the client's experience qualifies as a trauma because of its life-threatening nature and her intense emotional response, the interviewer addressed PTSD symptoms.

Therapist: Scary stuff. Do you have thoughts or memories or nightmares about the car accident that you can't seem to shake?

Jenny: No, I don't think about it much anymore, and I never really had dreams about it. It did really bother me a lot right after it happened, though. We had to get a new car, and every time I saw that horrible car I would get upset.

T: How about now; do you get upset when things remind you of the accident now?

J: No, not really. I needed to talk about it a lot right afterwards, but now I think I have kind of worked it out of my system. My sister and I went over every detail of it, from beginning to end, so many times that now I can think about it more objectively.

T: How about when you are driving on the highway?

J: Yeah, I see what you mean. No, actually, I don't think my problem with the highway driving is because it makes me think about the accident.

T: So, you are okay thinking about the accident?

J: Well, yes and no. I mean, I can remember the accident and be calm about it. But at the same time the accident gave me this new viewpoint about cars. It's terrifying really, what cars can do. This sounds silly, but they are like these dangerous beasts to me.

T: Hmmm, say more.

J: Well, when I am driving, it makes me really tense because I never know what the car is going to do. I feel like it could just jump off of the road at any minute. I know it sounds crazy. It just feels so unpredictable, like the car might not do what I want it to. And that's too much for me. I get all panicky, and I just go right back home.

Although Jenny denied reexperiencing symptoms of PTSD in the preceding excerpt, at a later time the interviewer returned to the topic of reexperiencing and assessed for the presence of numbing and hyperarousal symptoms. After a thorough review of possible PTSD symptoms, it was determined that Jenny did not have PTSD. In the preceding excerpt, however, Jenny has raised the possibility of panic attacks. It is not yet clear whether her description of feeling "panicky" is simply a synonym to express her fear and anxiety or whether she is experiencing the physical and psychological symptoms of a panic attack. The interviewer chose to pursue this, asking questions about the panic.

Therapist: Jenny, can you describe for me how you feel when you get panicky?

J: Well, I start feeling kind of dizzy and faint, and my vision gets a little blurry, and I worry that it will make me crash. I feel like I can't get any air, a little like I am smothering, you know?

T: Uh huh. Anything else?

J: Well, my chest just feels really tight, and I can feel my heart racing. And my palms get sweaty. It starts to come on gradually, but then it gets worse and worse, and I feel like I'm going to pass out or lose my mind or something, and I have to either pull over or go right home.

With several more questions the interviewer establishes that the client is indeed regularly having full panic attacks that peak within 10 minutes. Next their origins are explored.

Therapist: When did the panic first start happening?

J: Oddly enough, it was when I was watching TV. My husband and I were just on the couch and suddenly I can't breathe, and I feel like I'm going to faint and like I'm going to jump out of my skin. It was so strange because we weren't even doing anything.

T: What was on TV?

J: Oh, good point. I never thought of that. The movie was pretty scary, actually, pretty tense. Maybe that was it. Do you think that could be why?

T: That definitely could have contributed, sure. What was going on in the movie?

J: No idea, I just remember that it was scary.

T: Sure, that could have pushed you over the edge. Sometimes there are other factors that can contribute to it, like whether things are tense in general or you have been drinking a lot of caffeine.

J: Oh yeah, I'm a caffeine fiend. I can drink a pot of coffee in the morning, if I have a lot of grading to do or something.

T: Well, that could definitely play a role too. How often do you drink coffee or caffeinated beverages?

J: Every day. I like my coffee in the morning, and then I drink cokes with lunch and dinner and snacks. So I probably have three or four cups of coffee and then another three or so cokes. Boy, that sounds like a lot when I say it now. I should probably cut back on that, shouldn't I? And I guess I do get stressed out pretty easily. I am kind of high strung.

The client went on to report that the panic attacks started a month after her accident and, with the exception of her first attack, are cued by driving. This suggests that her panic may occur as part of a driving phobia caused by the conditioning experience of her car accident. Later Jenny denied persistent worry about future attacks or their implications, but she reported some worry about whether the panic symptoms would lead to a car accident. Because she also alluded to anxiety before going on long trips, fear and avoidance about agoraphobic situations such as buses, trains, airplanes, and crowds were also explored. In the end, Jenny reported subthreshold anxiety and avoidance related to a number of agoraphobic situations. Because her avoidance of driving was her presenting complaint, and she reported marked fear in response to actual and anticipated driving situations, recognition that her fear was excessive, and significant life impairment, she was diagnosed with specific phobia, situational type, and with PDA as a rule-out diagnosis. Jenny underwent exposure therapy, practicing driving in increasingly difficult situations and eventually driving on the highway at night. During the course of treatment Jenny developed frequent, apparently uncued nocturnal panic attacks. Treatment was supplemented with interoceptive exposure for her panic. After approximately 4 months of weekly treatment Jenny was able to successfully drive on the highway and was largely free of panic symptoms.

Multicultural and Diversity Issues

There is little evidence of multicultural influences in the specific phobias. There are some findings regarding gender, race, and ethnicity, but there are large gaps in the existing literature, with particularly little known about anxiety and phobias among Asian Americans and Native Americans. This section reviews evidence about specific phobias in diverse populations and related information from clinical and social psychology.

One particularly important diversity variable in the specific phobias is gender. Specific phobias are diagnosed more often among women than men, across a range of samples and phobia types (Curtis et al., 1998; Goisman et al., 1998; Himle, McPhee, Cameron, & Curtis, 1989). This gender difference has been attributed to bias in sampling and diagnostic criteria (Hartung & Widiger, 1998) and to differences in reporting, treatment seeking, and learning history (Antony & Barlow, 1997). In any event, women are likely to be disproportionately represented among those seeking assessment and treatment for phobias, and gender prevalence rates appear to vary as a function of age and type of phobia (Barlow, 2002).

Race is also likely to be an important variable in assessing for specific phobias. An early analysis of epidemiological data found that Black racial status was related to scores on a phobia scale (Warheit, Holzer, & Arey, 1975). Some more recent data suggests that African Americans, particularly women, are more likely to have phobias than are Caucasians (Robins & Regier, 1991; Zhang & Snowden, 1999).

Cultural, ethnic, and racial differences in symptom presentation should also be taken into account. For example, the interviewer should carefully assess physical complaints among minority

populations because somatization is more common among African American, Hispanic, Native American, Alaska Native, and Asian populations (Hsu & Folstein, 1997; Robins & Regier, 1991; U.S. Department of Health and Human Services [USDHHS], 2001). A number of culture-bound syndromes seen in Hispanic Americans are particularly relevant in the assessment of anxiety and phobias, including *susto* (fright), *nervios* (nerves), and *ataque de nervios*. Although symptoms may include those that are typically associated with anxiety, such as trembling, the clinician should attend to a broader range of symptoms (e.g., crying, screaming, aggression, or dissociation for *ataque*) in identifying culture-bound syndromes (USDHHS, 2001).

Some knowledge of typical cultural differences in interpersonal interaction and reporting styles can also be helpful in an interview context. Cultural norms for body language and emotional expression vary. For instance, Asians and Asian Americans typically make less eye contact than other groups. They may also be less likely to identify and express emotions (Le, Berenbaum, & Raghavan, 2002). Interviewers should also be conscious of the influence of their own culture on their clinical judgment. An awareness of clinician-client cultural differences is particularly important in light of the typical discrepancy between the race and culture of the clinician and client (Holzer, Goldsmith, & Ciarlo, 1998), which may help account for the underdiagnosis of psychiatric disorders, particularly for African Americans and particularly for anxiety disorders (Kunen, Niederhauser, Smith, Morris, & Marx, 2005).

Underdiagnosis may also occur as a result of purposeful minimization of symptoms by the client. One reason for such misrepresentation is social desirability. For example, occasionally in our clinic male clients have had difficulty disclosing the extent of their phobic fear or disgust to an attractive female clinician. A lack of trust or rapport may also lead to initial distortion. In all such cases, behavioral assessment strategies can be particularly enlightening because the clinician has the opportunity to observe the extent of avoidance behavior and nonverbal behaviors such as posture and facial expression. Such information should be duly noted in final judgments about diagnosis and symptom severity.

The clinician should also attempt to determine the influence of cultural beliefs and meanings on symptom presentation. For example, among the Hmong, masks are a symbol of death. Recent Hmong immigrants may be expected to display strong fear reactions in response to masks worn at Halloween or Mardi Gras. Such culturally influenced reactions should not be considered psychopathological if they are normative for the culture, and the interviewer will need to investigate the customs and beliefs of the client's culture to make this determination. Birth country and level of acculturation should also be considered because these may function as risk or protective factors. For instance, people of Mexican origin living in the United States for longer periods of time appear to have higher phobia prevalence rates (Vega et al., 1998). The clinician should also consider whether cultural background may predispose certain populations to specific phobias. For example, because disgust responses have been linked to specific phobias and cultural differences in disgust have been reported (Haidt, Rozin, McCauley, & Imada, 1997; Rozin & Fallon, 1987), disgust sensitivity may be one important focus of clinical attention.

Because there is evidence that anxiety disorders are more likely for people with elevated stress, the interviewer should be sensitive to various experiential and environmental sources of stress, such as being the victim of a violent crime (see Kilpatrick & Acierno, 2003, for a review). Racial and ethnic minorities often are at higher risk for violent assault, particularly women (Greenfeld & Smith, 1999; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997), as are those in poverty (Reiss & Roth, 1993). Furthermore, some ethnic and racial minorities are overrepresented in high-risk groups such as those who are incarcerated, homeless, or refugees (USDHHS, 2001).

In other cases, environmental sources of stress may be fairly subtle, such as the effects of discrimination. A recent meta-analysis by Saucier, Miller, and Doucet (2005) suggests that racism has become more covert. Examinations of helping behavior found evidence that discrimination against Blacks is more likely when issues of race are not at the forefront and contextual factors provide an excuse (e.g., assistance would entail more risk, difficulty, or time) or, unfortunately, in cases of extreme emergency. Given that minority populations are more likely to experience violent crime, the availability of aid and assistance are important variables to consider. Not surprisingly, Black Americans report more stress in response to trauma than White Americans (Norris, 1992).

Differential Diagnosis and Behavioral Assessment

Accurate assessment is particularly important for differential diagnosis of specific phobias because the treatment of choice may vary between disorders. For the specific phobias, exposure-based treatments have received strong empirical support (Antony & Swinson, 2000; Hirai, Vernon, & Cochran, 2006). Although exposure-based techniques have been supported for a range of anxiety disorders, the focus of the exposure, the use of adjunctive treatment techniques, and the appropriateness of pharmacotherapy interventions vary from disorder to disorder. For example, if a fear of hospitals is a symptom of specific phobia, BII type, then treatment would involve graded exposure to hospitals. On the other hand, if a fear of hospitals is rooted in OCD obsessions about cleanliness and contamination, the exposure to hospitals would be only a small part of a treatment including exposure to a range of potentially contaminating stimuli and response prevention of compulsive washing after such exposure. Along the same lines, breathing retraining may be appropriate for a subset of clients with panic disorder (PD) but is unlikely to be needed by the majority of specific phobia clients (Antony & Swinson, 2000). Furthermore, combining cognitive and exposure-based therapeutic techniques appears quite useful for PD and social phobia, but there is little evidence of incremental efficacy from the addition of cognitive strategies for most specific phobias. Similarly, selective serotonin reuptake inhibitors and benzodiazepines have been shown effective for PD and social phobia, but there is no research demonstrating their efficacy for specific phobias, and there are some theoretical grounds for avoiding their use (Foa & Kozak, 1986).

Although differential diagnosis can have important implications for treatment planning, it can be particularly difficult in the anxiety disorders given their high symptom overlap. For instance, anxious apprehension may be symptomatic of many anxiety disorders, including specific phobia, social phobia, agoraphobia, and PD. However, in each case the target of the anxiety is different, such as anxiety regarding potential exposure to a feared situation, to negative evaluation, to inescapable situations, or to a situation eliciting a panic attack, respectively.

Comorbidity

There is evidence that specific phobias tend to be comorbid with one another and with other anxiety and mood disorders (Brown, Campbell, Lehman, Grisham, & Mancill, 2001; Curtis et al., 1998; Sanderson, Di Nardo, Rapee, & Barlow, 1990). It appears that when a specific phobia is the principal diagnosis, other comorbid disorders are less likely. However, specific phobias are rarely principal diagnoses and are much more common as an additional diagnosis, particularly accompanying other anxiety disorders (Sanderson et al., 1990). There is also some evidence that specific phobias may coexist less commonly with some disorders, such as bulimia nervosa and alcohol use disorders (Barlow, 2002).

Differential Diagnosis

The *DSM-IV* specifies that for a specific phobia diagnosis fear must not be better accounted for by another disorder. In the following sections recommendations are made for distinguishing specific phobia from PD and agoraphobia, social phobia, PTSD, and OCD.

PD and Agoraphobia. The presence of panic attacks can sometimes cause confusion about the appropriate diagnosis. It should be noted that panic attacks have been found to occur in conjunction with all of the anxiety disorders (see Craske, 1991, for a review of panic attacks and phobic fear). An excellent way to distinguish between specific phobia and PD is to assess what cues the panic attacks. In the context of a specific phobia, panic attacks usually are cued by situations or thoughts involving the phobic stimulus. In the driving phobia case study, Jenny initially reported having all of her panic attacks (except the first one) while driving. Clients with PD, on the other hand, typically report more frequent uncued panic.

Clients with specific phobia need not be able to link every panic attack to their phobic concerns, however. It may be the case that the client was not aware of the way in which "uncued" panic attacks were actually associated with the phobic stimulus. For example, Jenny's first panic attack occurred while she was watching a tense movie, and a scene (a car chase, perhaps) may have triggered thoughts or memories of her accident. It may also be true that not all panic attacks

can be traced back to phobic triggers, yet a diagnosis of PD may still not be appropriate if the panic attacks developed after the specific phobia, increase in frequency or intensity when phobic symptoms peak, remit when phobia symptoms decline, or consist of only a couple symptoms (a minimum of four symptoms is required). Furthermore, people with PD typically report marked concern about their panic attacks, anxious anticipation of having another attack, and changes in their behavior to avoid future panic attacks. For those with panic attacks in the context of specific phobias, concerns about panic attacks are not central but instead are part of a larger complex of thoughts and behaviors related to the phobic stimulus.

A distinction between agoraphobia and specific phobia can also be difficult because the two may involve avoidance of similar situations. In such cases, the reasons behind the avoidance should be probed. Jenny's driving avoidance could signal agoraphobia if it was motivated by a fear that escape would be difficult (PDA if the need to escape was focused on a possible panic attack) instead of a fear of crashing. Similarly, avoidance of flying may point to PDA if the client does so out of fear of being trapped during a panic attack, especially if the client also avoids public transportation, elevators, and shopping malls.

Distinguishing situational phobias from PDA can be particularly difficult, and there has been some argument about whether claustrophobia may be a variant of PDA. The two seem to share comorbidity (Starcevic & Bogojevic, 1997), patterns of onset age and manner of acquisition (Öst, 1985, 1987), uncued panic (Craske, Zarate, Burton, & Barlow, 1993), fear and avoidance of interoceptive stimuli (Clark, 1986; McNally, 1990), and use of safety signals (Rachman, 1984; Sloan & Telch, 2002). Although Vickers and McNally (2005) report that fear of dying may distinguish PD from panic attacks. There is also some evidence challenging ideas of overlap between PDA and situational specific phobia, displaying differences between those with PDA and driving phobia (Antony et al., 1997a, 1997b).

It should also be noted that multiple diagnoses may be appropriate for some people. For example, had the client in the case study avoided driving both because of her fear of a crash (a symptom of specific phobia) and because of her fear of having a panic attack and being unable to escape (a symptom of PDA), consideration of both diagnoses would have been appropriate.

Social Phobia. Specific phobia and social phobia may also appear to share similar fear and avoidance symptoms. As with the distinction between specific phobia and PDA, information about the focus of the fear and the reasons for avoidance are paramount for determining the appropriate diagnosis. For example, Jenny described a fear of driving. Had her fear occurred only in the presence of other people and focused on looking foolish, incompetent, or unattractive, social phobia may have been a more apt diagnosis if she also had concerns about negative social evaluation in other situations. Similarly, avoidance of a range of other potential phobic situations, such as flying, eating in restaurants, or riding in elevators, may be motivated by social concerns or may be associated with a specific phobia. For instance, clients may avoid eating in restaurants for fear of choking and dying (symptom of specific phobia, other type) or for fear of embarrassing themselves (symptom of social phobia). Asking clients what they are afraid might happen in each situation or what the worst outcome would be can help tease apart these diagnoses.

Posttraumatic Stress Disorder. PTSD is another disorder that typically includes strong fear and avoidance responses. In our case illustration, Jenny developed fear and avoidance of driving after a serious automobile accident. Based on her description of the accident and her intense response, it would certainly meet diagnostic criteria for a trauma. However, PTSD is associated with a variety of reexperiencing symptoms, including intrusive and uncontrollable memories and images from the trauma, nightmares about the trauma, or, in extreme cases, flashbacks during which the person feels as though the trauma is actually happening all over again. Specific phobias do not include such reexperiencing symptoms, and Jenny did not report them. Nor did she report other symptoms of PTSD, such as numbing, including diminished positive affect or general hyperarousal symptoms such as trouble sleeping and an exaggerated startle response. Presence of reexperiencing, numbing, and hyperarousal symptoms is a useful way to distinguish between PTSD and specific phobia.

Obsessive-Compulsive Disorder. People with OCD may also occasionally appear to have specific phobias. Those with OCD may fear and avoid certain objects and situations because of obsessions. Antony and Swinson (2000) describe a woman who presented with an extreme fear and avoidance of snakes. Although she was initially thought to suffer from a snake phobia, in due course it was learned that her snake fear was part of a larger obsessive concern about contamination. The woman was diagnosed with OCD because her concern about snakes was only one fear among a broader set of obsessions. In our case illustration, Jenny might have been diagnosed with OCD if her avoidance of driving was caused by obsessions about having run someone over and the need to compulsively stop and check. Clients with OCD may be distinguished from those with specific phobia by the focus of their fear and by their need to perform compulsive rituals in response to their fear or anxiety.

Although issues pertaining to differential diagnosis have been reviewed for a number of anxiety disorders, it should be noted that situations of symptom overlap also arise with other disorders, particularly those in which fear is an important symptom, including hypochondriasis and anorexia nervosa. In most cases of differential diagnosis, it will also be useful to integrate interview findings with information obtained via questionnaires (a useful overview of those for specific phobia can be found in Antony, 2001), self-monitoring, and behavioral assessment.

Behavioral Assessment

Behavioral Approach Task (BAT). Avoidance is an integral part of the diagnostic criteria of specific phobia. Consequently, a behavioral approach task (BAT) with phobic stimuli has often been used as one index of phobia severity, along with reported fear during the BAT. The approach task, sometimes called a behavioral avoidance or assessment task, asks the client to enter a feared situation or approach a feared stimulus. The phobic stimulus may be approached down a walkway, or the client may perform several tasks that entail increasingly close contact with it (e.g., touching the outside of a mouse's cage, taking the cage lid off, touching the mouse using a pen, touching it with a bare finger).

Because of strong avoidance tendencies in specific phobia, clients may not have encountered the stimulus recently and may not clearly remember details of their reactions to it. A BAT allows exposure in a largely controlled way. The client can then give reports of thoughts, feelings, and physical sensations, and the clinician can observe subtle avoidance or other behaviors outside the client's awareness. The BAT also allows the clinician to gauge the accuracy of the client's self-report.

BATs have been used for initial assessment and to monitor treatment progress, outcome, and retention. In research on spider phobia, for instance, BATs with a live spider often are used as one index of symptom severity (Merckelbach, de Jong, Arntz, & Schouten, 1993; Mohlman & Zinbarg, 2000; Mystkowski, Mineka, Vernon, & Zinbarg, 2003).

BATs can include contrived, naturalistic, or imagined scenarios and settings. For example, in a contrived BAT, the client's approach to a caged animal can be measured in feet. In other cases, the number of tasks successfully performed with the stimulus may quantify approach behavior. Contrived BATs are especially popular in the assessment of specific phobias because they can be brief, portable, and easy to set up and can provide some objective measure of avoidance. Naturalistic BATs strive for greater external validity, asking the client to perform increasingly feared or avoided tasks in the natural environment. One example of naturalistic BATs are height avoidance tests, in which clients are asked to ascend to the highest level they can in a building with balconies, a multitiered parking garage, or a fire escape (Marshall, 1985; Williams, Turner, & Peer, 1985; Williams & Watson, 1985). There is also evidence that imaginal assessments including physiological monitoring can provide useful information about specific phobias (McGlynn & Vopat, 1994).

BATs can vary in terms of stimuli used, number of steps involved, instruction content, instruction timing, and positioning and behavior of the assessor. For instance, for an unbiased index of symptom severity clinicians will need to ensure that their demeanor, presence, or location is not perceived as overtly reassuring. The assessor can unwittingly become a safety signal, encouraging approach behaviors the client ordinarily would not be capable of performing and giving an underestimate of avoidance. When administered

correctly, BATs can provide a wide variety of information, including approach distance, approach latency, subtle avoidance behaviors (e.g., turning one's face away, crossing arms defensively in front of one's body), facial expression, self-reported emotion and cognitions, and physiological response (e.g., heart rate, vagal tone, skin conductance, respiration, cortisol). If the BAT involves multiple steps, called a progressive BAT, such information may be taken at each step.

Ratings during a BAT often use subjective units of discomfort or distress (SUD) scales (Wolpe, 1973). They may use a 0–100 rating scale (0 = *no fear, disgust, discomfort, or avoidance,* 50 = *moderate,* 100 = *highest imaginable*). Other rating scales, such as 0–8 and 0–10, are also commonly used, as well as fear thermometers (Walk, 1956). Visual analog scales (McGlynn, Moore, Rose, & Lazarte, 1995) and dials allowing continuous input of fear levels (McGlynn, Rose, & Lazarte, 1994) have also been used.

Progressive BATS may involve a standard hierarchy of tasks specifically designed for the disorder or may be tailored to the specific fears and avoidance of the client. Although a standardized BAT can provide normative information allowing comparison across clients, those tailored to the client may be the most clinically informative. When selecting tasks for a BAT, the clinician may include multiple difficult and emotion-provoking tasks or steps representing a range of difficulty levels.

Biological Challenge. Another form of behavioral assessment is a biological challenge, such as carbon dioxide inhalation, which produces unpleasant physical sensations. In such cases, rather than be exposed to an external stimulus, the client is exposed to interoceptive stimuli. Although biological challenges typically are associated with PD, there is emerging evidence that natural environment and situational phobic people may also have strong reactions to the kinds of uncomfortable physical sensations produced by biological challenges (Antony et al., 1997b). For instance, reactions to biological challenges may be particularly illuminating with clients with claustrophobia symptoms. The same kinds of information gathered during a BAT can be collected during biological challenge tasks, and the same considerations apply.

Selection of Treatment Targets and Referral

It is widely agreed that confronting one's phobic stimulus in some way is an essential ingredient in treatment for specific phobia. Researchers have found that exposure treatment is successful for phobias of spiders, snakes, rats, blood, dental procedures, flying, enclosed places, heights, and water (Antony & Swinson, 2000; Hirai et al., 2006). Current exposure-based treatments have their roots in systematic desensitization, imaginal flooding and implosion, and modeling. Exposure treatment manuals for specific phobias are widely available (Antony, Barlow, & Craske, 1997).

In exposure therapy for specific phobias, it is often the case that the behavioral tasks used for assessment can be adopted for in-session and between-session exposure practice. In most cases the client and clinician will develop a fear and avoidance hierarchy together. During assessment, the client will have generated examples of situations that are feared, avoided, or endured with difficulty. The clinician can review the list with the client and ask that he or she expand on it. When a representative list has been compiled, the client should rank the items from least to most feared and avoided. For example, an exposure hierarchy for blood phobia might include looking at photos of blood as an easy step, holding a sealed vial of blood as an intermediate step, and having blood drawn as a difficult step.

Once the list has been ordered the client should assign SUD ratings to each item. The list can then be modified and expanded based on the addition or subtraction of important components (e.g., safety signals, calming and controllable vs. frightening and unpredictable elements). It may be particularly important to break down tasks higher on the hierarchy into smaller parts if there is a big gap in the hierarchy between easy or moderate steps and a highly difficult step. For instance, a claustrophobic may find it easy to stand in a closet with the door ajar, assigning it a SUD score of 50. However, the same person may view the task as intolerable if the door is completely shut, rating it as 100. In this case, additional detail should be added to the hierarchy until more moderate ratings are

achieved. After some discussion and brainstorming, the client and clinician might modify the "closed door" task to include being in a large empty closet with the door shut for 15 s with the light on, the client's hand on the doorknob, and the clinician immediately outside the door. Such modifications may change the client's rating to 75 and also emphasize that exposure will be gradual and under the client's control. The highest step on the hierarchy represents the ultimate goal of therapy and gives the clinician an objective measure of treatment success.

It has been suggested that in generating the hierarchy clinicians may initially want to avoid disclosing its purpose, lest the client withhold information (White & Barlow, 2002). Such a decision will require clinical judgment, weighing the degree of collaboration and rapport. If a client is sufficiently cooperative, open, trusting, and motivated, withholding information may be damaging to the working relationship and unnecessary. On the other hand, the hierarchy may overwhelm highly anxious and skeptical clients, and treatment information should be delayed until the client's confidence and motivation have increased.

Self-monitoring diaries before, during, and after treatment can serve a range of functions. They can be important for aiding in assessment and providing additional items or details for the fear and avoidance hierarchy. Additional self-monitoring forms should be completed during exposure practice and may also be used for other treatment exercises, such as cognitive restructuring. They may be carried around in a pocket or purse to record incidents of phobic fear or avoidance during and after treatment, as part of an ongoing assessment process.

Depending on the type and severity of the specific phobia and the existence of complicating disorders or conditions, the format and length of treatment may vary widely. Researchers have demonstrated the efficacy of 2.5- to 3-hour single-session exposure treatments for specific phobias (Arntz & Lavy, 1993; Hellström & Öst, 1996; Öst, 1989; Öst, Salkovskis, & Hellström, 1991). One-session group treatments have also been used successfully with up to eight clients (Götestam, 2002; Öst, 1996; Öst, Ferebee, & Furmark, 1997). In vivo observation and video observation of the exposure treatment of another client also appear to lead to symptom improvement, although the most effective strategy was direct exposure experiences by the client (Götestam, 2002; Öst et al., 1997). A recent review suggests that motivated simple phobics may be the best candidates for self-administered treatments (Newman, Erickson, Przeworski, & Dzus, 2003).

Virtual reality (VR) treatment is another exciting form of exposure therapy (see Krijn, Emmelkamp, Olafsson, & Biemond, 2004, for a review). Although it does not appear especially effective for driving phobia (Wald, 2004), it has been used fairly successfully with spider phobia (Garcia-Palacios, Hoffman, Carlin, Furness, & Botella, 2002) and flying phobia (Mühlberger, Wiedemann, & Pauli, 2003; Mühlberger, Weik, Pauli, & Wiedemann, 2006; Rothbaum, Hodges, Anderson, Price, & Smith, 2002; Rothbaum, Hodges, Smith, Lee, & Price, 2000). Clients can venture into a computer-generated environment in which the therapist is able to control their exposure experience. For example, the possibility of rapid or unpredictable spider movement or a spider bite can be removed, and the spider's size, color, orientation, position, speed, and movements can be controlled. Flying phobics can undergo simulated takeoffs, landings, turbulence, and thunderstorms of carefully graduated severity. Perhaps the chief advantage of VR exposure is its cost-effectiveness. Time with a therapist and expensive elements such as taking a commercial airplane flight can be eliminated or reduced.

In cases in which exposure treatments are not available, the clinician should help the client find suitable resources. Sometimes clinicians do not have such referral information readily available, perhaps because the clinician is new to the area and operating independently or needs to refer a client to another location. In such circumstances national professional societies such as the Association for Behavioral and Cognitive Therapies, the Anxiety Disorders Association of America, and the APA can be invaluable. Some professional societies have online lists of professionals by specialty area and geographic location. Others have phone help and referral lines and e-mail groups for such questions. Regional and local professional organizations, such as the Midwestern Psychological Association and the Southeastern Psychological Association, and state and provincial professional societies (listed on the APA Web site) can also be quite useful.

As discussed earlier, the interview is a key aspect of assessment that is crucial for determining diagnoses, which in turn inform the selection of appropriate treatment strategies and referral. Furthermore, in the case of specific phobias, the information gathered in the assessment can be used immediately in generating an exposure hierarchy, which will guide treatment. Thus, in cases of referral, a clear and detailed report will be a useful aid to the treating clinician. Whether a single session, group format, or VR treatment is appropriate depends on the individual situation. A thorough assessment provides knowledge of the client, his or her signs and symptoms, and the broader context that will allow appropriate referrals and treatment planning. The interview serves as an important first step in the treatment process, not only for gathering information about the client and making a diagnosis but also for providing the client with a sample interaction with a mental health professional.

Summary

This chapter described assessment strategies for specific phobia, briefly reviewing specific phobia types, epidemiology and etiology, and emerging evidence about the role of disgust. Interviewers are encouraged to use semistructured interviews when possible, and considerations for selecting structured, semistructured, and unstructured interview formats are reviewed, along with suggestions regarding basic assessment areas. Given the likelihood of interviewing obstacles, such as client minimization or misrepresentation of difficulties, clinicians should take steps to improve client awareness of symptoms through specific prompts regarding common types of obvious and subtle fear and avoidance behavior. The development and use of behavioral assessment strategies will also aid in the process. The role of gender and potential cultural, ethnic, and racial differences in symptom presentation, cultural beliefs, learning, and developmental history are explored. A case illustration of a driving phobia demonstrated interviewing techniques to assess symptom presentation, etiology, and course to clarify issues of differential diagnosis and comorbidity. Given the comorbidity of specific phobias with one another and with other anxiety and mood disorders, careful consideration of differential diagnosis is crucial for appropriate treatment selection.

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15

SOCIAL PHOBIA

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DESCRIPTION OF THE DISORDER

Social phobia (social anxiety disorder) is characterized by marked distress brought on during social or performance situations in which one may be subject to scrutiny by others. The disorder was first described in the literature in 1966 by Marks and Gelder. It often follows a chronic course (Amies, Gelder, & Shaw, 1983) and can negatively affect functioning in social, occupational, and other domains (Schneier et al., 1994; Stein & Kean, 2001).

Social phobia is a common anxiety disorder (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Epidemiological studies found a slightly higher prevalence rate in females than in males (3:2 female-to-male ratio; Kessler et al., 2005). The disorder is observed in all cultures, although the cultural mores of different societies can affect both presentation and prevalence of the disorder (Heinrichs, Rapee, et al., 2006). Public speaking is the most commonly feared social situation in U.S. studies (Pollard & Henderson, 1988). Other typical situations that may cause anxiety include eating or writing in public, initiating or maintaining conversations, meeting strangers, going to parties, and dating.

Diagnostic and Statistical Manual Diagnostic Criteria

According to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR;* American Psychiatric Association [APA], 2000), the defining feature is anxiety provoked by social or performance situations, and the *DSM-IV-TR* goes on to outline the typical presentation of social phobia and some exclusionary criteria for the diagnosis.

Researchers studying social phobia have noted heterogeneity across presentations of the disorder (Hofmann, Heinrichs, & Moscovitch, 2004). The *DSM-IV-TR* includes a *generalized subtype* specifier if the fears include "most social situations" (APA, 2000, p. 451). Unfortunately, there are no specific guidelines as to how many situations are considered "most," and people have interpreted the term in varying ways. For example, some assign a *generalized subtype* specifier if the person's fears affect a variety of social interaction situations (e.g., fear of initiating or maintaining a conversation), whereas the disorder is considered *nongeneralized,* or specific, if the fear is limited to performance situations (e.g., giving a speech, using public restrooms), even if multiple performance situations are problematic (Stemberger,

Turner, Beidel, & Calhoun, 1995; Turner, Beidel, & Townsley, 1992). Other authors distinguish between generalized, nongeneralized, and circumscribed subtypes, depending on the number of feared social situations (see Heimberg, Holt, Schneier, Spitzer, & Liebowitz, 1993, and Hofmann et al., 2004, for a review). Other systems that capture the heterogeneity of social phobia are based on the quality of the emotional expression in social situations (Hofmann et al., 2004) or cultural norms (Heinrichs, Rapee, et al., 2006; Hofmann & Barlow, 2002).

It remains uncertain whether these subtypes represent qualitatively or quantitatively different subgroups. Similarly, it remains unknown whether the diagnostic category social phobia and the highly comorbid Axis II category avoidant personality disorder (APD) represent distinct disease entities or whether they are simply extreme expressions of normal social anxiety. Another area of current research is the relationship between social phobia and shyness (Hofmann, 2000b). The diagnostic criteria of APD and social phobia overlap extensively, and studies have found that both feature high levels of social anxiety, high trait anxiety, greater overall psychopathology, depression, and poor overall psychosocial functioning (Turner et al., 1992). For our discussion, we subsume all subtypes under the term *social phobia* because there is no evidence that issues related to interviewing are subtype specific.

One final consideration in the clinical presentation of social phobia is its relationship to social skill deficits. Some early models of social phobia (e.g., Stravynski & Greenberg, 1989) implicated lack of social skills as the culprit underlying the anxiety. However, studies of social skills in people with social phobia have not demonstrated that difficulties in this arena consistently contribute to the origin or maintenance of the disorder (for review, see Stravynski & Amado, 2001). Nonetheless, it is recognized that some people with social phobia may indeed have deficiencies in social skills, and awareness of such difficulties is useful while one is interviewing patients with social phobia.

Interviewing Strategies

Structured Versus Unstructured Interviews

Clinical interviews can be either structured or unstructured. Some think that unstructured interviews offer greater flexibility, whereas others stress the importance of structured interviews in order to gather thorough and reliable information. Either approach is greatly enhanced through practice. An experienced clinician should be able to conduct a smooth interview while gathering enough information to formulate accurate diagnoses, regardless of the interviewing format he or she chooses.

A thorough understanding of the diagnostic criteria is essential for conducting a successful assessment interview. Although this is clearly important for unstructured interviewing, it is equally critical in structured interviews so that appropriate follow-up questions are asked. Many structured diagnostic instruments are available, including the Anxiety Disorders Interview Schedule for *DSM-IV* (ADIS-IV; DiNardo, Brown, & Barlow, 1994), the Structured Clinical Interview for *DSM-IV* (SCID-IV; First, Spitzer, Gibbon, & Williams, 1994), the Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978), and the Composite International Diagnostic Interview (Robins et al., 1988). Each instrument covers a range of psychological disorders and contains a specific section for diagnosis of social phobia. The interviews offer specific screening and follow-up questions while also allowing the clinician to ask additional questions necessary to clarify important points. Administration of the interviews typically requires training, and the instruments vary in their degree of structure. For example, the ADIS-IV leaves follow-up questions to the interviewer's discretion, whereas the SCID-IV offers sample follow-up questions to typical responses while also allowing the interviewer to generate other questions as necessary. The Composite International Diagnostic Interview is a fully structured instrument, and interviewers are trained to formulate standardized follow-up questions to reduce interrater variability.

Goals of the Interview

Potential goals of conducting an interview are establishing rapport, making the diagnosis, and gathering specific information about the client's clinical presentation that is relevant for treatment. Putting the client with social phobia at ease during the assessment is essential. Because many who suffer from social phobia may feel uncomfortable interacting with others, it is important to establish good rapport and to

make the person feel comfortable during the interview. People with social phobia often find it helpful to learn that social phobia is a very common and very treatable condition. Patients also appreciate it if the therapist acknowledges the fact that an interview can be a very stressful social situation. The clinician might encourage the client to let him or her know how to make the interview process less stressful.

Assessment Measures

Assessment measures for social phobia include clinician-administered and patient-rated instruments. These measures may be used to supplement the information gathered during the assessment interview. We do not recommend using these assessment measures as the sole means for formulating a diagnosis. Proper diagnosis should be made only by trained clinicians. Ideally, we suggest that clinicians follow a structured diagnostic interview to ensure that important clinical information is gathered. Standardized measures will allow more objective validation of the clinical impression.

Clinician-administered scales include the Liebowitz Social Phobia Scale (Liebowitz, 1987) and the Brief Social Phobia Scale (Davidson et al., 1993). Both instruments measure fear and avoidance of common social situations that can be anxiety provoking. The Brief Social Phobia Scale also includes four items to assess somatic symptoms. Functional impairment may be assessed using the Sheehan Disability Scale (Sheehan, 1983) or the Liebowitz Self-Rated Disability Scale (Schneier et al., 1994).

Commonly used self-report measures of social phobia include the Social Phobia and Anxiety Inventory (Turner, Beidel, Dancu, & Stanley, 1989), the Social Interaction Anxiety Scale and the Social Phobia Scale (Mattick & Clark, 1998), and the Fear Questionnaire (Marks & Matthews, 1979). The Social Phobia and Anxiety Inventory measures both social phobia and agoraphobia and assesses specific thoughts, behaviors, and physiological symptoms. The Social Interaction Anxiety Scale focuses on anxiety caused by social interactions, and the Social Phobia Scale measures anxiety caused by performance situations (including such activities as eating and writing in front of others). The Fear Questionnaire allows the therapist to identify the client's primary phobia in order to assess the degree of distress and avoidance prompted by the situation.

Additionally, the Social Anxiety and Distress Scale (Watson & Friend, 1969), the Fear of Negative Evaluation Scale (Watson & Friend, 1969), the Social Interaction Self-Statement Test (Glass, Merluzzi, Biever, & Larsen, 1982), the Self-Statements Public Speaking (Hofmann & DiBartolo, 2000), and the Cognitive-Somatic Anxiety Questionnaire (Schwartz, Davidson, & Goleman, 1978) were designed to measure specific aspects concomitant to social phobia.

General Issues

Before the start of the interview, it is recommended that the clinician provide the client with a few general guidelines and inform him or her of the nature and structure of the assessment. Assurances with regard to the confidentiality of the information can make the client feel more comfortable about disclosing sensitive information. It is helpful to remind the client about the purpose of the assessment and to tell him or her what kinds of questions can be expected. We advise that the clinician inform the client of the estimated duration of the interview. Anxiety about the overall process can be reduced through such explanations that familiarize the client with the interview format.

When interviewing, the clinician should be mindful about the use of open- and closed-ended questions. Open-ended questions (e.g., "How did this make you feel?") invite the client to describe experiences in his or her own words. Such narrative descriptions are a rich source of information and can help the interviewer determine topics worthy of further exploration. Closed-ended questions (e.g., "Did this make you feel upset?") make it possible to gather specific information quickly.

Interviewing Obstacles and Solutions

Because people with social phobia are especially concerned about the opinions of others, the clinician faces unique challenges when interviewing these clients. Given the nature of the disorder, the clinician may need to take extra care in putting the client at ease in order to make the assessment as productive as possible. For example, some people may have fears related to interacting with authority figures, whereas others may have anxiety related to feelings of being evaluated. An interview situation involves an evaluation by an

authority figure. Awareness of the specific concerns of the client before the assessment interview can be very helpful. Where possible, we recommend having the client fill out self-report questionnaires to measure general or specific aspects of social anxiety before the interview. This can help guide the course of the assessment and alert the clinician to specific issues that may arise.

Fears of Interactions With Strangers

With all clients, establishment of rapport is important for conducting a successful interview. This is especially important when assessing people with social phobia, particularly if the anxiety is heightened during interactions with strangers. A warm, friendly attitude throughout the interview can help put the client at ease. Nonverbal behaviors (e.g., sympathetic smiles and understanding nods) can be reassuring. Severely anxious clients may avoid eye contact, and the clinician should not attempt to force clients to maintain eye contact. Skilled clinicians are able to infer the client's level of distress by monitoring his or her eye contact and nonverbal, paraverbal, and verbal behaviors.

The clinician may use open- and closed-ended questions strategically to make the assessment run more smoothly. People with social phobia who are afraid of the interview situation are likely to be more uncomfortable with open-ended questions than closed-ended questions, especially at the beginning of the interview. We recommend starting with closed-ended questions to acclimate the client to the question-and-answer format of the interview. It is important that the clinician adjust the type of questions to the client's comfort level during the interview without sacrificing the quality of the information gathered during the interview.

Fears of Interactions With Authority Figures

Some clients feel particularly apprehensive because the clinician represents an authority figure. It is always helpful to think of the assessment process as a collaborative effort in which two people work together toward a common goal. When the clinician adopts this attitude, it can be easier for the client to view him or her as less intimidating. Additionally, the client may feel threatened by items in the environment such as one-way mirrors, diplomas on the walls, or a large desk placed between interviewer and interviewee, and where possible, we recommend conducting the assessment in a warm environment rather than a cold office that displays the clinician's power and authority.

Fears of Evaluation

When the client has difficulty revealing personal information because of concerns about being evaluated, the clinician can be supportive in a number of ways. First, it may be helpful to remind the client about the confidentiality policy and the reasons for the assessment. Clients should be informed about who will and who will not have access to the information. We recommend that clinicians use empathy and express appreciation for how difficult the self-disclosure must be while stressing the importance of collecting information as completely and accurately as possible in order to make the assessment successful.

We recommend that clinicians adopt a nonjudgmental stance toward the interview and convey this attitude to the client both verbally and nonverbally. For example, the client may be reassured by reminders that many people have difficulties with social anxiety and that there is no reason to feel ashamed of it. It is helpful to make encouraging comments throughout the interview, but it is important that such comments be genuine and not contingent on the types of responses being given. We generally discourage clinicians from sharing their own social fears and concerns with their clients, although there may be exceptional circumstances in which it is appropriate. However, we believe that the potential harm that self-disclosure can cause to a therapeutic relationship does not outweigh the potential benefits.

When assessing people with social phobia, we recommend that clinicians allot extra time for the interview. People with social phobia can be sensitive to subtle verbal or nonverbal cues. Therefore, any sense of hurry on the part of the clinician may prompt the client to give abbreviated responses. This can result in inadequate information for making a diagnosis or may necessitate more time for the assessment in order to further explore important details. Because the interview often is a challenging social task in and of itself, frequent breaks could make the situation less challenging. Although this might add additional time to the interview, it can make the process less taxing for the client. At the same time, however,

the clinician must avoid conducting an unnecessarily long interview because this can be tiring for both interviewer and interviewee. We recommend briefly discussing the length, number of breaks, and other issues related to the interview format at the beginning of the interview.

Social Skill Deficits

In some patients with social phobia, social anxiety may arise from a genuine lack of appropriate social skills. These patients may feel uncertain about how to behave during social interactions and are painfully self-conscious about their social skill deficits. During the assessment interview, these clients may appear nervous and awkward, and we recommend an accepting, nonjudgmental attitude from the clinician to help put the client at ease. Again, we advise that clinicians be explicit in letting clients know what will happen throughout the interview and what is expected of the interviewee because he or she may feel particularly anxious about behaving appropriately during the interview.

Problems With Assertiveness

Some clients with social phobia may have particular difficulties with assertiveness. This can be problematic during the assessment if it prevents the client from speaking up to clarify points of confusion or to inform the clinician of issues that have been overlooked. Throughout the assessment, it is important for the interviewer to offer the socially anxious client many opportunities to speak up. It can be helpful to reiterate information the client has just conveyed, and ask questions such as "Does that sound accurate to you?" We recommend that the clinician ask whether the interviewee has anything else to add before ending each topic of discussion and moving on to the next. If the client has nothing to say at that point, the clinician can offer assurances that the topic can be revisited if any other relevant information comes to mind later. However, the clinician should give the client enough time to answer these questions. People with social phobia often take long pauses during conversations for a variety of reasons. For example, the client might monitor his or her answers or prepare his or her nonverbal response. Such safety a behavior would be discouraged during treatment but should be accepted during the assessment interview because the clinician could otherwise miss important information.

Case Illustration With Dialogue

Here we provide a case illustration and an excerpt from the diagnostic interview of a patient with extreme fears in social situations.

John is a 48-year-old divorced man who presented to our clinic with concerns about what he described as "shyness that made it difficult for me to interact and get along with others." He reported that he had always been shy and anxious in social situations and that in the past 7 years, his shyness and social phobia had become disabling. He reported significant anxiety in multiple situations, including attending parties, participating in meetings and classes, talking in front of a group, speaking with unfamiliar people, talking to people in authority, dating, being assertive, and initiating and maintaining conversations. During his initial interview he noted that in these situations he is afraid that he will say something stupid or humiliating and that others will think poorly of him. He described multiple ways in which his social phobia interfered with his life. For example, he reported having to rely on his sister to interact for him in most social situations. He reported that his social phobia impeded his career advancement in that he had declined job offers and promotions because of his aversion to making presentations in front of and interacting with colleagues. The following is a part of his initial interview.

Interviewer:	John, do you remember the first time you felt your anxiety in social situations was incapacitating?
John:	Oh yes, I clearly remember the situation. I must have been about 8 years old or so. I was forced to participate in a Christmas play at school. It was just terrible.
I:	Can you tell me a bit more about what happened?
J:	Well, it's hard to talk about it even now. I get all anxious and stressed out just thinking about that day.
I:	I understand this must be distressing. Why don't you tell me what happened?

J: Hmmm. . . . I had a tiny role—just a couple of lines. I remember that I was obsessively practicing my lines for weeks and weeks, and I couldn't sleep in the nights leading up to the play. I had this ridiculous feeling I still have today: "How is it that everybody is excited about things like a play, or parties, and I just hate them so much?"

I: Did you try to get out of it?

J: Absolutely! On the day of the play, I felt sick to my stomach. Surely, it was all anxiety. I get the same feelings today.

I: I see. What other symptoms did you have?

J: I felt like my mind was wiped clean, and I couldn't remember a single word of what I had to say. Obliviously, my parents pushed me to go. The next thing I remember was walking on stage. God, I remember how the light felt so bright, and I felt like everybody in the audience stared at me and could see in my stupid face how terrified I was.

I: What happened next?

J: Hmmm. . . . I felt that my legs were wobbly and I couldn't move. My heart was beating like crazy, and I could feel the sweat running down my face. While I was waiting to say my line, my vision started to become blurry, you know, as if I would pass out any minute. Not only that—I was truly convinced that I would throw up or start crying. God, it was just pathetic. . . . When it was my turn, I heard myself saying the first lines, and then I remember nothing. I really felt as if I blanked. The next thing I remember was that I was walking off stage.

I: What happened then?

J: Well, I remember that I felt overwhelmed by relief, and at the same time I felt like the biggest idiot and failure.

I: I understand that you must have felt really awful in this moment. Did the event affect your performance at school?

J: I think it made everything worse. I totally started to withdraw from everything.

I: What do you mean by that?

J: Well, for example, in class I never raised my hand, and I was terrified that the teachers would call on me. I was sure all my classmates thought I was weird. It's funny—even today I am convinced most people think that. I guess that is why I never really had many friends. I just can't trust anyone. . . .

I: Does this issue of not trusting others affect other areas of your life?

J: Sure it does. It happens at work just like it did in school. The worst thing is talking to my colleagues, since I always feel that I say stupid things, and they only talk to me because they pity me.

I: Can you give me an example?

J: Well, last week there was a little gathering at the office. I dread these occasions and usually try to get out of them if I can. Everybody was standing around chatting, and one of my colleagues walked over to me and asked me if I had a nice weekend. I just nodded stupidly and turned all red. Before I could even get out a word, she was already talking to someone else.

I: And what happened afterwards?

J: Usually, I end up dwelling on these things, sometimes for weeks. I'd call myself names and beat myself up for acting stupidly. I sometimes create these fictional scenarios where I actually say and do what I should have. . . .

I: Do you think that this affects your performance at work?

J: Well, that's why I am here. I am sure sooner or later I will get laid off because of it.

I: What do you mean by "because of it"?

J: I can't do the work I would like to do because I am terrified to interact with others. I am sure that my bosses only assign me writing tasks because I am incapable of talking with customers. The problem is, I can't even concentrate on the writing task because I am constantly dwelling on what other people may think or say about me.

I: Mm-hmm. . . . I understand. Are there other situations that make you feel that same way?

J: Well, basically any situation where I have to interact with people. Even little things like ordering coffee are ridiculously hard for me. . . . I stumble over words and just feel awkward. It happens all the time that people have to ask me twice what I want because I simply can't speak up. That's why it's better for me to just not get into those situations.

I: And are there any other situations that you avoid or that would cause you great fear or anxiety to get into?

J: Any kind of social gathering: parties, private invitations, sometimes even family events. Can you imagine, I even started to avoid answering the phone.

I: Do you believe that your fear and anxiety in social situations are excessive or unreasonable?

J: Well, I know it is excessive; that's the whole problem. Everyone else is so much calmer and more competent than I am. I guess deep inside I know that I should not be so anxious about what other people think about me, but I just can't help it.

John was diagnosed with generalized social phobia and was offered individual cognitive-behavioral therapy (CBT). The information gathered during the ADIS-IV-L (DiNardo et al., 1994) suggested that he met criteria for a generalized subtype of social phobia. For example, he reported *experiencing exaggerated and persistent fear in multiple social situations,* such as work gatherings and private invitations (Criterion A). He further reported that he holds a strong *belief that people judge him* as being an awkward, incompetent person (Criterion A) and stated that his fears in these situations trigger *strong physical symptoms* such as heart racing and shakiness (Criterion B). The clinician's impression was that John has *insight* into the excessiveness of his fear of social judgment (Criterion C) and that he tries to *avoid social interactions or situations* or endures them with *great distress* when confronted unexpectedly or forced (Criterion D). John's description of his problem suggested that his *life is greatly impaired* in that he feels isolated, he has difficulty trusting others, and his work and social life have suffered (Criterion E). The specifier of *generalized* social phobia was given because of his *fear and avoidance of most types of social interaction* (as opposed to fear and avoidance limited to a specific domain such as public speaking).

Multicultural and Diversity Issues

Researchers have encountered social phobia in all countries in which the disorder has been studied, and it is recognized to affect people from a variety of social, cultural, and socioeconomic backgrounds. During an initial assessment, awareness of the background and life experiences of the client is essential for making a proper diagnosis and ensuring a smooth interview.

One specific example of the influence of culture on the expression of social phobia is *taijin kyofusho* (TKS), an emotional disorder that is believed to be particularly prevalent in the Japanese and Korean culture (Takahashi, 1989). A person with TKS is concerned about doing something or presenting an appearance that will offend or embarrass others. In contrast, social phobia in the Western culture is defined as the fear of embarrassing oneself. Awareness of different cultural phenomena in social phobia helps the clinician be sensitive to atypical presentations of the disorder.

Cultural norms and societal expectations can affect the presentation of social anxiety and shyness across a number of cultures (Heinrichs, Rapee, et al., 2006). For example, deferent and retiring behavior can be perceived as a weakness in Western cultures, whereas the same behavior suggests competence in China (Xinyin, Rubin, & Boshu, 1995). Thus, behaviorally inhibited people from these two cultures may have very different perceptions of their social competence. When forming clinical impressions, it is helpful to consider the presenting symptoms in the cultural context of the client.

Differing degrees of formality between assessor and client may be dictated by cultural expectations. Whereas Western attitudes may allow more collegial interactions in the assessment setting, people from some cultures (e.g., Korean, Japanese) may feel more comfortable adhering to rules of formality. Some people may be put at

ease by being on a first-name basis with the interviewer, whereas such informality may cause distress in people raised in a culture with more firmly established rules of social hierarchy. It is recommended to err on the side of formality unless the client indicates otherwise.

The client's self-disclosure is essential in the assessment interview, yet this can be difficult for many people. In some cultures, self-disclosure may be considered entirely inappropriate between two people who do not know each other well. Additionally, clients from diverse backgrounds may struggle with discussing what they consider family secrets. Establishment and maintenance of good rapport are of particular importance in interviewing these clients, and extra time may be needed for the assessment so that the client does not feel rushed while trying to reveal sensitive personal information. The clinician can help put the client at ease by acknowledging the difficulties of self-disclosure and assuring the client that such feelings are normal. We advise the clinician to emphasize that the interviewing situation differs from everyday social interactions because the purpose of the interview is to gain information about the client that will be useful in treatment. We advise reminding the client that the information he or she shares will be kept confidential, which can also help assuage some fears.

Differential Diagnosis and Behavioral Assessment

Differential Diagnoses

Social phobia has many faces, and comorbidity with other disorders is the rule rather than the exception. A report of panic attacks in the context of social anxiety is a prevalent diagnostic issue. In this case a thorough exploration of the pathogenesis of the disorder provides the most valuable information. In *social phobia,* the fear of possible scrutiny by others typically develops long before the onset of panic attacks. They are usually limited to a typical set of social situations involving evaluation by others (e.g., public speaking). For those with social phobia who experience panic attacks, major concerns are related to appearing out of control in front of others and being able to escape the situation if necessary. At the same time, people with social phobia typically avoid a range of social situations in which panic attacks never occurred.

In *panic disorder with agoraphobia,* panic attacks may also occur in social situations, but usually they are not limited to evaluative social situations. Major concerns usually are related to fainting or dying of a heart attack. Sometimes, an initial onset of unexpected panic attacks in a social situation can lead to subsequent avoidance of similar situations thought to trigger the panic attacks. This might complicate a clear diagnosis because the onset of social fear may coincide with the development of panic attacks. However, if panic attacks are not limited to specific social situations only but occur unpredictably in a variety of other situations (e.g., alone on a bridge), panic disorder with agoraphobia is the more appropriate diagnosis. If somebody meets criteria for social phobia but also experiences unexpected panic attacks in nonsocial situations, both diagnoses can be given.

Distinguishing *agoraphobia without history of panic disorder* from social phobia can be complex because both disorders may involve the fear of possible humiliation. In social phobia, this would be the main characteristic defining all feared situations, whereas agoraphobia without history of panic disorder typically involves a set of situations, some of which may or may not involve scrutiny by others.

A close examination of the reasons for social avoidance is the key to distinguishing *separation anxiety disorder* from social phobia. People with separation anxiety disorder do not fear social situations themselves. Problems arise from being separated from a needed caretaker. Consequently, social avoidance may be reinforced by feelings of embarrassment and shame when a person wants to go home early, and he or she may need a parent when it's not developmentally appropriate.

Similar to social phobia, fears of being humiliated, scrutinized, or embarrassed in a social situation may also be essential concerns in *generalized anxiety disorder.* However, the fear and worries usually permeate a much broader range of issues. If clinically significant fear of embarrassment or humiliation is present in addition to other anxieties, both disorders may be diagnosed.

Specific phobias usually are elicited by a cluster of situations featuring distinct key stimuli, such as certain objects, people, or a specific combination of them. In specific phobia, anxiety usually emerges regardless of whether evaluation is part of the situation, but this is the key element in social phobia.

Pervasive developmental disorders comprise a set of behavioral difficulties often associated with *autism.* Typical characteristics include poor social interaction and communication, social avoidance, and anxiety in new and unpredictable social situations. Milder expressions of the disorder may appear similar to social phobia. However, the ability to form meaningful relationships in social phobia is more constrained by the person's anxiety, not a lack of ability or interest in social interactions.

A lack of significant social relationships is also characteristic of *schizoid personality disorder.* This could be misinterpreted as avoidance behavior. However, the driving force is not anxiety but a lack of interest. Although some people with social phobia may lack social skills and practice to perform comfortably in social situations, they have the capacity and usually a strong interest in building social relationships with other people.

Depressed mood is characteristic for people with social phobia and often is a major motivation for seeking treatment. However, if depression is a reaction to the ongoing difficulties and limitations that accompany social phobia, it is usually possible to identify specific memories or thoughts that reinforce negative mood, such as difficult or embarrassing situations or missed opportunities. Furthermore, social avoidance can be a common characteristic in those with depression. However, people with social phobia avoid out of fear of being scrutinized and humiliated, whereas anhedonia or anergia is the reason in depression. Thus, a person with *major depression* or *dysthymic disorder* would demonstrate avoidant social behavior only during periods of low mood, whereas someone with social phobia shows more chronic patterns of social avoidance.

Other mental disorders or a *general medical condition* such as Parkinson disease, obesity, anorexia nervosa, facial disfigurement, body dysmorphic disorder, or stuttering might promote social anxiety and avoidance behavior. Caution is advised if there are signs of *substance abuse* or *substance dependence* because people with social phobia often try to alleviate anxiety and increase sociability by abusing alcohol or other substances. Primary substance abuse, on the other hand, can induce anxiety (e.g., sympathomimetics, neurostimulant bronchodilators, caffeine, corticosteroids, antivirals, or heroin) and often leads to social withdrawal. If social avoidance is clinically significant but full criteria for social phobia are not met, a diagnosis of *anxiety disorder not otherwise specified* may be considered.

Finally, *performance anxiety, stage fright,* and *shyness* are common phenomena, especially in new and unfamiliar situations or when there is a risk of being scrutinized. The cutoff for clinical significance is not easy to define and may vary individually over time. A diagnosis of social phobia should be made only if the symptoms cause significant emotional distress (e.g., fear and avoidance) or functional impairment (e.g., questioning the ability to accomplish social, educational, or professional goals). Shyness when encountering new people, objects, or events (also called behavioral inhibition) and self-consciousness are discussed as precursors of social phobia during childhood. Therefore, exploring the pathogenesis may provide valuable information to corroborate the diagnosis for an adult.

Behavioral Assessment

Behavioral assessment can provide unique supplemental information to subjective reports, questionnaire data, and measures of psychophysiological reactivity. Its primary focus is on overt motoric behavior, such as entering feared social situations, degree of eye contact with an audience or individual cohort, or frequency and duration of pauses in a conversation. This section provides an overview of general principles and examples to help the practitioner create an optimal assessment strategy for people with social phobia.

One major concern in the assessment of behavior is the need to increase the reliability of the measurement. In this pursuit, a precise definition of the behavior under observation is crucial. Straightforward criteria such as "duration of a speech" and "frequency of eye contact" allow objective quantification (Hofmann, Gerlach, Wender, & Roth, 1997).

For recurring behavior, time-based logging (i.e., counting how often certain behaviors occur during a defined time interval) or event-based logging (i.e., recording the time for every occurrence of a behavior) is possible. Although the first strategy helps with observing frequent behavior, information about the timing in relation to co-occurring behavior is lost. Event-based logging helps to uncover possible causal relationships between different behaviors. However, tracking more than three items at a time might overburden a single observer. Minimizing the number of

predefined measurement categories by differentiating them in accord with diagnostically relevant criteria improves efficiency and helps reduce the observational workload. In this context, it should be pointed out that a lack or reduction of behavior typically present in healthy people may provide even more clinically informative indicators than the presence of diagnostically distinctive characteristics. Examples include immobility (e.g., going blank when giving a speech), camouflage (e.g., blending into the background in a social gathering), or submission (e.g., avoiding confrontation, mitigation; Marks, 1987). Furthermore, generic categories such as verbal (content) versus nonverbal (paralinguistic [tone of voice, inflection, spacing of words, emphasis, and pauses] vs. proxemic-kinesic [body movement, gestures, and facial expressions]) behavior and approach versus avoidance reactions provide useful landmarks for creating concise measurement categories.

In addition to such a microanalysis of socially anxious behavior, a macro perspective on global indicators of social phobia (e.g., quality of social skills) can be implemented in a similar way (for a review, see Heinrichs, Gerlach, & Hofmann, 2006). For example, it usually yields highly reliable results to have two independent raters assess the overall impression they get about a certain person. However, one should note that this kind of assessment is susceptible to interpretation biases by the rater. A review by Scholing and Emmelkamp (1990) may supplement details about sophisticated coding systems for the analysis of different levels of behavioral specificity. Unfortunately, high reliability sometimes conflicts with the goal of increasing the validity of an assessment because naturalistic behavior in real-life settings tends to be highly unpredictable.

Self-monitoring is an option combining very high ecological validity with a reasonable level of reliability. Diaries and logbooks for recording particular behaviors are useful for homework assignments of behavior observations. Less reliable but often useful because of the instant availability of information are retrospective ratings (e.g., satisfaction with a social interaction) or estimations of the frequency of a certain behavior (e.g., cognitive restructuring, exercises completed). However, memory and self-enhancing bias are an important concern (Becker & Heimberg, 1988). To improve the validity of self-reports, for example, Mattick, Peters, and Clark (1989) interviewed patients at each treatment session about their activities, independent from data collected in a diary. Compliance can be increased by involving the patient in the decision on what, and how, to record. People with social phobia tend to avoid social situations and interpersonal interactions, which would provide the most information about their issues. Therefore, one should be alert to subtle avoidance strategies when behavior with critical therapeutic value does not occur during the scheduled observation.

Standardized behavioral measures provide a strategy to overcome this problem. The most commonly feared situation in patients with social phobia, and in the general population, is public speaking. Therefore, the most widely used behavioral test in research is to give an impromptu speech in front of a small audience (two or three people). This test shows good reliability (Beidel, Turner, Jacob, & Cooley, 1989). Also, conversations with a same- or opposite-sex partner are commonly used (McNeil, Ries, & Turk, 1995). Situations such as performing under evaluation (e.g., solving simple mathematic problems on a blackboard while two observers watch) and situations necessitating self-confident appearance (arguing against another person with the opposite opinion) are valuable variations (Hofmann, 2000a). The main advantage of standardized tests is their comparability across individuals or groups.

One consequence of standardized evaluation criteria across all applications of the test is that a behavioral goal may be too easy to accomplish for some people and therefore might be of no diagnostic value. A common way to overcome this problem is to gradually increase the difficulty within a given task (single task, multiple step). To increase the sensitivity of a behavioral test, it should be made as easy as possible to avoid while quantitatively assessing this behavior. An example of such a behavioral avoidance test would be to arrange for a signal to quickly end the situation (e.g., holding up a stop sign).

Role plays are the typical format of behavioral tests. They usually consist of a series of enactments and simulations of social situations in the therapist's office or a research laboratory. The main advantage of this setting is a high level of control over situational and procedural details. However, the assessed person is aware that the situation is artificial and may not give a typical response to, for example, a confederate's sudden

anger. Therefore, in highly structured role plays, confederates typically respond only minimally to keep the focus on the patient. The test usually lasts for a predetermined period of time (2–5 minutes) and targets one particular issue.

Standardized role play assessments are commonly used in research settings because of their high comparability and provide information for comparing an individual to representative data. One example is the Simulated Social Interaction Test (Curran, 1982; Curran et al., 1980). This test has been shown to have substantial discriminative validity, high test-retest reliability, good interrater reliability, good generalizability, and sensitivity to treatment change (Mersch, Breukers, & Emmelkamp, 1992). However, it is designed only for use with male subjects. Furthermore, Mersch et al. (1992) question the convergent validity of the test because of low correlations with other supposed measures of the same construct. Other standardized role play tests developed for research include the Taped Situation Test (Rehm & Marston, 1968), the Dating Behavior Assessment Test (Glass, Gottman, & Shmurak, 1976), and the Heterosocial Assessment Test (Perri & Richards, 1979).

Extended role plays are more realistic and individualized, but this increases the amount of idiosyncratic and unplanned interactions. The Social Interaction Test (Trower, Bryant, & Argyle, 1978) is an example that still offers a high level of standardization. It consists of three 4-minute interactions with a female and a male confederate. They are unaware of the conversation topic, but briefings, instructions, situational setting, and verbal and nonverbal behavior of the confederates are standardized. Usually, an independent judge and the confederates evaluate videotapes of the interactions (ratings of behavioral components and general impression ratings on 13 bipolar adjective scales) and write behavioral descriptions for the two general impressions considered most faulty. Gershenson and Morrison (1988) report details about psychometric characteristics, suggesting adequate reliability across different raters (e.g., lay vs. professional raters) and conversation topics, given appropriate training of the raters. Trower (1980) and Beidel, Turner, and Dancu (1985) provide support for convergent validity with clinical judgments of social skill deficits.

Individualized role play assessments allow a test to be optimized for specific individuals. Barlow and Hersen (1984) provide detailed guidelines on how to construct such a test.

Altogether, behavioral tests have been shown to provide unique, reliable, and valid information for diagnosis and therapy of social phobia when applied appropriately. Self-monitoring and retrospective behavior ratings of the patient are especially useful for gathering information about behavior in real-life situations. Standardized tests and their individualized adaptations are necessary to examine situations that tend to be avoided. In their most common form, as role plays, behavioral tests can conveniently integrate diagnostic and therapeutic goals because they are a core element of most contemporary cognitive-behavioral programs for the treatment of social phobia (Heimberg & Becker, 2002).

Selection of Treatment Targets and Referral

For the clinician, the assessment interview serves the purpose of gathering information necessary to make a diagnosis and identifying factors that may be of clinical relevance during treatment. For the client, the assessment often is merely a necessary first step in pursuing treatment, so he or she may be eager to discuss treatment options at the end of the assessment. This stage of the interview should include both selection of treatment targets and a dialogue about the different options available to the client. It is important to listen carefully to the client's needs and preferences and to work collaboratively to arrive at a treatment approach that is acceptable to client and that the clinician thinks will adequately address the identified problems.

For the many clients who present with comorbid disorders, the first step is to identify the primary problem that will form the main focus of treatment. In beginning this discussion, we recommend that the clinician provide an overview of the findings from the diagnostic interview and asks the client what he or she would like to address first in treatment. The patient usually can identify the problem he or she finds most distressing or impairing. Often, this problem will make a good primary treatment target because the patient is already motivated to address it. However, clinical judgment is advised in considering the feasibility of the patient's decision. Sometimes, for example,

a comorbid disorder may interfere with the client's ability to successfully address his or her desired treatment target (e.g., treatment of social phobia may be hampered if the client clearly struggles with fatigue and amotivation caused by a major depressive episode).

The second step in selecting treatment targets is a discussion of the patient's goals (i.e., the major changes the patient would like to achieve during treatment). The patient may identify both specific goals, such as being able to give a presentation for a class, and more general goals, such as feeling more comfortable while interacting with strangers. The process of identifying treatment goals can help clarify for the client his or her reasons for pursuing treatment and can also be informative as the discussion turns to selection of a specific treatment approach.

Overview and Comparison of Treatment Options

Selective serotonin reuptake inhibitors (SSRIs) often are considered the first-line pharmacological treatment, although practitioners have also used benzodiazepines, beta blockers, monoamine oxidase inhibitors (MAOIs), and atypical antidepressants to treat social phobia, with varying degrees of success (for a thorough review, see Blanco, Schneier, & Liebowitz, 2001). CBT is the most widely supported psychological treatment approach for social phobia. It has demonstrated superior efficacy over nonspecific treatments such as support groups (Heimberg et al., 1990; Heimberg et al., 1994). More recent studies suggest that CBT is mediated through changes in maladaptive cognitions that are specific to the feared social situations (Hofmann, 2004). CBT often involves the combination of several cognitive and behavioral interventions, including psychoeducation, cognitive restructuring, exposure therapy, and possibly social skill training and relaxation training. This form of therapy can be administered individually or in a group setting.

Several meta-analyses have been conducted comparing the efficacy of pharmacological and psychological treatments for social phobia. These analyses suggest that treatments incorporating various aspects of CBT are largely efficacious in producing lasting improvements in social phobia symptoms (Taylor, 1996). One meta-analysis comparing CBT with pharmacotherapy found the two to be roughly equivalent on the whole but with much heterogeneity in the effectiveness of pharmacological treatments (Gould, Buckminster, Pollack, Otto, & Yap, 1997). Specifically, SSRI treatments were found to be significantly more efficacious than other treatments (both pharmacological and psychological), and treatment with beta blockers was not helpful. Use of MAOIs and benzodiazepines was equivalent to treatment with CBT. Studies that combined CBT components with non-SSRI medications fared slightly worse than treatment with either modality alone.

Research suggests that pharmacotherapy and CBT are equivalent in patient tolerability, with dropout rates averaging 10% for CBT and 14% for pharmacotherapy (Gould et al., 1997). However, the reasons for premature termination of treatment vary across these two modalities. Unpleasant side effects are a common cause for dropout with pharmacological treatments, and some people feel uncomfortable with the idea of relying on a medication to address psychological problems. Sometimes, a desire to remain medication-free can be the impetus for the patient to seek CBT, and a lack of time or motivation can lead to early termination.

Factors to Consider in Treatment Selection

Selection of any particular treatment approach for social phobia depends on a number of factors, such as the patient's expectations and commitment to treatment, the acceptability of different approaches to the patient, and his or her specific history and symptom profile. Many different options are available, including combinations of multiple approaches, so clinician and client should be able to decide on a treatment that is acceptable to the patient and that will properly address his or her specific needs.

With regard to treatment acceptability, the clinician should be mindful of any biases the patient has toward the different approaches. Some patients may reject the idea of pharmacotherapy, for example, out of fear of becoming dependent on medications. Others may feel too intimidated by the prospect of seeing a psychotherapist regularly to discuss difficult problems and may see medication as an easy alternative. In considering the client's preferences, it is important to dispel any misconceptions in order to help him or her make a fully informed decision. Sometimes the client can be persuaded to try a potentially helpful approach after receiving accurate information

about what can be expected from the treatment. On the other hand, it can be detrimental for the clinician to push one particular treatment option if the patient is highly resistant to it.

CBT often is the treatment of choice for social phobia because it has demonstrated efficacy even long after termination (Heimberg, Salzman, Holt, & Blendell, 1993), whereas pharmacotherapy typically is effective only for the duration of use, and relapse rates are high after discontinuation (Gelernter et al., 1991). However, client motivation is a key component to the success of CBT. A good candidate for this therapeutic approach should feel committed to seeing a therapist regularly and should have the time and motivation to engage fully in homework assignments in order to benefit from treatment. If the patient is not sufficiently motivated to invest the time and effort necessary to make CBT work, pharmacotherapy is the more viable option.

CBT should be tailored to the patient's needs, such that individual treatment components are included to address specific areas of difficulty. Almost all CBT approaches for social phobia include some elements of psychoeducation, cognitive restructuring, and exposure therapy. Relaxation training is recommended when the patient has marked difficulties with physiological reactions to anxiety, and social skill training can be helpful when deficits in social skills are a major contributing factor to the patient's anxiety.

Group CBT for social phobia carries several advantages, such as numerous opportunities for spontaneous social interaction between group members, a supply of willing people to act as cohorts during in-session exposures, and a collaborative and supportive therapeutic environment. However, we do not recommend this approach for patients with severe social phobia, who may feel uncomfortable participating in a group. Additionally, patients with more atypical presentations of the disorder (e.g., those whose primary concerns are eating or writing in public) may be inappropriate for group treatment. Such patients may not be able to identify with the problems of others in the group, and excessive heterogeneity within a group can be an unnecessary burden on the therapist.

When selecting a treatment approach, we recommend that the clinician be attentive to client expectations. It is important that the client feel optimistic about the treatment he or she wishes to pursue, which can increase motivation and commitment. On the other hand, the clinician should manage the patient's expectations so he or she is realistic about what changes the treatment can bring. An open discussion about what can be reasonably expected from treatment can be very helpful in this regard.

One final, important consideration in selection of a treatment approach is the patient's previous treatment history. Here, it is necessary to ask what treatment the patient has had in the past and how beneficial it was. Disappointment over previous attempts can make a patient wary about pursuing the same type of treatment, but a discussion about factors that may have led to nonresponse can help determine whether another attempt under different circumstances may be more successful.

Summary

Social phobia (social anxiety disorder) is the most common anxiety disorder and the third most common mental disorder in the population. The interpersonal nature of the interview presents a number of unique problems for this population. In this chapter, we outlined specific strategies for dealing with these issues. Advantages and disadvantages of structured and unstructured interviews, open-ended and closed-ended questions, and issues closely linked to social phobia, such as the fears of interacting with strangers and authority figures, social skill deficits, and problems with assertiveness, were discussed and illustrated with case examples. The chapter emphasized the importance of the client's cultural background, diversity issues, and differential diagnoses. We concluded with a brief review of behavioral assessment techniques and the selection of treatment targets and referrals.

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16

POSTTRAUMATIC STRESS DISORDER

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DESCRIPTION OF THE DISORDER

Although posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000) was not formally recognized as a disorder per se until 1980, it is today considered one of the most serious and disabling anxiety disorders (Rosqvist, 2005). PTSD, or trauma and various stress reactions, is certainly not a new concept; in fact, the notion that people may experience psychological difficulties after exposure to traumatic situations has an extremely long history (Breslau, Peterson, Kessler, & Schultz, 1999; Finkelhor, Hotaling, Lewis, & Smith, 1990; Norris, 1992; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993).

Early literature is littered with references to problematic psychological sequelae that may follow threatening or harmful events. Andrews et al. (2003) point out that even in Homer's *Iliad,* nearly three thousand years ago, suggestions were made about "psychological problems following a traumatic experience" (p. 465). Later writers and philosophers (e.g., Shakespeare) are also known to have alluded to a particular set of symptoms that today we call PTSD or acute stress disorder (ASD; American Psychiatric Association, 2000). Although both PTSD and ASD are driven by trauma, the central difference between the two trauma-related anxiety disorders is that ASD occurs soon after trauma, whereas PTSD occurs after a delay of at least a month (Rassin, 2005). Nonetheless, recent history, such as the American Civil War and World War I, also produced such early but not formally organized descriptions of these phenomena as *shell shock* and *battle or combat fatigue.* Fortunately, for many people with symptoms of PTSD, such problems subside with time, but some need formal intervention to achieve true relief. Although exposure to threatening or harmful life events is common, not everyone who is exposed to a potentially traumatic experience develops problems; indeed, PTSD lifetime prevalence rates are about 5% to 10%. Yet, importantly, high social costs are associated with the course and impact of PTSD ($3 billion per year from absenteeism and reduced productivity and disability) (McLean & Woody, 2001).

Indeed, anyone who has experienced a serious car accident, been the unfortunate victim of an assault, seen combat or war, or has found himself or herself in the midst of a natural disaster probably already understands that threatening experiences can be difficult to cope with in the moment. Nonetheless, most people somehow manage it. However, people may know substantially less about how to integrate such events and experiences into their own existing world view of presumed safety. Although most people probably do not have unrealistic views of just

how safe our world is, most probably do not leave their homes each day with the expectation of encountering death and mayhem. Instead, most people appreciate the world as a place of relative safety where they are unlikely to be harmed, but they also probably acknowledge that chance exists (i.e., bad luck, though a statistical anomaly, does happen). Most probably also appreciate that there are things people can do to increase their odds of more favorable or positive daily experiences (e.g., do not drink and drive). Thus, on most days people assume that it will be just another uneventful day.

Although it is characterized by various symptoms, PTSD is perhaps best known for its effect on memory and the effect of troubling memories of past traumatic events on one's ability to live a productive and effective life in the present. This particular aspect of the disorder consists of intrusive thoughts and memories of the event and sometimes outright flashbacks to the event or dissociation from reality, to such an extent that the person feels as if the trauma is happening again, in the present. Continued perceptions of danger and harm often lead to extremely high arousal and flight responses in which the person experiencing flashbacks or disturbing memories may have a panic attack, flee, or display other signs of extreme fear, such as freezing and dissociating. Such people often go out of their way to prevent either the experience or the associated symptoms from recurring, so they often avoid both actively (e.g., avoiding physical locations, people, situations) and passively (e.g., through autonomic responses, such as feeling numb or being dissociative). Additionally, when people are aroused to this extreme level, it is often difficult to be attentive, display normal affect regulation, make basic decisions, and effectively engage in normal, everyday restorative behaviors (e.g., sleep). Over time, especially without formal treatment, PTSD worsens, making it increasingly difficult to function normally. Gross disability in all aspects of life is not unusual in patients with chronic, untreated PTSD.

The first formal criterion (Criterion A) for a diagnosis of PTSD is the experience of a traumatic event. This criterion is controversial in that authorities on the topic cannot seem to agree on a definition of *traumatizing*. It is important to note that *perception* of threat is actually a better predictor of PTSD than actual physical injury (Taylor, 2004), which leaves open the question of cause and effect in the development of PTSD. After all, if all car accident victims automatically developed PTSD, as is not the case, then mental health clinics around the world could not possibly meet treatment demands of the sheer masses of people who presented with PTSD. Something else, beyond a threatening or harmful event, contributes to the development of PTSD. Especially in cases of litigation over injury and suffering, this can lead to accusations of malingering or the faking of symptoms or at least the suggestion that the problem is all in the victim's mind, which is undeniably true in that all psychological phenomena are psychologically derived.

The remaining three criteria are less controversial and more at the root of what practitioners actually set out to treat patients for (i.e., they cannot change that certain events have happened, but they can influence the most common problem sequelae). Criterion B is the "reliving cluster" of symptoms, which commonly consists of such things as negative, intrusive memories, intrusive images and other perceptions (e.g., smells, sounds), negative dreams and nightmares about the event, and actual flashbacks. The central tenet of this reexperiencing criterion is its invasive nature. It is not sufficient to simply ruminate or think a lot about the event; the intrusions must have an involuntary, uncontrollable quality to them whereby the sufferer cannot push these recollections away or turn them off. Researchers suggest that images are more common in PTSD than thoughts per se or lexical cognitions (Ehlers, & Steil, 1995; Ehlers et al., 2002). Others (de Silva & Marks, 1998) report that intrusive thoughts do not necessarily have to be about the event per se but can instead be questions about the event or questions based on the event and typically fall into three domains: threat and danger (e.g., "Am I safe?"), negative thoughts about the self (e.g., "Am I a bad person?"), and thoughts about the meaning of the event (e.g., "Why did this happen to me?"). Criterion C's central feature is in its focus on avoidance, whether voluntary or involuntary, of stimuli associated with the traumatic event. Classically, this criterion is marked by physical avoidance of locations, circumstances and activities, thoughts and feelings, and people that somehow would remind the person of traumatic events (e.g., avoiding driving or being a passenger in a car by someone who developed PTSD after a car wreck). This criterion also includes involuntary avoidance, such as numbing

of general responsiveness to one's surroundings and internal world, so that sufferers "feel nothing," as much as that is humanly possible. Broadly, this often leads people to progressively restrict their lives to avoid recurrence of painful memories, which could be triggered by something as simple as a conversation with another person. Some may also begin to avoid things that trigger such memories (e.g., tall men with long hair, or who wear particular cologne, because of similarities to a perpetrator's characteristics or behavior). Criterion D is thought of as an arousal cluster of problems, with difficulty sleeping (often caused by nightmares), irritability or anger (often a side effect of hypervigilance), concentration difficulties, extensive vigilance, and exaggerated startle reflexes being most typical of the problem. This criterion is focused mostly on an overall and substantially increased arousal that is linked closely to hypervigilance.

The complete diagnosis of PTSD also includes criteria about duration (the disturbance must have lasted at least 1 month), and the aforementioned clusters must cause significant clinical impairment and personal distress to a degree that interferes with personal, social, occupational, and other important areas of life functioning. In fact, most people with PTSD do not function well in most life venues, and their impairment often is at the level of true disability.

Interviewing Strategies

Assessment of traumatic experience and its psychological consequences can be a difficult and complex process that involves consideration of multiple components as an integrated part of the interview. Although the scope of the interview may vary depending on the goals of the clinician (Keane & Barlow, 2002), getting detailed information may be particularly helpful in elucidating the client's unique experience and provide important information for treatment planning. During the interview, it is important for the clinician to be aware of his or her own emotional responses as the client describes his or her experience. It is critical for the clinician not to display discomfort or avoid asking questions about difficult traumatic experience because doing so may reinforce the client's avoidance behavior or even may confirm that such traumatic experience is unacceptable to discuss (Orsillo, Batten, & Hammond, 2001). Therefore, the interviewer needs to become familiar with terms and phrases used in the interview and practice talking about sensitive topics (Rheingold & Acierno, 2003).

Right from the beginning of the interview it is imperative to exhibit empathetic listening skills and create a nonjudgmental atmosphere. Each interview should begin with an overview of what will take place. This will help create a supportive environment and may reduce the client's anxiety or discomfort. During the overview it is particularly important to acknowledge that talking about a traumatic experience and its consequences can be distressing, and therefore it is understandable that the client might want to avoid talking about the experience (Flack, Litz, & Keane, 1998). Furthermore, it is critical to explain why talking about the event and its consequences is an important step in determining the right treatment. Finally, it is important to be aware of that many trauma survivors suffer from chronic pain caused by injuries sustained during the event (Blanchard & Hickling, 2003). This may make it difficult for the client to endure sitting through an interview. Therefore, it may be helpful to allow the client to take breaks or make other arrangements that will make the assessment less physically strenuous.

Indeed, providing a brief overview of the interview process and acknowledging potential feelings patients may experience may facilitate a more thorough and complete interview. Such preambles and disclosures can ensure that patients are aware that information collected during the interview and assessment is central to proper diagnosis, assessment, treatment planning, and treatment. As stated previously, the understandable and common desire to avoid discussing traumatic experiences in detail may indeed produce incomplete responses, so an overview statement can be helpful. The following is a sample of an opening comment to someone who is being evaluated for PTSD and its treatment:

> Today I will be asking you many questions about events and circumstances that may be quite uncomfortable for you to talk about at length or in detail. Although it is possible that these questions may feel intrusive and unpleasant, I need to ask them to get as complete a picture, or understanding, as is possible about what has been going on for you lately and about the kinds

of things that have happened to you in the recent and distant past. I ask these questions because it is important for me to recognize all the areas that go into figuring out a meaningful plan to help you deal with the problems that bring you here today. I appreciate that some of these questions may make you feel anxious, or they may be difficult to talk about, but perhaps we can examine some ways of coping while we talk about these challenging topics so that you can manage such distressing feelings during and after this interview. I want to be absolutely sure that you know that ultimately the depth and details of the topics are up to you, and you should also know that we can go at whatever pace feels most tolerable to you. Please do not hesitate to tell me if you want to take a break, get something to drink, or use the restroom; again, while I ask these questions, I am ultimately interested in making sure you are as comfortable as you can be while I get to understand your experiences and concerns. Do you have any questions for me, or is there anything you would like to say before I begin to ask you some questions?

Overviews such as this help patients understand what will happen during the interview, and they can defuse much anticipatory anxiety and stress. Additionally, normalizing avoidance and anxiety responses is important and sets a supportive tone in which patients may feel safer to discuss challenging topics. After providing an overview of the interview, the clinician can move on to gathering information about the trauma event and its consequences. It will be particularly important to assess each of the four major areas: Trauma characteristics (Criterion A), history of other potentially traumatic experiences, 17 symptoms of PTSD, and other potential comorbid diagnoses (Resnick, Kilpatrick, & Lipovsky, 1991; Resick & Calhoun, 2001). Often it is helpful to start the assessment by asking the client to describe what led him or her to seek help. Starting out with an open-ended question not only provides important information about the client's main concern but also may give the interviewer an idea of the client's willingness to talk about the event and its consequences. Furthermore, this will allow the clinician to move logically into more detailed questions about characteristics of the event and individual responses to the trauma. This is necessary both to determine whether the event meets Criterion A for PTSD and to identify possible factors that may predict the severity of posttraumatic symptoms (Resnick et al., 1991).

Numerous studies have documented that people often have a complex trauma history that may include diverse traumatic events such as serous accidents, physical assault, and rape. Therefore, it is essential to identify the trauma associated with the reported posttraumatic symptoms. Furthermore, a person with a complex trauma history may report a very different symptoms than a person with less extensive history (Resnick et al., 1991). Research has shown that the method selected to assess for prior trauma history may have great impact on the accuracy of what is reported (Keane, Weathers, & Foa, 2000). In particular, research has shown that survivors of different, potentially traumatic events often fail to disclose their experience when not asked directly. For example, it is certainly possible that trauma survivors choose not to disclose, but after rape it may certainly be possible for a woman to deny the event out of feelings of shame or self-blame, and she may not use the term *rape* to describe forcible sex perpetrated by a husband (Kilpatrick, 1983). Therefore, using behaviorally specific questions that leave little room for interpretation rather than unspecified subjective words or constructs provides more accurate assessment of prior potential trauma history. For example, one way to identify a history of rape using a behaviorally descriptive prompt might be asking, "Has a man or a boy ever made you have sex by using force or threatening to harm you or someone close to you? Just so there is no mistake, by sex we mean putting a penis in your vagina" (Resnick, Falsetti, Kilpatrick, & Freedy, 1996). During assessment of past trauma history it may be helpful for the interviewer to start with questions about noninterpersonal events and then gradually move into more sensitive events such as interpersonal crimes (Resick & Calhoun, 2001). In addition to asking whether a particular event has happened, it is necessary to follow up by asking about emotional responses to the event (i.e., whether the event meets Criterion A). This will allow the interviewer to determine whether further information is needed about the event and its impact on the client.

After a traumatic event that meets Criterion A is identified, an assessment of PTSD symptoms is in order. This should include evaluating each of

the three symptom clusters of PTSD reviewed earlier. For each of the 17 symptoms it is necessary to determine whether the symptom is present after a specific traumatic event and to find out the frequency and intensity of each symptom. Finally, an assessment of how long the symptoms have been present is needed to determine whether the criterion for PTSD is met. During the evaluation of posttraumatic symptoms and throughout the assessment it is beneficial to pay attention to the client's report of situations he or she is avoiding and those that trigger upsetting memories of the event. Getting behavioral descriptions of how the client copes with these memories can be particularly helpful in understanding how the traumatic event is interfering with his or her life and what needs to be targeted in treatment. Additionally, an inquiry about several environmental factors should be made because they may influence the development or maintenance of PTSD. For example, social support has been identified as a strong predictor of PTSD across different populations (Brewin, Andrews, & Valentine, 2000). Also, it is important to examine other life stressors before and after the trauma and ask about family history of psychopathology and occupational adjustments that may have been made in response to the trauma (Resnick et al., 1991).

Several structured interviews have been developed to aid in the interview process. These measures have been shown to provide more reliable and valid assessment of PTSD. Furthermore, their use may improve treatment planning (Litz & Weathers, 1994), and therefore their use is highly recommended. Because space is limited, only a few of these assessment tools are reviewed in this chapter. The tools reviewed here are well established and have good psychometric properties. Broader overviews of measures can be found in Orsillo (2001) and Keane and Barlow (2002).

One of the most widely used and perhaps the most comprehensive diagnostic tools for PTSD is the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990). The CAPS is a structured interview that assesses all the 17 symptoms of PTSD and common associated features. An important aspect of the CAPS is that it assesses frequency and severity of each symptom using behaviorally anchored questions and scales. Additionally, the CAPS contains standardized questions assessing subjective distress, impairment in social functioning, and impairment in occupational or other important area of functioning caused by the PTSD symptoms. Psychometric data show that the CAPS is a sound measure of PTSD with excellent psychometric properties. The CAPS has strong support because of its good reliability and validity (Weathers, Keane, & Davidson, 2001) and has been shown to be sensitive to the detection of PTSD across different clinical populations (Blanchard et al., 1996; Mueser et al., 2001).

Another widely used and well-established structured interview to assess PTSD is the Structured Clinical Interview for *DSM-IV* (SCID-I; First, Spitzer, Gibbon, Williams, & Benjamin, 1996). In addition to PTSD, the SCID-I assesses the other Axis I and II psychiatric disorders. The PTSD module of the SCID assesses PTSD symptoms related to the most distressing event reported by the client. The SCID provides a count of numbers and results in a diagnosis. The PTSD module of the SCID appears to be both clinically sensitive and reliable. In particular, the SCID has shown excellent interrater reliability on assessment of symptoms across a variety of disorders (Skre, Onsted, Torgersen, & Kringlen, 1991; Venture, Liberman, Green, Shaner, & Mintz, 1998).

Another commonly used structured interview is the Anxiety Disorders Interview Schedule (ADIS-IV; DiNardo, Brown, & Barlow, 1994). The ADIS-IV focuses primarily on assessing the anxiety and mood disorders. The PTSD section of the ADIS-IV uses closed-ended questions to assess the 17 symptoms of PTSD. After assessment of the symptoms, a series of questions to evaluate severity of the symptoms are asked. Finally, the interviewer assigns a global rating that indicates his or her judgment of the distress and impairment associated with the disorder. The ADIS-IV is recognized as providing reliable and valid diagnoses (Blanchard, Kolb, Gerardi, Rayan, & Pallmayer, 1986; Brown, DiNardo, Lehman, & Campbell, 2001; DiNardo, Moras, Barlow, Rapee, & Brown, 1993).

In addition to structured interviews, numerous self-report questionnaires have been developed to assess posttraumatic symptoms. Although most of these measures do not provide a diagnosis of PTSD, they can be helpful screening tools to identify clients who might benefit from further assessment (Brewin, 2005). A handful of measures have identified a cutoff score to aid in identifying clients who may suffer from PTSD. Two of these measures are the Impact of Event

Scale (IES; Horowitz, Wilner, & Alvarez, 1979) and the PTSD Symptom Scale–Self-Report (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993). The IES contains 22 items that are distributed across two subscales, which assess intrusion and avoidance. Test-retest reliability is good, and the scale appears to possess sound psychometric properties (Weiss & Marmar, 1997). The PSS-SR contains 17 items, reflecting the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) symptoms of PTSD, which are rated on a three-point Likert scale and summed to yield a total score. This measure has good test-retest reliability over a 1-month interval and high internal consistency (Foa et al., 1993). A score of 39 on the IES and a 15 on the PSS-SR for crime victims (Wohlfarth, van den Brink, Winkel, & ter Smitten, 2003) and a score of 27 on the IES and 15 on the PSS-SR for motor vehicle accident survivors (Coffey, Gudmundsdottir, Beck, Palyo, & Miller, 2006) have been identified as good cutoffs to use when determining who might benefit from further assessment of PTSD.

Interviewing Obstacles and Solutions

Challenges are likely to arise during the assessment of PTSD. These problems may vary slightly based on the type of traumatic event a person has experienced. For example, if a client's presenting trauma is rape by a man, this client may have great reservation about discussing the trauma with a male therapist. In addition, if a client was knocked unconscious during the traumatic event, the client's memory of the event may be impaired. In addition to problems that are specific to the traumatic event, some difficulties are common to all types of traumatic events. For example, most people who have experienced or witnessed a traumatic incident will have trouble discussing the event simply because the event in question is distressing. Despite the potential problems that may arise in PTSD assessment, most can be handled or even eliminated when dealt with appropriately.

By definition, people who are diagnosed with PTSD have experienced or witnessed a traumatic event. Discussing the traumatic event may result in distress for both the client and the therapist. As noted earlier, creating an environment in which the client feels safe and comfortable, the therapist should follow certain steps. Establishing rapport is crucial to the assessment phase and should be a principal focus of the first session. In addition, the therapist should adequately inform the client beforehand about what the assessment will entail and be prepared to pace the interview based on the client's emotional state. Despite many therapists' fear that asking clients about traumatic events will elicit extreme distress, researchers have found that discussing the event can actually decrease psychological symptoms and increase indices of physical health (Briere, 2004; Brown & Heimberg, 2001; Petrie, Booth, Pennebaker, Davison, & Thomas, 1995). Therefore, questioning clients about traumatizing events should not be viewed as necessarily or inordinately upsetting and is actually more likely to be helpful.

Therapists may experience personal distress when assessing and treating trauma victims. Vicarious traumatization describes the transformation therapists may go through because of empathic engagement with clients' disturbing information (Pearlman & Saakvitne, 1995). With repeated exposure to vivid details of traumatic events, therapists may experience vicarious traumatization that continues to intensify if not suitably addressed (Brady, Guy, Poelstra, & Brokaw, 1999). In order to address this important concern, therapists are encouraged to seek supervision, support, and training in trauma assessment and treatment (Cunningham, 2004). In addition, researchers have found that therapists who are aware of their own personal history, maintain a regular self-care routine, and are spiritual report less distress as a result of working with trauma victims (Cunningham, 2004).

Traumatized clients are also likely to avoid answering questions or discussing topics related to the traumatic event, making it difficult to gather sufficient, important information relating to the trauma. Avoidance may present as emotional or cognitive suppression, denial, dissociation, distraction techniques, or memory impairment (Briere, 2004). For example, client who has experienced a motor vehicle accident may deny having bad dreams at night, may not remember important aspects of the accident, may dissociate when asked about the trauma or when retelling the story, may suppress emotions regarding the accident, and may avoid thinking about the accident by sleeping all day. These may all be symptoms of avoidance; however, particularly in accidents or more profound physical injury scenarios, it is crucial to sufficiently rule

out undiagnosed head injury, which could well masquerade as some psychological symptoms (e.g., forgetfulness, dissociativeness).

Such denial or avoidance often results in the posttraumatic symptoms being less obvious during the assessment, which may result in difficulty in diagnosis. Unfortunately, underreporting and avoidance are difficult to identify through psychological tests. At present, therapists are limited to reliance on validity scales that measure defensiveness or a desire to look good (Briere, 2004). These scales are likely to identify extreme cases of underreporting; however, they are less likely to detect subtle attempts at underreporting or avoidance. The therapist therefore should not automatically rule out the possibility that a client has experienced or witnessed a traumatic event. This is not to suggest that therapists should assume that a client who denies a trauma history is simply "repressing" the event and instead is meant to remind therapists to consider this as a potential hypothesis.

In addition to the intentional denial or underreporting of a specific traumatic event, it is also plausible that the client can truthfully not remember the event in question. The client may have been unconscious during the event and, as a result, have little or no memory of the details of the event. For example, the client may have hit his or her head during a car accident and been knocked unconscious, or perhaps the client was drugged and then raped. Little research has been done on how this may affect the development of PTSD; however, beginning research suggests that PTSD and other psychiatric problems are as common in those who were briefly unconscious as in those who were conscious (Mayou, Black, & Bryant, 2000). In these situations, clinicians should do as much as they can to ensure that their inquiries and interventions do not persuade or elicit false reports (Briere, 2004). Gathering information from other sources may also prove beneficial in such situations.

In contrast to underreporting, forgetting, or denying traumatic events or symptoms, some clients may unintentionally misrepresent trauma histories or trauma-related symptoms (Briere, 2004). This may occur in the context of a severe personality disorder or psychosis; for instance, severe child abuse has been linked to borderline personality disorder and with some psychotic presentations (Briere, 2004). Such information therefore should not be discounted immediately and instead, like all other information gained during an assessment, critically evaluated for the credibility of the report.

Although it is not as common, overreporting may also occur as part of a factitious disorder, in which the client may feel driven to report nonexistent traumatic events as a result of the psychological disorder (Briere, 2004). In addition, there may be a financial motivation for some trauma histories and trauma symptoms. This is especially true for forensic evaluations. A proficient forensic evaluation should always consider the possibility of malingering (Simon, 1995). Similar to underreporting, overreporting or the misrepresentation of a trauma history or trauma symptoms is difficult to assess. Overreporting may also be detected through the use of validity scale scores; however, researchers have found that people who genuinely experience distress and have been exposed to child sexual abuse, combat, or other traumas often score more deviantly on such validity scales, thereby reducing the utility of such scales with trauma victims (Briere, 2004; Elhai, Ruggiero, Frueh, Beckham, & Gold, 2002; Flitter, Elhai, & Gold, 2003).

Case Illustrations

The two case examples in this section show the diversity of symptoms and problems reported by people who have experienced traumatic events. Although both cases share similar features of PTSD, their presentations are different. Both the nature of the traumatic event and other related factors will play a role in how these cases are conceptualized and what treatment is selected.

Case 1

Anna is a 35-year-old married female homemaker who presented with complaints of anxiety, depression, and low motivation. According to Anna, these symptoms had been bothering her on and off since she was a sexually abused as a child. Anna reported that a 15-year-old neighborhood boy and family friend would come to her house, open his pants, and force her to touch his penis and bring him to climax. She denied vaginal or anal penetration. The abuse happened repeatedly over 1 year when she was around 9 years of age. Anna reported having been constantly fearful of the perpetrator and what might

happen if her father found out about the abuse. The abuse ended after a disclosure to a female teenage friend who confronted the perpetrator. According to Anna, her symptoms escalated significantly a year before she sought therapy. She reported that two events led to the increased symptoms: One of her daughters turned the same age that she was when the abuse occurred, and she saw the perpetrator again when visiting her hometown. Anna stated that she had been hiding from her "big secret" for years, and it was not until she became overly concerned about her daughter's safety that she realized how much it was interfering with her life. Anna reported frequent intrusive thoughts about the abuse. These memories were distressing to her and were daily triggers for physical symptoms, such as accelerated heart rate, sweaty palms, and queasiness. Anna stated that she tried to stay busy to distract herself from these memories, but when that did not work she would go to sleep to get away from the memories. Also, Anna reported that she tried to avoid men who reminded her of the perpetrator. Anna stated that she often felt distant from people and felt unable to feel loving toward her family. Furthermore, she reported increased irritability and anger without being able to identify the source of the emotions. Anna commented that she often had difficulty concentrating and felt as if she had to be on guard constantly. She denied having difficulty sleeping at night but usually woke up feeling unrested. Anna described frequent panic attacks that were generally triggered by trauma reminders (e.g., seeing a man who looked like the perpetrator, hearing about an assault on the news, the smell of sweat, sexual relations with her husband), but sometimes they appeared to come out of the blue. As a result of these panic attacks she reported sometimes avoiding situations in which she had experienced panic in the past (e.g., a local shopping center, being intimate with her husband). Anna also reported feeling significantly depressed mood and loss of interest in most activities that she used to enjoy. Along with the depressed mood she reported loss of appetite, energy, and motivation. Anna denied suicidal ideations but reported feelings of worthlessness. As a result of her low motivation, Anna was having a hard time getting things done at home. Anna reported good support from her husband and their four daughters. In particular, her husband tried to help her around the house and drove the children to different activities. However, she stated that over the past year her symptoms had increasingly started to interfere with intimacy with her husband. Anna denied experiencing other past traumas. Anna stated that over the years she had on two different occasions sought treatment for anxiety and depression but never disclosed the abuse. Although Anna found therapy to be helpful, she stated that she knew that she needed to address her "big secret" to feel better. Anna's score on the IES was 47.

Case 2

Loren is a 36-year-old woman who lives with her second husband and a teenage son from her first marriage. Loren presented with significant symptoms of fear and avoidance after a motor vehicle accident that happened 2 years before she sought treatment. Loren was on her way home from work on a rainy afternoon when the accident happened. She was stopped at an intersection when she looked in her rear-view mirror and noticed a car approaching fast. Seconds later she felt the impact as the car rear-ended her. As a result of the impact, Loren's car was thrown into a spin, hit a barrier wall, and came to a stop. Loren was trapped in the car for some time before a rescue team was able to get her out using the "jaws of life." She reported believing that she was going to die. Loren was taken to a hospital, where she was examined and allowed to go home. As a result of her accident, Loren suffered two herniated disks and a tear in her lower back. Because of her injuries Loren has not been able to return to work as a full-time counselor. At the time of the interview, Loren reported severe physical pain due to her injuries and was taking medications to help manage her pain. In addition to the car accident, Loren reported two other traumatic experiences. Specifically, she reported being repeatedly physically abused by her first husband.

Loren reported significant posttraumatic problems associated with her motor vehicle accident. She reported daily intrusive thoughts about the accident and emotional and physical distress when exposed to accident-related cues. Loren reported daily struggles with these feelings, and at times she felt overwhelmed by her emotions. Her physical reactions included sweating, shaking, and shortness of breath, which often continued to upset her for a few hours. Loren reported having had frequent unpleasant dreams in which

she was involved in different car accidents. The dreams usually woke her up, and it took her at least an hour to calm down and fall back to sleep. Loren stated that she actively avoids thinking and talking about the accident. Furthermore, she reported avoiding driving as much as possible. Specifically, she completely avoided driving on major highways, in heavy traffic (e.g., around noon or between 4 and 6 p.m.), and in bad weather. Loren commented that she was feeling distant and cut off from other people and emotionally numb most of the time. Loren reported a clear sense of foreshortened future and a "bad feeling" that she might die before her time. She reported feeling especially irritable most of the time and indicated that every little thing (e.g., her husband forgetting to bring milk home) would set her off. Despite significant effort she was usually not able to suppress her anger. Loren also reported difficulty concentrating. For example, she stated that before the accident she used to read a lot but afterward found it very hard to keep track of a story line in a book. Finally, Loren reported significant hypervigilance and strong startle reactions. Specifically, she stated that she was overly concerned about safety both while in the car and in her home. For example, while driving she constantly felt the need to look in the rear-view mirror, and at home she often checked to make sure her door was locked. Loren stated that she was bothered by her symptoms and felt that they were not manageable. She reported that her symptoms were significantly affecting her relationships with her family and friends.

Loren reported a period of depressed mood and loss of interest in her normal activities since the accident. Also, she reported significant loss of appetite, feeling fatigued yet unable to sleep, and was feeling guilty about her inability to handle her symptoms. Loren reported having thought about suicide (i.e., thoughts about taking all her prescribed pain medications at once) a few times since her accident. At the time of the interview, she stated that she was not having any thoughts of hurting herself. She stated that her depression was not as bad as before, and she was feeling more emotionally numb. Loren stated that her husband and son tried to be helpful, but most of the time she just wanted to be left alone. She stated that before the accident she used to be very active socially, work out, and entertain at her home. However, because of her fear of leaving the house and her physical limitations, she no longer participated in these activities and felt very isolated. Loren's score on the IES was 52.

Differential Diagnosis and Behavioral Assessment

As noted earlier, trauma is part of modern life. Fortunately, most people exposed to trauma do not develop PTSD. Several factors increase the risk of PTSD after a traumatic event, including preexisting depression or anxiety disorder, family history of anxiety, female sex, and early separation from parents, to name a few (Breslau, Davis, & Andreski, 1991). It is therefore important to obtain a detailed history of the person presenting with the trauma in order to gauge previous coping strategies and to incorporate these findings into a comprehensive treatment plan.

Difficulties often arise when one is attempting to distinguish PTSD from other possible or additional diagnoses. PTSD is often present in the context of other symptoms and disorders. It has been demonstrated that people diagnosed with PTSD often also suffer from coexisting disorders, such as depression, anxiety disorders, alcohol and drug abuse, eating disorders, and borderline or antisocial personality disorder (Breslau & Davis, 1992; Briere, 2004; Green, Lindy, Grace, & Gleser, 1989). This high rate of overlap results partially from an actual comorbidity of various disorders with PTSD and partially from the fact that many of the criteria for depression and anxiety overlap with the criteria for PTSD, making it difficult to accurately diagnose (Briere, 2004). It is therefore imperative to evaluate for a wide range of psychological disorders when assessing the traumatized client. When one is assessing for PTSD, one or more comprehensive or general measures of psychological disturbance should be administered with measures that specifically assess for trauma symptoms. Additionally, data should be followed up with one or more clinical interviews (Briere, 2004).

For a diagnosis of posttraumatic disorder, according to *DSM-IV-TR* (APA, 2000), the client must experience the traumatic event as threatening to the life or physical integrity of himself or herself or others. Also, the response to the event involves intense fear, helplessness, or horror. Three symptom clusters define the disorder:

reexperiencing (e.g., nightmares, flashbacks, intrusive and distressing memories of the trauma), pervasive avoidance (e.g., not talking about the trauma, avoiding situations, circumstances, or people that remind the person of the trauma, and emotional numbing), and increased arousal and hypervigilance (e.g., disturbed sleep, exaggerated startle response, anger or irritability, and concentration problems).

After a traumatic event, a person initially receives a diagnosis of acute stress disorder if the symptoms occur within 4 weeks of the traumatic event and symptoms resolve after 4 weeks, according to *DSM-IV-TR*. However, the person is diagnosed with PTSD if the symptoms persist longer than 1 month. It is also important to differentiate between adjustment disorder and PTSD. The stressor must be of an extreme nature (i.e., threaten the life or physical integrity of the client or another) in order to meet PTSD criteria, but in adjustment disorder it can be of any severity (e.g., divorce). To differentiate PTSD from obsessive-compulsive disorder, intrusive thoughts that are experienced in PTSD must have a clear link to the traumatic event. These thoughts are different from recurrent intrusive thoughts in obsessive-compulsive disorder that are experienced as inappropriate and are not related to the events that triggered the trauma. It is also important to clarify that flashbacks that are experienced as part of PTSD are different from illusions, hallucinations, and other disturbances that are usually part of psychotic disorders.

PTSD often follows a chronic course and is often comorbid with other psychiatric disorders such as depression, other anxiety disorders, and substance abuse (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). For example, of those who were screened in the Kessler et al. study, the major comorbid disorder was depression, with just under half (48%) of both males (n = 139) and females (n = 320) presenting with both PTSD and depression. It is very important to be aware that many people with PTSD who seek help initially present with comorbid depression as primary complaint, which often leads to failure to diagnose the primary PTSD. If left untreated, chronic PTSD can cycle into abuse of alcohol, drugs, and medication. Therefore, it is very important to assess for substance abuse in patients with PTSD (Kessler, 2000).

Often patients with PTSD also present with pain and various somatic symptoms. Therefore, careful consideration of the person's physical pain and other somatic complaints and their impact must be evaluated. In particular, it is important to assess how physical limitations or pain affect functioning. For example, a person with significant back injuries may avoid leaving the house not because of fear of trauma-related triggers or situations but rather because he or she is afraid of reinjury. Also, the person may report that he or she sleeps lot during the day but also report taking significant medication for chronic pain. Sedation and increased napping during the day may be common side effects of the medication; however, it also is possible that the person is using pain medication to help himself or herself avoid trauma-related thoughts. In such instances it is critical to evaluate possible overuse of medication and, if necessary, provide a referral to a doctor that specializes in pain management.

In addition to establishing the proper diagnosis of PTSD, it is essential to conduct a thorough behavioral assessment of the three symptoms clusters and the impact of these symptoms on the person's quality of life. In fact, in one study people with PTSD were found to experience greater impairment than people with major depression or obsessive-compulsive disorder across several domains of their life (Malik, Connor, Sutherland, Smith, Davidson, & Davidson, 1999). It is clear that the life of a person with PTSD is greatly affected by his or her symptoms, and he or she will avoid almost any reminders of the trauma. This avoidance can severely limit the person's mobility and functionality. Furthermore, the person may keep reliving the experience and have recurrent, intrusive thoughts about the trauma and struggle with sleep disturbances, hypervigilance, and irritability.

Assessing the erroneous and negative cognitions that the person may have about the traumatic event and their importance in maintaining the PTSD symptoms is essential. Foa and Jaycox (1999) propose that there are two themes of erroneous cognitions associated with the development and maintenance of PTSD: that the world is extremely dangerous (e.g., there is no place safe and people are not trustworthy) and that the person who experienced the trauma is extremely incompetent (e. g., he or she should have been able to prevent the trauma, and because it happened it is a sign of weakness). Once assessed and clarified, these erroneous negative cognitions can be challenged in a safe, nurturing therapeutic

environment through various cognitive-behavioral interventions (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Resick, Nishith, Weaver, Astin, & Feuer, 2002).

Selection of Treatment Targets and Referral

Thorough behavioral assessment of the three symptom clusters defines the targets of treatment and other related factors that impede the person's ability to function. The behavioral assessment and diagnoses guide the treatment. If the person is struggling with alcohol or substance abuse, then it must be addressed before the trauma can be treated. However, some researchers state that it is important to address both substance or alcohol abuse and PTSD symptoms simultaneously (see Coffey et al., 2002). Regardless of whether a period of abstinence is required before the client engages in trauma treatment, it is imperative to evaluate and identify triggers for alcohol or drug cravings and establish a plan to prevent relapse.

Similarly, it has been shown that the client's level of depression greatly influences treatment outcomes, and therefore it is imperative to address severe depression before proceeding with the actual treatment of trauma. For example, if a person is not able to actively participate in treatment or get out of bed, is suicidal, and has other depressive symptoms, the first step in treatment may be to alleviate some of the depressive symptoms. This could be achieved by behavioral activation, followed by exposure-based cognitive-behavioral therapy. This applies to comorbid issues of panic attacks as well. Falsetti and Resnick (2000) designed multiple channel exposure therapy, which specifically treats comorbid PTSD and panic attacks.

Cloitre, Koenen, Cohen, and Han (2002) demonstrated that patients who struggled with affective dysregulation and received skill training in affective and interpersonal regulation followed by exposure treatment demonstrated significant improvements. Thus, enhancing emotional regulation (reduce affect dysregulation) can enhance the benefits of cognitive-behavioral therapy that uses exposure therapy.

Whether the person suffered from single-episode trauma (e.g., one rape) or repeated trauma (e.g., repeated sexual abuse) makes a tremendous difference in the selection of treatment targets and referral. Nevertheless, a single traumatic event can lead to chronic PTSD. People who develop chronic PTSD often have more sophisticated avoidance mechanisms and more subtle ways to manage traumatic triggers. For example, they have much more practice in reorganizing their lives around their avoidance. A person who was traumatized by an automobile accident might take very elaborate and complex route to get to work and excuse the extra effort, stating, "It is not a big deal; it only takes 15 extra minutes," "I'm used to it by now," or "I don't ever drive on a busy road." After sexual assault the person may state, "I never go out after dark; it's not a big deal," "My friends know that I will not go out after 6 p.m., so they know not to ask." It is important to distinguish between safe choices and choices tied to a trauma-related trigger or avoidance. These factors influence the course of treatment and selection of treatment targets.

PTSD treatment outcomes have focused almost entirely on cognitive-behavioral therapies, and the data suggest that these interventions are efficacious (see Nemeroff et al., 2006). There are generally three subtypes of cognitive-behavioral interventions: exposure therapies, anxiety management, and cognitive therapies. Of those, exposure therapy is the most empirically supported therapy for PTSD (Nemeroff et al., 2006). One meta-analysis found that when clinician-rated measures were used, exposure therapy was more efficacious than any other type of treatment of PTSD (Van Etten & Taylor, 1998).

Summary

In recent years the way PTSD is conceptualized has changed to reflect the generally accepted fact that traumatic experiences are more common than rare and, realistically, trauma and its potential negative human responses are not thought of as unusual anymore. Indeed, trauma and PTSD are now thought to be within the range of usual human experience, not outside. This de facto reality makes good clinical interviewing essential; given the nature of trauma and its potential deleterious sequelae, there is no better way to obtain needed information. Although an effective interview may seem tightly choreographed, the interviewer has to create an environment that imparts empathy, validation, and understanding while simultaneously eliciting data about the trauma and its effects. This

can represent a challenge for the most seasoned interviewer, making practice and multiple interviewing experiences of paramount importance.

Novice interviewers faced with trauma, ASD, and PTSD may want to familiarize themselves with trauma-sensitive interview methods and role play multiple scenarios before encountering real survivors and victims. Good interview skills will elicit sufficient clinical information to inform accurate and complete diagnosis, case conceptualization, treatment planning, and, ultimately, intervention.

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17

GENERALIZED ANXIETY DISORDER

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DESCRIPTION OF THE DISORDER

Generalized anxiety disorder (GAD) is a common disorder associated with significant distress and functional impairment. Using hierarchical exclusion rules for current panic and depression, Judd et al. (1998) report a lifetime prevalence of GAD of 3.6%. Similar results have been found when using *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III-R;* American Psychiatric Association [APA], 1987) criteria; the National Comorbidity Survey suggested a 12-month prevalence of 3.1% and a lifetime prevalence of 5.1% (Wittchen, Zhao, Kessler, & Eaton, 1994). More recently, data from the National Comorbidity Survey Replication (Kessler, Berglund, Demler, Jin, & Walters, 2005) found lifetime prevalence of 4.2% (using a 12-month minimum duration requirement) to 12.7% (using a 1-month minimum duration requirement), all using *DSM-IV* (APA, 1994) criteria. Females are more likely to receive a diagnosis of GAD than males (Grant et al., 2005; Kessler et al., 2005). The age of onset has ranged from childhood (Brown, Barlow, & Liebowitz, 1994) to early adulthood (early 30s, Grant et al., 2005; early 20s, Kessler et al., 2005).

Fortunately, advances in pharmacotherapy and psychotherapy have resulted in a greater likelihood of effective treatment (Mitte, 2005). However, before patients with GAD can be treated, they must be identified through a careful evaluation. The goal of this chapter is to provide a thorough description of how to assess for GAD. First, we describe the diagnostic issues related to GAD, including diagnostic criteria and descriptive psychopathology. Then we discuss interviewing strategies related to GAD, including interview measures and self-report measures, and discuss possible obstacles a clinician may face when interviewing a patient with GAD. Then we discuss cultural and diversity issues related to GAD. Next, we discuss the differential diagnosis of GAD. Finally, we address the common treatment targets in GAD.

Diagnosis of GAD

GAD is a new diagnosis, changed from a "wastebasket" diagnosis pertaining to anyone suffering from anxiety who did not fit into another anxiety disorder listed in *DSM-III* to a discrete entity in *DSM-III-R* and *DSM-IV*.

According to *DSM-IV,* the diagnosis of GAD includes two major aspects: uncontrollable, unrealistic worry about more than one topic and accompanying physiological symptoms including muscle tension, difficulty sleeping, fatigue, restlessness or feeling keyed up or on edge, irritability, and difficulty concentrating. For a diagnosis of GAD, these symptoms must be persistent for a 6-month period and interfere with functioning or be distressing to the client. According to the *DSM-IV,* if these symptoms are better accounted for by another disorder, the diagnosis of GAD should

not be made. In addition, the diagnosis of GAD cannot be made when it occurs solely during an episode of a mood disorder (i.e., major depression or dysthymia). The basic assumption behind this decision is that most people who are depressed are also anxious (see Barlow, 2002, for more details).

GAD has been shown to be a chronic disorder (Bruce et al., 2005), and as mentioned previously it typically presents in childhood (Brown et al., 1994) or early adulthood (Grant et al., 2005; Kessler et al., 2005). In view of these and other data, some argue that, in contrast to other anxiety disorders, a subtype of GAD (chronic, pervasive symptoms since childhood) may be better understood as an underlying personality trait that serves as a risk factor for anxiety disorders (Sanderson & Wetzler, 1991). However, recent research by Brown, Campbell, Lehman, Grisham, and Mancill (2001) suggests that some anxiety disorders such as social phobia may be likely to precede GAD. Other recent research suggests that the age of onset is commonly not in childhood (Kessler et al., 2005). Clinical experience suggests that a major stressor often exacerbates symptoms (e.g., the birth of a child or another role transition). Research (Wells, 1994b) and our clinical experience with GAD have led us to believe that people with GAD often report perfectionism, feel a greater need to control their environment, feel greater personal responsibility for negative events that occur or are predicted to occur in their environment, and have difficulty tolerating ambiguity (see Heimberg, Turk, & Mennin, 2004).

Phenomenology

Worry. Worry is the major cognitive component of GAD. Worries in GAD are thoughts and fears about future harm or negative outcomes and often are not completely formulated or thought through to the final concerns. Patients with GAD often describe worry episodes in which they think about one problem for a few moments and then move on to another worry. For example, one may think, "My husband is late. What if something happened to him on his way home? What if it was a car accident? How will I manage with the kids? What will happen to us financially? Is our insurance sufficient?" An important aspect of this worry is that the patient usually does not try to attempt to answer the questions he or she poses; instead, concerns stay threatening and ambiguous.

People who suffer from GAD tend to worry most of the day, nearly every day (Brown, O'Leary, & Barlow, 1993). However, it should be noted that worry in itself is not pathological. It is an attempt to predict future danger or to gain control over events that appear uncontrollable (and usually negative or dangerous; Rapee, 1991). However, it is clear that worry in GAD is dysfunctional in that it is, by definition, excessive or unrealistic and feels uncontrollable. As a result, patients tend to overpredict the likelihood of negative events and exaggerate consequences if the events were to occur (Brown et al., 1993; Butler & Mathews, 1983). Abel and Borkovec (1995) found that 100% of patients with GAD described their worry as uncontrollable, compared with none of the nonanxious controls. Additionally, anxious people tend to selectively attend to threatening, personally relevant stimuli (Mathews, 1990). Often there is an implied belief that worry will make the world more controllable and predictable. Consistent with this, worriers report five major functions of worry: superstitious avoidance of catastrophes, actual avoidance of catastrophes, avoidance of deeper emotional topics, coping preparation, and motivating devices (Borkovec, 1994).

Research supports the idea that pathological worry may have a functional role for patients with GAD. Worry has been shown to inhibit autonomic arousal in patients with GAD when they are shown aversive imagery (Borkovec & Hu, 1990). Counterintuitively, relaxation has been shown to increase the amount of worry in some patients with GAD (Borkovec, Shadick, & Hopkins, 1991). It is possible that for these patients, relaxation signals a lack of control, which triggers an increase in anxiety, or that patients sit quietly with their thoughts, resulting in greater exposure to their worries. Worrying may cause the avoidance of aversive imagery that is associated with an even greater emotional state (Borkovec et al., 1991). Therefore, worry may be maintained by both the avoidance of certain affective states and the reduction of anxious states through the decrease in arousal that occurs when someone worries. Research has recently supported the role of worry in avoidance of emotions (Mennin, Turk, Heimberg, & Carmin, 2003; Roemer & Orsillo, 2002).

Patients with GAD may also exhibit emotional dysregulation (Mennin, Heimberg, Turk, & Fresco, 2005). Mennin et al. found that students

with GAD reported heightened intensity of emotions, poorer understanding of emotions, greater negative reactivity to emotional experience, and less ability to self-soothe after negative emotions than controls. Additionally, people with GAD have been found to endorse higher levels of emotional awareness than controls (Novick-Kline, Turk, Mennin, Hoyt, & Gallagher, 2005).

Although worry is an important component of GAD, Ruscio (2002) demonstrated that many people report excessive worry but do not meet criteria for GAD. Approximately one third of people in a college sample endorsed high levels of worry but did not meet criteria for GAD, and approximately 6% met criteria for GAD. Non-GAD worriers had less frequent, less excessive worry, more control over their worry, fewer physiological symptoms, and less distress and impairment. Therefore, the other criteria for GAD, including the physiological symptoms, are important to assess in evaluating a patient for GAD.

Somatic Symptoms. Patients with GAD experience unpleasant somatic sensations. Although they usually increase during a worry episode, both the worry and the somatic sensations can be described as persistent and pervasive. The most common somatic symptom reported by patients with GAD is muscle tension. Often associated with worry and tension, patients may experience other symptoms including irritability, restlessness, feeling keyed up or on edge, difficulty sleeping, fatigue, and difficulty concentrating. Because these symptoms may be the focus of concern for a patient with GAD, it is essential to evaluate them carefully, and they may be targets of treatment in their own right.

Interviewing Strategies

Initial Interview Stance

People with GAD may present as quite controlled, anxious, or irritable in the first session. Given their preoccupation with worry, they may come across as guarded or circumstantial in their speech. It can be tense or tiring to interview patients with GAD because their anxiety can be quite contagious, and trying to engage with them in a relaxed fashion can be tiring in its own right. Some people with GAD may be worried about whether seeking treatment is worthwhile or whether they are in the right place for treatment. They may be worried about answering questions fully or correctly. In addition, they may question the interviewer regarding their credentials or experience in order to seek reassurance that they are receiving high-quality care. Open-ended questions may be more difficult for them. However, most people with GAD are able to focus on the interview and describe their difficulties and concerns. If one does feel that the interviewee is quite distant, it is useful to ask what is going through his or her mind. If it becomes clear that the person is stuck on a worry, then acknowledging this as part of the problem can be useful. Another problem that can occur immediately in an interview with patients with GAD is that when asked what is bothering them or what brought them in for an evaluation, they may immediately begin describing a detailed problem and look for immediate advice or solutions. For such patients, it can be helpful to describe the desire for immediate relief and solutions as a core problem of some people who are anxious. Then, the assessor can state that the goal of the evaluation is to develop a complete picture of what is going on for the patient before addressing any individual issue. This may be disappointing for the patient, but suggesting that getting to know the whole patient and how he or she deals with problems is essential for helping him or her in the long term may be useful. In addition, the use of structured or semistructured interviews may help keep both the interviewer and the patient focused.

Tools for Assessment

The main structured or semistructured interviews used to assess GAD include the Hamilton Rating Scale for Anxiety (HAM-A; Hamilton, 1959) and general interviews for anxiety disorders such as the Anxiety Disorders Interview Schedule (ADIS-IV; Brown, Di Nardo, Lehman, & Campbell, 2001), the Structured Interview for *DSM-IV* (SCID; First, Spitzer, Gibbon, & Williams, 1995), or the Mini-International Neuropsychiatric Interview (Sheehan et al., 1998). The HAM-A, which measures general anxiety symptoms, is considered the gold standard interview for evaluating GAD symptoms. It is used in most clinical trials as the main outcome measure. Although there has been much controversy about the reliability of the HAM-A, Shear and colleagues (2001) recently developed

a coding system that greatly improves the interrater reliability of this measure. Borkovec and colleagues (e.g., Borkovec, Newman, Pincus, & Lytle, 2002) use the HAM-A integrated with the ADIS in order to more fully evaluate GAD.

The HAM-A asks many questions about physiological symptoms of anxiety, even though many of these symptoms are excluded from the diagnosis of GAD in *DSM-IV*. Anxious apprehension and muscle tension are assessed along with cardiovascular, gastrointestinal, and other symptoms. Many patients with GAD are in frequent states of stress and tension and therefore experience many of these symptoms. However, one of the cardinal features of GAD according to *DSM-IV* is worry about a number of different areas, and the HAM-A does not inquire about this.

The ADIS is quite thorough in its evaluation of worry. The ADIS is designed to ask first whether a person experiences worry about a number of different areas that feels uncontrollable or exaggerated for the situation. This is an important aspect to evaluate because worry about financial ruin is quite realistic for a person who is significantly in debt, is unemployed, and has no support system. One line of questions that can help distinguish a stress reaction from GAD is to determine how the patient views his or her worrying compared with other people going through a similar situation. If the answer is that he or she is much more preoccupied with it than others would be and that this preoccupation seems to interfere with active planning and coping, then further inquiry into the symptoms of GAD is warranted. Another aspect of worry that the ADIS suggests evaluating is the different content area of worry. If someone is only concerned about his or her marriage and nothing else, then there are not multiple areas of concern, and alternative diagnoses should be considered. A systematic evaluation of different content areas of potential concern can be quite helpful. Some different areas of concern include family, friends, health, finances, one's job, and minor matters. Roemer, Molina, and Borkovec (1997) found that worriers are significantly more likely than other groups to worry about minor matters such as getting daily chores done. In addition to identifying content area, it is useful to know how excessive and how controllable the worry is. In addition, it is very useful to determine the percentage of the day that the patient engages in worry. A number of informal questions seem to help identify patients with GAD, including "Are you a worrier?" "Have you always been a worrier?" "If someone else were to be experiencing the same life situation as you, would they be as worried as you are?" "Are you worried about worrying?"

Several self-report measures may also help supplement or expedite the interview process. The GAD-Q-IV is a self-report measure of GAD symptoms (Newman et al., 2002). The Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) measures uncontrollable worry, and the Intolerance of Uncertainty Scale (Buhr & Dugas, 2002; Freeston, Rhéaume, Letarte, & Dugas, 1994) measures one's perceived ability to cope with uncertainty. The Worry Domains Inventory assesses the areas of concern for the patient (Tallis, Eysenck, & Mathews, 1992). The metaworry inventory (Wells, 2005) also measures the concept of worry about worry. In addition, given recent theoretical accounts of emotional avoidance and interpersonal issues in GAD (Borkovec, Alcaine, & Behar, 2004; Newman, Castonguay, Borkovec, & Molnar, 2004; Roemer & Orsillo, 2002), one may want to examine emotional avoidance and interpersonal relationships. Specific methods have been developed to assess these issues (Roemer, Salters, Raffa, & Orsillo, 2005; Newman et al., 2004).

Given the high comorbidity of GAD and depression, it is useful to include a measure of depression as well. In fact, the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979) is the most common measure used within an assessment battery for GAD (Huppert & Sanderson, 2002). In addition, the Spielberger State-Trait Inventory (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) is another commonly used self-report measure in the assessment of GAD (Fisher & Durham, 1999). Finally, the Depression, Anxiety, and Stress Scales (DASS; Lovibond & Lovibond, 1995) evaluate the three constructs that the scale is named for, and patients with GAD tend to be elevated in both the depression and stress scales (see Brown, Chorpita, Korotitsch, & Barlow, 1997).

Interviewing Obstacles and Solutions

Different disorders tend to have different issues that become obstacles in the interview. In addition to difficult presentations and styles of interaction, patients with GAD may have difficulty

providing some of the core details that would help the evaluation and may be a key part of the case formulation and treatment plan. For example, patients may have difficulty determining whether their worry is excessive. If they believe that they are engaging in worry in order to prevent catastrophe, they may believe that their worry is beneficial. One way to attempt to deal with this is to ask patients whether they are worried more than their significant others or whether friends and relatives have commented on the things they worry about. Many patients with GAD state that they are considered "worry warts" and have been worriers since childhood.

Another common problem when interviewing patients with GAD is that they may not be as aware of the content of their worries as they are of the physiological symptoms associated with their worrying. When asked about worry, they may say that they don't know, but they are just always anxious. One way of helping a patient think about worry is to explain that most of the time, there are triggers for feeling anxious, and then provide examples (e.g., worrying about finances, work, family, one's health).

Even if one is able to identify the global content of worries, many patients are unable to articulate the ultimate consequences of the worries. For example, if they say that they are very worried about their significant others, they may not be able to articulate what worries them. The patient may say something such as "I am afraid something bad will happen to them" but not expand on this at all. Usually, worries are fleeting ideas related to a theme that do not spiral down in a coherent fashion. The worry may be "My wife is late, what if she got in a car accident, or what if she got mugged? What if she is sick and didn't make it to the car?" This list of what-ifs is followed not by answers to the what-ifs but by other related questions.

Case Illustration With Dialogue

The following is an example of an assessment of an adult patient seeking treatment. In order to protect the identity of individual patients, this is a composite of a number of patients. Jack is a 45-year-old executive at a midsize company who called seeking treatment because he has been feeling stressed and tense a lot and feels that it is affecting his ability to work and his home life. Jack was sent a self-report packet before his initial visit, which included the DASS-21 and the PSWQ. His scores on these measures were 75 on the PSWQ and 26 on the stress scale and 16 on the depression scale of the DASS, both in the clinical range for GAD.

Therapist: So what brings you in for treatment?

J: I don't know. I am not sure I should be here.

T: Whose idea was it for you to come in?

J: Mine.

T: What were you thinking when you called and scheduled an appointment?

J: I am too stressed out. But on the way here I began to think that being here is just going to stress me out more. I should be at work or at home, doing something about my problems, not here talking about them.

T: It sounds like you are quite stressed out.

J: Uh huh.

T: Have you tried just doing things and ignoring your worries before?

J: Yes.

T: And how did it go?

J: [irritably] All right, I get your point.

T: Well, what kinds of things get you stressed out?

J: What doesn't? I get stressed about work, about my family, about any time I have free. Free time is a luxury I don't have.

T: So you feel like you need to keep busy all the time?

J: There is just so much to do. At least when I am busy, I feel like I am making some progress. When I sit down, even for 5 minutes, I feel like I am wasting time, and I should be doing something. Thoughts just start racing in my mind.

T: So it is hard to find time to just relax. That is common with people who have a lot of anxiety: The time that they want to feel relaxed ends up just being more stressful, with lots of worries.

J: Exactly.

T: People feel stress differently. Some people feel it more in their bodies, like in muscle tension or in stomach aches or other gastrointestinal problems, and some feel it more in their heads, through headaches and dizziness. Still others feel it more in their heads, with racing thoughts, lots of what-ifs, and other worries. Or it could be a combination. How does your stress manifest itself?

J: Well, I get lots of worries about getting things done, and whether the quality is good enough at work. I feel a lot of muscle tension. These lead to me having a short fuse a lot. Even when I try to sleep, I have these worries keeping me awake, and my muscles are in knots.

T: So it sounds like you have a lot of worries, and muscle tension, sleep trouble, and irritability along with them?

J: Definitely, but what can you do to help me relax and get rid of these worries?

T: Well, the first thing to do to help anyone is to get a full, accurate picture of what is going on. That is my goal for today.

J: You mean you won't give me any way to stop this today?

T: Unfortunately, that is not the way things work. If I knew a quick fix, I would give it to you. However, once I have a good picture of what is going on, we can come up with a program that you agree to that may start helping you soon.

J: Well, all right, I guess. What else do you need to know?

T: Let's go through some questions a bit more systematically now, to make sure I cover all my bases. You said that you worry about work and home?

J: All the time. I can't even sit for 5 minutes without worries about work and my family creeping in quickly. I need to keep busy to try to feel better.

T: So what do you do to try to keep busy?

J: I need to keep my mind occupied. If I am home, I need to be reading the paper, watching something engaging on TV, listening to music, talking to someone, anything to distract me from my worries. I can't sit and play with my kids for more than 10 minutes without my mind going back to work, or thinking about how I am going to pay for their colleges. They are only 5 and 8, but do you know how much college will cost? How am I supposed to pay for it?

T: So you worry about long-term finances, too.

J: You should, too.

T: So it sounds like you think that your worry may be useful at times? Well, let's talk more about that in a few more minutes. Do you worry about minor matters?

J: Yes. For sure. Like even how am I going to get the kids to their sports games on Saturday? Or how will I get all the forms I need to get done for work by Tuesday? Or will I get to the cleaners to pick up my stuff before they close?

T: Okay. How about your or your family's health?

J: Everyone is fine. I don't think about people getting sick, if that is what you mean. Though I do have thoughts about what would happen if my wife died. How would I manage? That kind of thing. But those thoughts come a lot less than work and kids. I guess I also worry that something could happen to my kids. I know it isn't likely, but you hear every once in a while about kids getting killed in car accidents, etc. Those thoughts pop into my mind from time to time.

T: And do you worry about your relationship with your wife or kids?

J: With my wife, I probably should more than I do. I know I snap at her too much, especially when she tells me not to worry about something, or tries to distract me while I am trying to figure something out.

T: So it sounds like your worry and anxiety interfere with your relationship with your wife in ways that you would like to change?

J: Definitely.

T: But not that you worry about your relationship like you worry about work, your kids, and minor matters.

J: Right. My kids I worry about more that way. I worry if I am a good enough father, whether something will happen to them, whether they will turn out okay. Being a parent is a lot of responsibility.

T: And you can never be sure how they will turn out in the end.

J: Right. But you need to try as hard as possible to prevent harm.

T: And worrying does that?

J: Yes.

T: Okay, so you have a lot of areas of worry. Do you feel that these worries are uncontrollable or excessive? By uncontrollable, I mean that it is difficult to turn your attention from them or stop them. By excessive, I mean, do you think that other people in your life situation (e.g., being married, full-time job in your line of work) would be as anxious and worried as you?

J: I can't stop if I want to, and I would like to be less stressed, more like other people are.

T: What percentage of the day do you think you are worrying?

J: 80.

The therapist then asks about physiological symptoms of GAD, including irritability, sleep loss, muscle tension, concentration, fatigue, restlessness, or feeling keyed up or on edge. Jack acknowledges all of these and does not meet criteria for other disorders. The end of the initial interview should describe findings about GAD and its treatment, orient the patient to the treatment model, and motivate the patient toward treatment.

Therapist: It is my impression that you have generalized anxiety disorder, or GAD. GAD is also known as the worry disorder. Many people with GAD describe having been a worrier since childhood.

Jack: Yes, that is definitely me.

T: Right. The cardinal signs of GAD are the uncontrollable, excessive worry and associated irritability, muscle tension, feeling keyed up, and difficulty with sleep. The good news is that the data are quite strong regarding the treatment of GAD. Most people describe significant reductions in worry and other symptoms with cognitive-behavioral therapies. These therapies tend to focus on the function of worry, which some researchers argue is to avoid negative feelings and outcomes. In addition, substantial amounts of research have demonstrated that people with GAD tend to notice and focus more on negative things and to interpret even things that are unclear in a more negative fashion. The goal of treatment will be to help you change these thought patterns and the physiological symptoms associated with them. But in order to do so, you may have to be more willing to give up some of the control you are trying to keep.

J: I don't know if I can do that.

T: Well, if you thought you could easily, you wouldn't be here. It is a good sign you didn't say "I will never do that." The first part of treatment is helping you learn why and how to do so. Any questions about anything I have gone over today?

Multicultural and Diversity Issues

A review of the literature on cultural and diversity issues in GAD returns few findings. Results from the National Comorbidity Survey Replication (Kessler et al., 2005) include the following statistically significant sociodemographic predictors of receiving a diagnosis of GAD (minimum 1-month duration): being younger than 60 years of age, having more than a high school education, having occupational statuses of unemployed or disabled, and being previously married, non-Hispanic White, and female. Using the same data, Ruscio et al. (2005) report a lower prevalence of GAD among males, non-Hispanic Blacks and Hispanics, and those who are unemployed. Data from Grant et al. (2005), who examined another U.S. sample, also found a lower risk of being diagnosed with GAD among Asians, Hispanics, and African Americans.

Data from nonclinical populations suggest some differences between ethnic groups in self-reported levels of worry. Results from a confirmatory factor analysis by Carter et al. (2005) show that African Americans scored significantly lower on the PSWQ than the White American group. In addition, an exploratory factor analysis of the PSWQ revealed two factors (general worry, worry absence) among White Americans and three factors (general worry, worry absence, and

worry dismissal) among African Americans. The differences in subscale structure were minor according to the authors. In contrast, Novy, Stanley, Averill, and Daza (2001) found that English and Spanish versions of the PSWQ and other anxiety measures were equally reliable and valid, supporting the use of Spanish instruments in evaluating Hispanic patients.

Another study examining ethnic differences in worry in a college student population found no difference between ethnic groups (African American, Asian American, and Caucasians) in the degree to which they reported pathological worry (Scott, Eng, & Heimberg, 2002). However, there were some differences between ethnic groups relating to reported worry across several content areas. For example, African Americans reported less worry about work competence, future aims, relationship stability, and self-confidence than Asian Americans and Caucasians. However, African Americans reported the greatest amount of worry related to financial concerns.

Prevalence of GAD may vary across cultures. For example, in Mexico GAD prevalence (using a 12-month minimum duration) was reported to be 0.4% (Medina-Mora et al., 2005). Additionally, Lieb, Becker, and Altamura (2005) suggest a 2% prevalence rate of GAD in Europe (using a 12-month minimum duration). However, not all research has yielded similar findings. For example, Vega et al. (1998) report prevalence of GAD in Hispanics to be at least as high as in other ethnicities. Future researchers should target cultural and diversity issues related to GAD and other disorders. Overall, clinicians should take into account the possibility of differences in self-reported symptoms between ethnic groups.

Differential Diagnosis

Differentiating GAD from other anxiety disorders can be very complicated. First, worry is a common feature of anxiety disorders (e.g., worry about having a panic attack, worry about social situations, worry about germs). Additionally, there is a high level of comorbidity among the anxiety disorders, with GAD in particular, which requires one to consider diagnosing multiple disorders and making differential diagnoses (cf. Brown, Campbell, et al., 2001). The content and breadth of patient's concern are primary distinctions between GAD and other anxiety disorders. Patients with GAD experience uncontrollable worry about several different areas in their life. In fact, they often worry about their worrying (known as metaworry; Wells, 1994b). On the other hand, patients with other anxiety disorders often are concerned about topics specific to their respective disorder.

Panic Disorder

Patients with panic disorder are worried about having a panic attack, or the consequences of experiencing certain bodily sensations. Generally, their focus is on internal states. What makes the differential diagnosis between panic disorder and GAD particularly difficult is that the worry experienced by patients with GAD can lead to a panic attack or panic-like symptoms. However, patients with GAD are concerned primarily about a future event, usually an external event or an illness, and not about having an immediate panic attack per se. Another distinction is the course of onset of worry versus panic. Focusing on the physical symptoms of their anxiety is a feature of some patients with GAD, and this can lead one to think that the preoccupation with bodily sensations is a sign of panic disorder. However, panic attacks occur suddenly, and their peak typically lasts for several minutes, whereas the onset and course of GAD-related anxiety usually are longer and more stable. However, distinguishing features of GAD and panic disorder may be fewer and slightly different in older treatment-seeking adults (Mohlman, de Jesus, Gorenstein, Kleber, Gorman, & Papp, 2004). They suggest that such features include patients with GAD generally endorsing more symptoms on the Beck Depression Inventory and symptoms of anger and hostility, and patients with panic disorder having elevated scores on measures of sympathetic nervous system arousal and more agoraphobic avoidance.

Social Phobia

Social concerns are a common area of worry for patients with GAD. As a result, patients with GAD often are diagnosed with comorbid social phobia (Sanderson, Di Nardo, Rapee, & Barlow, 1990). However, one major guideline for differentiating the two disorders can be made. GAD concerns are more global and focused on a number of different areas, which may include

social situations. In contrast, patients with social phobia are specifically concerned with being evaluated, embarrassed, or humiliated in front of others.

Obsessive-Compulsive Disorder

Although the distinction between obsessive-compulsive disorder (OCD) and GAD seems obvious because of the behavioral rituals that are unique to OCD (Brown et al., 1994; Brown, Di Nardo, et al., 2001), some cases can be quite difficult to differentiate. Cases are especially complicated with patients with OCD who do not have compulsions or have only mental rituals. Assessing the focus of concern can help differentiate between obsessions and worries. Obsessions usually are short lived and focused on exaggerated or unrealistic expectations (e.g., "If I don't seal this envelope correctly, my wife will be injured on the way home from work"). Additionally, obsessions often follow an "if-then" form (e.g., "If I do or don't do or think something, then something bad will happen") or include vivid imagery (Wells, 1994a). Worry, on the other hand, usually is focused on future negative events that are not caused by the patient. Data from nonanxious subjects suggest that worry lasts longer, is more distracting, and usually consists of predominantly verbal thoughts as opposed to images (Wells & Morrison, 1994). Also, the thought content of a worry may be specified in a "what if" fashion but without a consequence being stated ("What if I get ill?"). Another common feature of patients with GAD and OCD is the fact that both may engage in reassurance-seeking behaviors that can be somewhat ritualistic and superstitious. Patients with GAD may report feeling compelled to act to neutralize a worry (Wells & Morrison, 1994; e.g., to call a family member at work to decrease worry about something happening to them) or to engage in other checking behaviors to see whether something bad has happened (Schut, Castonguay, & Borkovec, 2001). However, these behaviors are not as consistent, methodical, or ritualized as compulsive behaviors in patients with OCD.

Mood Disorders

The final distinction to be made is between GAD and mood disorders, especially major depression and dysthymia. More often than not, anxiety symptoms occur in the context of depression, and therefore GAD is diagnosed as a separate disorder only when the symptoms have occurred independently of depression at some point. Regardless of *DSM* exclusionary criteria, the nature of cognitions associated with each disorder can be distinguished: Ruminations (common in depressive disorders) tend to be negative thought patterns about past events, whereas worries (associated with GAD) tend to be negative thought patterns about future events. This is consistent with theoretical conceptualizations of anxiety and depression that posit that depression is a reaction to uncontrollable, inescapable negative events leading to feelings of hopelessness, helplessness, and deactivation, whereas anxiety is a reaction to uncontrollable negative events that the person attempts or plans to escape from (for a more detailed explanation, see Barlow, Chorpita, and Turovsky, 1996). Brown, Campbell, et al. (2001) present data suggesting that without the rule-out criteria, 90% of patients diagnosed with dysthymia and 67% of patients diagnosed with major depression would be diagnosed concurrently with GAD, but with the rule-out criteria only 5% were diagnosed with GAD.

Selection of Treatment Targets and Referral

There are a number of different theories of GAD, which suggest somewhat different treatment targets (see Heimberg, Turk, & Mennin, 2004). General treatment strategies include progressive muscle relaxation and cognitive restructuring (Leahy, 2004; see also Rygh & Sanderson, 2004, for a recent manual). Even the targets of cognitive restructuring differ according to different models of GAD. The most common issues are overestimations of the probability and cost of negative events (Butler & Mathews, 1983; Foa & Kozak, 1986), overestimation of threat as increasing over time (loomingness; Riskind & Williams, 2005), metaworry (Wells, 2005), and attention to threatening material and interpreting ambiguous information as threatening (attentional and interpretive biases; MacLeod & Rutherford, 2004). In addition to addressing cognitive distortions or biases, different psychological approaches address a number of other targets, including muscle tension (Borkovec, Grayson, & Cooper, 1978), sleep disturbance (Bélanger, Morin, Langlois, &

Ladouceur, 2004; Leahy, 2004), intolerance of uncertainty and problem solving (Dugas, Buhr, & Ladouceur, 2004), behavioral and emotional avoidance (emotional and behavioral; Borkovec et al., 2004), general affect regulation difficulties (Huppert & Alley, 2004; Mennin et al., 2003), mindfulness and acceptance of distress (Roemer, Orsillo, & Barlow, 2002), and interpersonal interactions (Crits-Christoph, Gibbons, & Crits-Christoph, 2004; Newman et al., 2004). Each of these targets is described briefly in this section.

Muscle Tension

Many cognitive-behavioral treatments for GAD include progressive muscle relaxation (PMR; Jacobson, 1938) to address physiological tension that characterizes GAD. However, other theories suggest that reduction of the core cognitive complaints will reduce muscle tension and that use of PMR can be an avoidance strategy. Thus, PMR is incompatible with treatments that focus on acceptance of distress rather than attempting to reduce it. However, some data suggest that PMR can be an effective technique for the treatment of GAD (Borkovec et al., 1987).

Sleep Disturbance

As noted in the diagnostic criteria, patients with GAD often have trouble falling or staying asleep, often because of their worries. At times PMR can be helpful in improving sleep. In addition, sleep hygiene can be important because some patients with GAD are so focused on trying to avoid negative outcomes that they do not follow normal sleep patterns. Therefore, sleep hygiene techniques can be useful for these patients (Leahy, 2004). Finally, some treatments for GAD improve sleep without directly addressing sleep habits (Bélanger et al., 2004).

Overestimation of Probability and Cost

Two of the major cognitive distortions that are emphasized in the anxiety disorders are overestimations of the probability of harmful events and the cost of mildly negative events (Beck & Emery, 1985; Foa & Kozak, 1986). For patients with GAD, probability of harm to oneself or one's family often is overestimated. The harm can be physical (e.g., illness, accidents), financial (including fears of losing one's whole savings or getting fired), or emotional (people getting very angry, hurting people's feelings). Fears of future bad outcomes such as one's children not growing up to be happy may also be included here. For many of these overestimations, it is helpful to spiral down and attempt to learn more what the feared consequences are if these overestimated things were to occur. This often leads to catastrophic thoughts such as "If it was a car accident, then he is dead and I will never be able to cope." There are a number of distortions here that are probably increasing the patient's anxiety. There are two overestimations of harm: the likelihood of the car accident and the likelihood of death by a car accident. There are also two catastrophic thoughts: any car accident means death, and one cannot cope if one has a loss. Therefore, evaluating these thoughts can be an important aspect of understanding the thought processes in GAD, which must be targeted in treatment.

Loomingness

Recent findings suggest that there is a specific cognitive style related to anxiety in which people are more likely to perceive the risk of threats as increasing over time (Riskind & Williams, 2005). When asked whether bad things are more likely to happen as an event unfolds or time passes, people with anxiety, including patients with GAD, are more likely than depressed or nonanxious people to say "yes." Thus, another target of treatment may be addressing the belief of looming danger.

Metaworry

Another aspect of GAD that has been a focus of some work is the idea that patients with GAD worry about worrying, or metaworry (Wells, 2005). Metaworry may be an important target for treatment because it is not captured by the aforementioned appraisals of probability, cost, or loomingness. Beliefs about the uncontrollability and negative effects of worry may need to be addressed in treatment.

Attentional and Interpretive Biases

People with GAD not only have overestimations of probability and cost but also a number of other cognitive biases. The predominant information-processing problems they have are paying

excessive attention to threat stimuli or having difficulty disengaging from threat stimuli (see MacLeod & Rutherford, 2004), developing threat interpretations in the face of ambiguity, and selectively remembering threat information. All of these biased processes can be viewed as targets for treatment. Many CBT treatments attempt to create situations in which patients strategically override these biases and rehearse alternative, adaptive strategies (Leahy, 2004). Furthermore, new procedures are in development to directly address these biases (see Mathews & MacLeod, 2005).

Intolerance of Uncertainty

One theory of GAD suggests that there are two main types of worry: worry about immediate issues and future, unrealistic worry. Both of these areas can be difficult for patients with GAD and therefore may be targets of treatment. The theory suggests that both types of worry are driven by the intolerance of uncertainty. People with GAD have been shown to be less able to tolerate uncertain outcomes than others (Dugas et al., 2004). This intolerance leads to worry about the many things in life that are ambiguous. The theory suggests separate methods of addressing more current worries and future, unrealistic worries. Future worries are addressed through practice in tolerating uncertain futures through imagery. More immediate issues are addressed through problem solving.

Problem-Solving Skills

Research by Dugas and colleagues (2004) and Davey (1994) suggests that people with GAD do not have trouble generating responses or solutions to problems but that they have trouble selecting solutions, particularly because they lack confidence in any solution. Thus, there is a problem-solving deficit in terms of selecting and executing solutions. This deficit may be a target of treatment, to be addressed through problem-solving skills.

Cognitive-Behavioral Avoidance

Models of GAD often suggest that patients with GAD attempt to avoid their feared outcomes through checking (Schut et al., 2001) or other behavioral avoidance strategies (Borkovec & Sharpless, 2004). In addition, significant research is accumulating showing that patients with GAD engage in cognitive avoidance, often attempting to avoid thinking about negative outcomes (Borkovec et al., 2004). These types of avoidance are important targets of treatment for GAD in most theories.

Emotional Avoidance

In addition to cognitive and behavioral avoidance, the past decade has seen a reemphasis on emotions per se and emotional avoidance. For example, Roemer and Orsillo (2002) suggest that mindfulness and acceptance-based strategies are important ways of reducing emotional avoidance.

Affective Dysregulation

Related to the idea of emotional avoidance, data suggest that patients with GAD have significant problems with multiple stages of affect regulation, including identifying, labeling, tolerating, modulating, and self-soothing (Mennin et al., 2005). Therefore, identifying difficulties in affect regulation may be another important target of treatment. Huppert and Alley (2004) suggest that imaginal exposure to multiple emotions may be a way of developing affect regulation strategies.

Interpersonal Difficulties

As discussed earlier, relating to patients with GAD can be quite difficult because of their interpersonal style. This issue has been identified not just as a consequence of other GAD symptoms but also as an important target in itself (Crits-Christoph et al., 2004; Newman et al., 2004). Some data have revealed that patients who receive cognitive-behavioral therapy for GAD and continue to exhibit interpersonal difficulties do not respond to treatment (see Newman et al., 2004) and therefore that this target is essential for treatment. Others have shown that interpersonal difficulties addressed through a psychodynamic treatment that focuses on interpersonal relationships can be effective in reducing symptoms of GAD (Crits-Christoph, Connolly, Azarian, Crits-Christoph, & Shappell, 1996; Crits-Christoph, Gibbons, Narducci, Schamberger, & Gallop, 2005). Interestingly, in their treatment supportive and expressive components can be divided, and analyses suggest that expressive components are most related to treatment outcome

(Crits-Christoph et al., 1996). Both of these treatments suggest that directly addressing interpersonal difficulties is an important target in the treatment of GAD.

Summary

GAD is a common, debilitating disorder that often goes untreated. A successful evaluation includes assessing many dimensions of worry and its antecedents and consequences and the physiological symptoms that are also associated with worry. Although GAD may overlap with a number of disorders, such as depression and the other anxiety disorders, it can clearly be differentiated, and doing so is an important part of treatment planning. In addition, there are many relevant treatment targets for GAD that should be identified and addressed.

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18

EATING DISORDERS

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DESCRIPTION OF THE DISORDERS

Eating disorders may be conceptualized as having multiple symptom domains that are significant for the assessment, diagnosis, conceptualization, and referral and treatment process. These key domains include body size, restrictive eating, binge eating, compensatory behavior (e.g., purging), body image disturbance, and general psychopathology. It is important to assess eating disorders in a multidimensional fashion, capturing all the aforementioned domains and physical problems, medical conditions, and comorbid psychiatric disorders. (For an "at a glance" reference for comprehensive assessment of eating disorders, see Stewart & Williamson, 2006.)

This chapter provides an overview of one modality of assessment for eating disorders: interviewing techniques. This chapter focuses on anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and eating disorder not otherwise specified (ED-NOS). Interview techniques may be used for the purpose of diagnosis, progress monitoring, or treatment outcome assessment. A brief summary of semistructured interviews for the assessment of eating disorders and a description of an unstructured clinical interview are provided. Obstacles that arise in the interview process are discussed, with suggestions to guide a successful interview. A sample case illustration and interview dialogue are also presented. Finally, information on differential diagnosis, behavioral assessment, multicultural and diversity issues, and treatment targets and referrals is summarized. The chapter begins with a brief description of the eating disorders.

Anorexia Nervosa

AN has been recognized as a psychiatric disorder for more than a century (Gull, 1874). Lifetime prevalence of AN is an estimated 0.5–3.7% of females (American Psychiatric Association [APA] Work Group on Eating Disorders, 2000), and it occurs 10 times more often in females than in males (Williamson, Zucker, Martin, & Smeets, 2001). A recent study showed 0.1–5.7% prevalence in females in Western countries specifically (Makino, Tsuboi, & Dennerstein, 2004). AN is the eating disorder most likely to result in severe medical consequences or death. The central diagnostic feature of AN is extreme weight loss. This weight loss often is achieved through restrictive eating or purgative behaviors (e.g., self-induced vomiting, excessive exercise). AN often is accompanied or maintained by an extreme fear of weight gain and body image disturbance, including body image distortion (overestimation of body size) or dissatisfaction with body size and shape. For a review of the diagnostic criteria for AN, see the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV;* APA, 1994).

People with AN often are in denial about the seriousness of their condition and minimize symptoms and consequences of restrictive eating, excessive exercise, and weight loss. AN is also associated with perfectionism and obsessive-compulsive symptoms. People diagnosed with AN often become withdrawn and do not participate in normal activities because they do not have the sufficient physical energy, because of depression or anxiety, or because they are engaging in the behaviors that maintain AN (e.g., excessive exercise or secretive restrictive eating). Medical consequences associated with AN are most commonly caused by chronic starvation. These symptoms include loss of or irregular menses, bradycardia, hypotension, cold intolerance, dry and brittle hair and nails, dehydration, and severe constipation (Pomeroy, 2004). Associated psychological disturbances include depression and anxiety and various personality disorders, with the most common being obsessive-compulsive personality disorder (Sansone, Levitt, & Sansone, 2005). Avoidant and borderline (most common in binge-purge subtype) personality disorders are also common.

Bulimia Nervosa

The syndrome of BN was first described by Russell (1979). For a review of the diagnostic criteria for BN, see the *DSM-IV* (APA, 1994). BN is characterized by repeated episodes of binge eating in which one feels a lack of control over the eating during the episodes (APA, 1994). These binge episodes are defined as objectively large. In the criteria for BN, an attempt is made to define an "objective" binge as eating a large amount of food in a short period of time. This definition has been interpreted many ways, but the general consensus is that the amount eaten is not an important distinction (Thaw, Williamson, & Martin, 2001). Another symptom of BN is the frequent use of purgative behaviors, including self-induced vomiting, laxative or diuretic abuse, restrictive eating, or excessive exercise to rid the body of calories or prevent weight gain. BN is also accompanied by concerns about body size and shape. Lifetime prevalence for BN is 1.1% to 4.2% for females (APA Work Group on Eating Disorders, 2000). Males with BN make up approximately 10% of all cases (Williamson et al., 2001). A recent study showed 0.3% to 7.3% prevalence in females and 0% to 2.1% prevalence in males in Western countries (Makino et al., 2004).

People with BN often have a fear of gaining weight and fears of fatness that motivate extreme behaviors to maintain weight status (e.g., vomiting after eating a meal). Socially, people with BN become so involved with maintaining eating disorder behaviors that they have difficulty in interpersonal relationships or maintaining required school or social activities (e.g., attending classes and work obligations). These behaviors typically produce shame, which motivates concealment of the behaviors from peers and family members. Common medical consequences associated with BN may include dental erosion from vomiting, abrasions on fingers or hands from vomiting, and peripheral edema (Pomeroy, 2004). Associated psychological disturbances include depression, anxiety, and various personality disorders, with the most common being borderline personality disorder. Other associated personality disorders include histrionic and dependent personality disorders (Sansone, Levitt, & Sansone, 2005).

Eating Disorder Not Otherwise Specified

The ED-NOS category is characterized by various eating disorders that do not meet full diagnostic criteria for eating disorders as defined by the APA (1994). Fifty percent of people who present for eating disorder treatment fall into this category (Thaw et al., 2001). For a review of the description of ED-NOS, see the *DSM-IV* (APA, 1994). Examples of eating disorders that may fall into this category include BN type syndrome characterized by binges on objectively small amounts of food and purging, and AN without a loss of menses.

Binge Eating Disorder

BED is characterized by binge eating without the presence of compensatory behaviors such as self-induced vomiting or laxative use. For a review of the proposed diagnostic criteria for BED, see the *DSM-IV* (APA, 1994). Prevalence rates for BED are estimated anywhere from 2% in community samples to more than 25% in obese populations (treatment seeking) (Yanovski, 1999). However, with the use of strict diagnostic criteria from the *DSM-IV,* full syndrome BED, on

average, is found in less than 3% of treatment-seeking obese adults and roughly 1% or less of the adult community population (Williamson & Martin, 1999). Currently, the *DSM-IV* criteria for BED allow binges to be episodic or nonepisodic (Williamson & Martin, 1999). Thus, binge eating in this context may be defined as binge eating in discrete time periods, a constant overeating pattern throughout the day, or a "grazing" pattern of binge eating. This vague definition has led to difficulty in the diagnosis and classification of BED. People with BED typically express shame about their binge eating, concern about their weight (if they are overweight), and a loss of control over the episodes or continual overeating patterns. Socially, people with BED often binge in private and become more socially withdrawn at times to hide their behavior. The primary medical consequences of BED result from complications of overweight and obesity. Associated psychological disturbances include depression and anxiety. Recent review indicates that there is complex heterogeneity in Axis II disorders among people with BED (Sansone et al., 2005). Therefore, it is difficult to ascertain prevalence trends toward certain Axis II disorders in this eating disorder subgroup.

Interviewing Strategies

Structured Interview Strategies

The nature of semistructured interviews typically includes a general guide by which an interviewer follows a certain set of questions to interview a client. Most semistructured interviews require clinically trained interviewers (e.g., psychologists) to conduct the interview properly, and some interviews may require special intensive training specific to the measure itself (e.g., the Eating Disorder Examination [EDE]; Cooper & Fairburn, 1987).

Eating Disorders

The purpose of semistructured interviewing strategies for eating disorders is to assess the nature and severity of eating disorder symptoms. This section briefly summarizes the use of semistructured measurement tools in the assessment of eating disorder pathology. Two primary semistructured interviews for eating disorders are the EDE (Cooper & Fairburn, 1987; Fairburn & Cooper, 1993) and the Interview for the Diagnosis of Eating Disorders (IDED-IV; Kutlesic, Williamson, Gleaves, Barbin, & Murphy-Eberenz, 1998). One additional measure with comparable psychometric properties is the Structured Interview for Anorexic and Bulimic Syndromes for *DSM-IV* and *ICD-10* (SIAB-EX; Fichter & Quadflieg, 2000). The SIAB-EX generates diagnoses consistent with both *ICD-10* and *DSM-IV*. Finally, a measure that is used primarily for the assessment of the longitudinal course of psychopathology is the Longitudinal Interval Follow-Up Evaluation (LIFE; Keller et al., 1987).

Eating Disorder Examination. The EDE is a semistructured interview designed to assess the primary psychopathology of eating disorders. The EDE is in its 12th edition and is designed to assess the key features of eating disorders in two ways: the frequency of key behavioral features of eating disorders (e.g., purging) and dimensions of disturbance generated through specific subscales. The EDE includes four subscales: dietary restraint, eating concern, shape concern, and weight concern. Items are rated on a seven-point Likert scale, with the higher scores representing a higher level of severity or frequency. The EDE is conducted by the interviewer, and the interviewer rates the severity of the symptoms as reported by the participant in response to the questions. Because of its investigator-based format and its strong psychometric properties including validity and reliability, it has come to be viewed as the gold standard in the assessment of eating disorders (Grilo, 1998). Although it is a highly recommended measure, the EDE requires special training and is time consuming to administer, which may make it less attractive to use in certain protocols where time is a concern.

Interview for the Diagnosis of Eating Disorders. The IDED-IV is a semistructured interview designed specifically for differential diagnosis of eating disorders using the *DSM-IV* diagnostic criteria for eating disorders (APA, 1994). The IDED-IV questions are related directly to *DSM-IV* diagnostic criteria, and the questions enable the interviewer to establish the presence or absence of the specific diagnostic criteria related to AN, BN, BED, and other various subthreshold presentations of ED-NOS (e.g., night eating syndrome). The IDED-IV has good reliability and validity (Kutlesic et al.,

1998) and is a very user-friendly and reasonably efficient measure to use in clinical or research settings.

Longitudinal Interval Follow-Up Evaluation. The LIFE is a semistructured interview measure that is specifically designed for longitudinal study of mental disorders. A modified version for eating disorders has served as a primary measure of longitudinal studies of eating disorders (Grilo, 2005). The LIFE measure has been found to have adequate psychometric properties (Warshaw, Dyck, Allsworth, Stout, & Keller, 2001).

General Psychopathology

Axis I psychiatric disorders and personality disorders are common associated conditions with eating disorders (Grilo et al., 2003a, 2003b). These associated problems are important targets in assessment and are significant targets for case formulation and treatment. For Axis I disorders, the Structured Clinical Interview for *DSM* Axis I Disorders (SCID-I; Spitzer, Williams, Gibbon, & First, 1992; First, Spitzer, Gibbon, & Williams, 1996) is recommended. For Axis II disorders, there are five reasonably psychometrically sound semistructured interview measures: the Structured Clinical Interview for *DSM* Axis II Disorders (SCID-II; First et al., 1995), the Structured Interview for the *DSM-IV* Personality Disorders (Stangl, Phofl, Zimmerman, Bowers, & Corenthal, 1985), the Diagnostic Interview for Personality Disorders (Zanarini, Frankenburg, Chauncey, & Gunderson, 1987), the Personality Assessment Schedule (Tyrer, Strauss, & Cicchetti, 1983), and the Personality Disorder Examination (Loranger, 1988).

Unstructured Clinical Interview

An unstructured clinical interview is an alternative to the semistructured clinical interview approach. This approach to assessment and diagnosis is more informal and is not guided by specific questions that have been found to valid or reliable. Generally, this format is used when a more efficient collection of information is needed or an update on information is needed from an initial, more thorough assessment. A brief summary of recommended material for inclusion in a general clinical interview for eating disorders is presented in Table 18.1.

Interviewing Obstacles and Solutions

Obstacles in the Interview Process

Overvalued Ideas. In addition to the key domains of eating disorders, there are many underlying themes and cognitive beliefs that often aid in the maintenance of these disorders. Although the eating disorders AN, BN, ED-NOS, and BED have many differences, they often hold one key feature in common: overvalued ideas (Stewart, 2003). These overvalued ideas are strongly held beliefs that are extremely difficult, if not impossible, for the person to overcome without help. Furthermore, when others try to confront the person with regard to these beliefs, they are met with great resistance. This resistance may come in many forms, including omission of information, denial, minimization, normalization, or simply a lack of recognition that the nature of their behavior is not healthy. Western society values thinness. Therefore, dieting behaviors and exercise behaviors are viewed as "health" behaviors as well as a way to obtain thinness. These behaviors often are supported by society, especially with the current obesity epidemic. Therefore, it becomes difficult to determine when a health behavior becomes detrimental or beneficial to health. For example, an anorexic person presenting in an interview for an eating disorder may view herself or himself to be in line with the values of society (i.e., engaging in diet and exercise behavior) and may have even been supported for these behaviors (to a point) by friends and family. In contrast, a person presenting for help with bingeing and purging behaviors would not necessarily view these as "health" behaviors (although the goal of thinness is a valued "healthy" goal) and probably would be viewed by family and peers as abnormal. Based on the values of society, certain thoughts and behaviors often are "normalized" by the patient and people around them until they become very extreme and threatening to health status, whereas other behaviors are not "normalized." Such patterns in belief systems and thoughts related to behaviors may determine how aware a person is of his or her problems and how willing the person is to cooperate with assessment, especially if the person believes that assessment or treatment may in some way force him or her to give up the overvalued beliefs surrounding his or her efforts to obtain thinness and other eating disorder behaviors.

Table 18.1 Basic Components of an Unstructured Clinical Interview for Eating Disorders

History and current experiences: Childhood (0–12 years) Adolescence (12–20 years) Young adulthood (20–35 years) Middle adulthood (35–49 years) Late adulthood (50 and older)	• Patient medical history, including treatment • Family medical history • Patient psychological history, including treatment • Medication history • Weight history: weight changes • Developmental history: mental and physical • Key life events • Social history • Family environment • Education and work history • Overall life functioning
Current psychological symptoms	• Eating disorder symptoms • Body image disturbance • General psychopathology • Personality disorder symptoms • Self-perception, physical and mental • Self-esteem
Current behavioral symptoms	• Restrictive eating • Binge eating • Compensatory behaviors • Excessive exercise • Behaviors associated with general psychopathology (e.g., social isolation associated with depression) • Behaviors associated with personality disorders (e.g., cutting)
Current medical consequences	• See Table 18.3 or Pomeroy (2004)

Partial Reporting. Partial reporting is common in patients referred to treatment by a family member, friend, or spouse. However, it can be observed in someone presenting for treatment without pressure from others. In the first case, patients who are not self-referred often are resistant to the interview process and may attempt to deceive the interviewer or omit pertinent information related to binge eating or weight control behaviors. Because these thoughts and behaviors often are secretive, they fear that exposure could lead to someone forcing them to change, leading them to be "fat" or "out of control." In the second case, even though some patients present for treatment on their own and really desire an understanding of their problems and treatment, they are often embarrassed or ashamed to share details and may minimize behaviors or severity to appear socially desirable during the assessment process. Both of these cases serve as significant barriers to initial information collection.

The Inexperienced Interviewer

- *Don't walk in unprepared.* Very few interviews are designed for the inexperienced clinician. Furthermore, some of the well-established interviews require more intensive training even for experienced clinicians (e.g., the EDE). People with eating disorders are extremely difficult to assess and treat and have a highly specialized group of symptoms and behaviors. It is unwise to approach assessment, particularly an interview modality, with little or no experience with eating disorder populations.

- *Don't alienate.* People who present for assessment for eating disorders vary in family history, age level, and ethnic and cultural background. Furthermore, they often have unique life experiences. Even within diagnostic categories, no two cases every look the same. Ideally, the patient should feel like part of the assessment team, working toward a common goal. Placing

too much focus on the disorder itself and not on the person engaged in the interview can alienate the person and disengage him or her from the assessment process.

- *Don't be insensitive.* Professional distance from patients is important. Interviewers with a history of eating disorders should not divulge this information to the patient. However, it is important that people being assessed and engaged in an interview feel as though they are identified with and that their struggle is valid. Therefore, it is also not recommended to talk down to the interviewee. Taking either one of these approaches may eventually sabotage the overall rapport and effectiveness of therapeutic relationship for the purposes of assessment and treatment.

- *Don't push it.* Assessment for an eating disorder often involves fear, anxiety, and feelings of loss of control. The line between gathering details of symptoms and pushing the client to divulge personal information is a fine one. Assessment often is a gradual process, and trying to be too efficient or trying to obtain information aggressively will not promote the goal of an adequate assessment.

- *Don't plant ideas.* The power of implication can be significant during the interview. Don't suggest reasons why a person might have the eating disorder, particularly ones that have not been shown in the literature to have a causal relationship (e.g., sexual trauma). This type of suggestion could be damaging to people who have experienced this type of trauma but are not ready to divulge such things in the interview, and it could be damaging to people who have not experienced this type of trauma because it could give them ideas for processing when they are most vulnerable that are unrelated to their actual life experiences.

Recommendations and Solutions

Neutralization of Ideas. As a rule, the interview is not the time to challenge overvalued ideas; however, it is important to recognize the potential relevance of overvalued ideas. Working through overvalued ideas related to eating disorders is a long-term process and is best accomplished when genuine rapport and a commitment to the treatment process have been established. It's often the case that challenging some of these notions, even minimally, without fully understanding them can threaten the credibility of the interviewer, compromise the interview, and make motivating the person to enter treatment difficult.

Gathering the Whole Story. In most cases, it is difficult to learn the full scope of the symptoms and severity in one interview. The initial interview can serve as a good basis from which to move forward in the assessment and treatment of eating disorders, however. In this process, it is important to act as a scientist, formulating hypotheses in order to ask additional questions needed to fill in any missing information. If an interviewee appears to be uncomfortable divulging certain types of information, it is important to note that because you can always revisit information or ease into it when greater rapport is established. In most cases, it is necessary to corroborate reports with family members or friends. Furthermore, it is possible that certain behaviors that occur only in secret (e.g., bingeing and purging), which the patient is very ashamed of, may be observed only in a hospital setting.

The Experienced Interviewer

- *Do get proper training.* Interviewers should get the proper training in the use of semistructured interviews for eating disorders and should practice. Having colleagues simulate certain disorders in order to practice rating severity and to compare reliability with others' ratings will help beginning therapists become more precise information gatherers and symptom raters, which helps to build confidence. This process eventually benefits both the interviewer and the patient, making the entire process more accurate and effective.

- *Do humanize the situation.* Reducing the stigma of eating disorders through education, including prevalence data, sociocultural influences, and maintenance factors can help the client become more comfortable disclosing information as he or she feels understood and not "crazy." It is also important to take into account cultural considerations and developmental level. The more the interview process is tailored to the interviewee's greatest level of understanding and unique needs, the more willing he or she will be to cooperate with the process.

- *Do express empathy.* Maintaining authority and rapport is a delicate balance in any therapeutic

relationship, but with regard to eating disorder assessment and treatment, this relationship is particularly difficult. This is the case because so often the patient believes that it is the interviewer's sole purpose to take control away from patients and possibly make them do things against their wishes (e.g., eat larger amounts of food without purging or gain weight). Therefore, the interviewer should be as empathetic as possible, which enables rapport and validates the patient's struggle. Furthermore, the clinician can use generic examples to illustrate points to express empathy or humanize details without making reference to eating disorder experiences he or she has had personally.

- *Do accept that comprehensive assessment is a process.* It is important to accept that not all of the necessary and relevant information can be obtained in one interview session. Assessment is a process, and significant amounts of information are learned over time. The interview often is one of the first steps in the process, and in this step it is important to establish rapport, gather symptom information, make a diagnosis if possible, and formulate hypotheses about case formulation and maintenance factors in order to do further assessment and treatment planning.

- *Do allow each interview to be an individual information-gathering process.* The interview is designed for the purpose of gathering information. This preliminary process is not designed to guide or lead the patient to specific conclusions about his or her situation. The interview is the first step in this information-gathering process and is also designed to establish rapport with the patient. Because the entire assessment process may involve several meetings over time and other forms of assessment (e.g., behavioral assessment), typically a feedback session is conducted in which a case formulation may be hypothesized and discussed with the patient. However, it is important that the interview process remain one of discovery and not be influenced by preliminary hypotheses or biases on the part of the interviewer.

Case Illustration With Dialogue

The following dialogue is an excerpt from a semistructured diagnostic interview for eating disorders. The interviewer's questions are drawn from the IDED-IV, developed by Kutlesic et al. (1998). This interview is designed to cover the bases of the core diagnostic features of eating disorders; however, additional questions often are needed to identify further relevant details for different interviewees. The following paragraphs describe the case example. The dialogue represents excerpts from a longer interview process.

The patient, Abby, was a 20-year-old single Caucasian woman who presented at a hospital treatment program for eating disorders, accompanied by her parents. She entered treatment at 5 feet, 6 inches tall and 98 pounds, with a body mass index of 16. She had not had a menstrual period in 4 months and was experiencing fatigue and dehydration. Abby was somewhat resistant to entering treatment but was open to finding relief for some of her symptoms (e.g., the need to binge and purge). She did not feel that certain habits were "useful," and they were causing her to have physical complications, such as extensive dental problems (e.g., many root canals in a short period of time), fatigue (not as productive in her sports activities), stomach pain, and "bloating."

Abby was an athlete at an early age and excelled in a number of activities, including basketball. She was a good student in school and was the youngest sibling of her family, with two older sisters and one older brother, all of whom excelled at sports. Abby's family members were of normal weight, and Abby was worried that she would look like her sisters as she began to get older, which included a somewhat bulky, masculine body shape. She also had concerns about not living up to the achievement in sports that her sisters had accomplished. Even though she was a college student, she still lived at home with her parents. She did not socialize with college friends and maintain a normal college life (e.g., attending social activities). Abby maintained a fairly rigid schedule of exercise, schoolwork, and sports that resulted in emotional withdrawal from her parents. She often avoided family meals even though she had no social plans. She would engage in chores, such as mowing the grass (additional exercise), or say she would eat later, which usually resulted in night bingeing and purging via self-induced vomiting and exercise rituals including running and sit-ups.

Interviewer:	What are your current concerns regarding your eating and your body weight?
Abby:	I feel that my current body weight is okay, but I do not want to go over

100 pounds. I also really would like to gain control over my overeating because I am worried it will lead me to gaining weight.

I: On a typical day, what do you eat?

A: I typically do not eat all day if I can. Sometimes I will drink some Diet Coke if I get hungry. At night, if I get really hungry, which I sometimes do, I will eat some salad, maybe some rice and meat with my family at dinner, and I will feel very full and fat.

I: When dieting, do you eat?

A: I really do not "diet." I try to not eat as much as possible, as often as possible. People, in general, eat too much. They say it all of the time on the news. Everyone is fat, and everyone is getting bigger and bigger. It is a good thing to eat healthy [endorsement of "health" behavior].

I: When did you first begin to lose weight by restricting your eating?

A: About a year ago. I weighed myself in the locker room one day and realized I had reached 130 pounds. That is just too much. That is what "heavy" people weigh, and it was weighing me down on the basketball court. Also, my sisters weigh that much and they look big. They are a size 6. You just look better if you are thinner [possible endorsement of overvalued idea].

I: Are there any factors or situations that seem to *increase* your periods of restrictive eating?

A: When I am stressed out over a test at school or when I have a game coming up or something like that. I feel like I have to be "on," in other words, perform and look good doing it. Also, if I weigh in the morning and it's close to 100, then I need to bring it down. I have to be under 100 pounds to look good and play good [endorsement of overvalued idea].

I: Are there any factors or situations that seem to *decrease* your periods of restrictive eating?

A: Not really, because I've been doing this so long that now, when I try to relax, it's all I can think about, and I'm constantly thinking about ways I can do a better job at getting my body into shape to do better at sports and look better [obsessional thinking]. It's a full-time job. You can't rest or it will sneak up on you [endorsement of a preoccupation with thinness]. You see all the time on TV, one minute a model is thin and the next she has gained like 20 pounds; that's totally out of control! That is why our country is so overweight [rationalization of the pursuit of extreme thinness due to idea that obesity is a problem].

I: Do you feel that your weight is normal right now?

A: Yes. I feel that I'm not one of those "sick" people that want to be 60 pounds or something, but I think 100 pounds is reasonable [denial and minimization of the seriousness of her body mass index of 16]. It's what everyone wants to be. I think it is a healthy weight for me.

I: How often do you weigh yourself?

A: Usually at least twice a day, morning and night, but if I eat something, like at night, I'll weigh after I eat [reflects preoccupation with body size and weight].

I: What emotional reaction would you have if you gained 2 pounds?

A: I would do more exercise, probably try to bring it down again. If I could do that, I wouldn't react that much.

I: What emotional reaction would you have if you gained 5 pounds?

A: I would freak out and probably be really down. I probably wouldn't leave the house until I could lose it. I would run and mow the grass and stuff. I might add some sit-ups.

I: What emotional reaction would you have if you gained 10 pounds?

A: Honestly, that would never happen because I keep things too much under control. I can't even imagine. It's too hard to think about. I would be so down, but I would be panicked about how to get it off. When I think about

it, my palms sweat [endorsement of severe fears of becoming fat or gaining small amounts of weight].

I: Do you wish to be thinner than you are now?

A: Hmmm, I could tone up a bit. I don't want to just be fit, I want to *look* fit.

I: Do you think or worry a lot about your weight and body size?

A: It's all I think about. I wake up in the middle of the night and think, "Hey, I can do a few sit-ups, I've got the energy." Sometimes, I never go back to sleep.

I: Do you ever feel fat?

A: Yes. My clothes touch me too much. Like when I eat, I feel my clothes, and I like them to feel loose, like I have room.

I: Tell me more about that.

A: If I eat a lot, I don't do this too much, I feel bloated, and [voice lowers, expressing feelings of shame] I have to get rid of it. Sometimes, I throw up.

I: What is too much?

A: If I eat dinner with my family sometimes, they make me eat what they eat, like rice, salad, and meat. It's a lot and it makes my stomach hurt. I can't take it.

I: Do you ever binge [rapidly consume a large amount of food in a discrete period of time, e.g., 2 hours]?

A: Sometimes if I get really hungry and haven't eaten all day I will get up late at night when everyone is sleeping and eat some things [endorsement of hiding binge eating].

I: What kind of foods?

A: Like cereal, ice cream, things like that.

I: How much food do you eat during a binge?

A: Sometimes, half a box of cereal and maybe a pint of ice cream and some cookies if we have some.

I: How long does the eating last?

A: Not too long, maybe 30 minutes or so. That is about all I can take, and then I just feel sick, and disgusting, like I'm a bad person or something. I'm so ashamed [endorsement of shame surrounding binge eating].

I: Do you feel you can stop eating once a binge has begun?

A: No. Usually I'm kind of into it until I start feeling stomach pain, then, I wake up and realize, "Oh my gosh, if I don't stop, I'll get fat." I feel so out of control.

I: When binge eating, do you feel your eating is more rapid than normal?

A: Yes. I'm such a pig. I feel so full, like I could pop.

I: Do you ever feel as though you have overeaten when you eat small portions of certain fattening foods?

A: Yes. I feel full if I eat anything, especially if I've gone all day without eating. My stomach is shrunk, which is what I like. I have thrown up two cookies before because I could feel them in my stomach taking up space. Also, it just bothers me to know they are there.

I: Explain that.

A: I feel worse when I eat bad food than when I eat pure food. When I eat bad food, no matter how much, I don't want it in my body.

I: Define "bad food."

A: High carb, high sugar, high fat. Anything that can make me fat [defining "forbidden foods"].

I: Define "pure food."

A: Anything that is low in calories that cannot make me fat. Lettuce is a good example. No one can deny that lettuce is a health food [attempting to normalize thoughts and behavior].

Abby presented with low body weight, restrictive eating behavior, binge eating, and purgative behavior, including self-induced vomiting and excessive exercise. In addition, she would offer to do extra chores for her parents (e.g., mow the grass several times per week), and her parents would concede, not catching on to her intentions (i.e., to burn extra calories). Throughout the

interview, Abby alluded to a strong fear of fatness and a drive for thinness, rationalizing that weight gain—or in her mind "obesity"—was "unhealthy." She also reported desiring a very low weight (100 pounds) for her height under the same caveat. Abby expressed shame related to her binge eating and reported engaging in behaviors to hide it. However, she endorsed her "healthy" behaviors and openly reported her exercise habits and her justification for why it was "healthy" behavior. She admitted to being preoccupied with her body size and weight and endorsed avoidance of forbidden foods. Abby also began to admit that on some level the thoughts and behaviors related to her eating disorder had become difficult to maintain even though she valued them, which was taken as a sign of some level of motivation for change. In sum, Abby was diagnosed with anorexia nervosa, binge-purge subtype, and was referred for treatment, beginning with an inpatient level of care to stabilize weight, reduce bingeing and purging behaviors, work toward healthy eating and exercise patterns, and reduce overvalued ideation related to body size and shape.

Multicultural and Diversity Issues

Over the years, research has challenged the notion that eating disorders and body image disturbances are limited to Caucasian populations, with more evidence that eating disorders and body image disturbance are present in men and women and in people of diverse ethnicities (e.g., African American, Latin American, and Asian populations: Yanovski, 2000). However, the presentations of such symptoms and concerns are complex and not fully understood. When assessing people for eating disorders, clinicians and researchers must take into account the intricate interactions between psychological, social, and ethnic factors that play a role in eating disorders. Throughout the literature, several important variables have emerged, including gender, ethnicity, and culture.

Men

Historically, research has focused on eating disorders and body image concerns in women. It is now clear that body dissatisfaction is common among men (Adams, Turner, & Bucks, 2005). The results of a recent study show that body dissatisfaction plays a key role in the relationship between homosexuality and eating disorder symptoms (Hospers & Jansen, 2005). However, body image concerns and eating disorders are not limited to homosexual men. Other issues related to body image concerns in men are steroid abuse (Blouin & Goldfield, 1995) and a "reverse anorexia nervosa" (Pope, Katz, & Hudson, 1993), later renamed "muscle dysmorphia" (Pope, Gruber, Choi, Olivardia, & Phillips, 1997). Muscle dysmorphia is characterized by the belief that the person looks small even though in reality he or she is of normal size or very muscular (Pope et al., 2005). This belief, not unlike other body image concerns, may lead men to engage in eating disorder behaviors to achieve their desired body size and shape, such as excessive exercise, unhealthy eating habits, and substance use.

African American and Hispanic Women

Overweight and obesity often are a risk factor for eating disorders. Given this fact, African American and Hispanic girls may be at risk for eating disorders because of their greater propensity for overweight. African American women have been shown to be less likely to diet than their Caucasian counterparts (Akan & Grilo, 1995). African American women and adolescents have been shown to have less body size dissatisfaction and choose a larger "ideal body size" than Caucasian women in studies of body image (Stewart, Williamson, Allen, & Han, 2005; Williamson, White, Newton, Alfonso, & Stewart, 2005). However, in a recent study of psychiatrically hospitalized female adolescents, African American adolescents endorsed some eating disorder symptoms at similar rates as Caucasian girls (White & Grilo, 2005). Recent studies show that Latina adolescents (ages 11–20) have prevalence rates of eating disorders consistent with U.S. trends (Granillo, Jones-Rodriguez, & Carvajal, 2005). Body dissatisfaction, substance use, low self-esteem, and negative affectivity were some of the main risk factors for the development of eating disorders in this population. In a recent study examining predictors of body image dissatisfaction and disturbed eating attitudes and behaviors in African American and Hispanic girls, approximately 13% of the Hispanic girls and 10% of the African American girls met criteria for a diagnosis of a probable eating disorder. In this study, fear of negative evaluation was a key differentiating factor between the groups with eating disorder

symptoms and groups without eating disorder symptoms (Vander & Thomas, 2004).

Asian Women

The study of body image disturbance and eating disorders in Asian populations has increased significantly in the past 20 years. Over this time period, research has generated conflicting results and many methodological problems associated with studying this population. The current *DSM* diagnostic criteria may not be appropriate for capturing eating disorder symptom patterns in Asian populations because they often present with different symptom profiles than their Western counterparts (Cummins, Simmons, & Zane, 2005). For example, it has been observed that some groups who receive treatment for eating disorders in Asian countries (e.g., Hong Kong, India) may be less likely to present with symptoms of body image disturbance than patients in Westernized countries. This makes it difficult to draw conclusions from studies directly comparing prevalence rates of eating disorders in Western countries and Asian countries. Furthermore, Asian countries are not homogenous. Research has yielded different results based on the population and country in which investigations have taken place.

Acculturation

Finally, there is a continuing debate on whether acculturation lends itself to higher or lower rates of eating disorders. A recent study concluded that the prevalence of eating disorders in non-Western countries is lower than that in Western countries but appears to be increasing (Makino et al., 2004). However, the results of many studies examining whether higher levels of acculturation led to higher levels of eating disorders in members of the minority group (e.g., Asians) acculturating to the dominant group (Westerners) are mixed. For a review, see Cummins et al. (2005).

Differential Diagnosis and Behavioral Assessment

In order to differentially diagnose AN, BN, BED, or ED-NOS, the interviewer must ask specific questions to determine the presence or absence of particular symptoms and the nature of those symptoms. The key domains that are used in differential diagnosis include body size, restrictive eating, binge eating, compensatory behavior (e.g., purging), body image disturbance, and general psychopathology. Furthermore, it is often beneficial to take into account physical complications and medical conditions (e.g., dehydration, constipation). Table 18.2 summarizes the primary symptoms required for differential diagnosis of AN, BN, ED-NOS, and BED.

Behavioral Assessment

It is useful to supplement interview methods with behavioral assessment methods and self-report methods to corroborate information obtained through interviews, particularly with regard to body image (Stewart & Williamson, 2004a). Furthermore, patients with eating disorders often have special problems that are unique to concerns about eating and body size and shape, including body checking, food craving, and muscle dysmorphia (Stewart & Williamson, 2006). Two methods of behavioral assessment are described here.

Self-Monitoring. Self-monitoring of food intake is a method of gaining insight about the eating patterns or eating experiences of people diagnosed with eating disorders. Self-monitoring of food intake may include types and amounts of food eaten, temporal eating patterns, frequency and topography of binge episodes and purgative behavior, and mood before and after the meal (Williamson, 1990). There is controversy over the reliability and validity of self-reported binge-purge episodes and food intake (Anderson & Maloney, 2001). In addition, because of the shame they experience, some people with eating disorders deliberately minimize or deny eating pathology on self-report forms (Crowther & Sherwood, 1997). Despite these concerns, self-monitoring can be a useful clinical tool in addition to other measurement tools for the assessment of eating disorder symptoms.

Test or Therapeutic Meals. Test meals may be used as part of the assessment or treatment process for eating disorders. A test meal allows the clinician or researcher to observe the direct act of food consumption. This is particularly useful in the event that the patient omits key details about his or her eating habits during self-monitoring. This method of assessment may be used for observing eating behavior (e.g., rate of eating, anxiety while

Table 18.2 Guidelines for Differential Diagnosis of Eating Disorders

Eating Disorder Diagnosis	*Presenting Symptoms for Diagnosis*	*Common Associated Symptoms*	*Common Physical Complications*	*Symptoms Contraindicated for Diagnosis*
Anorexia nervosa, restricting type	• 15% below normal body weight • Severe restrictive eating • Fear of weight gain • Loss of menses • Body image disturbance	• Depression • Anxiety • Denial or minimization of the seriousness of weight status or weight loss	• Inanition • Bradycardia • Hypotension • Hair loss • Low body temperature • Dry skin • Lanugo • Brittle hair or nails • Loss of or irregular menses • Cold intolerance • Headache • Fatigue	• Normal weight or overweight • Binge eating • Purgative behavior
Anorexia nervosa, binge-purge type	• 15% below normal body weight • Severe restrictive eating • Fear of weight gain • Loss of menses • Presence of bingeing and purging • Body image disturbance	• Depression • Anxiety • Denial or minimization of the seriousness of weight status or weight loss	• All physical complications associated with restricting type possible • Physical complications with bulimia nervosa, binge-purge type possible	• Normal weight or overweight
Bulimia nervosa, binge-purge type	• Normal to 10% below or above normal weight • Frequent binge eating • Frequent purging, such as self-induced vomiting or misuse of laxatives, diuretics, or enemas • Body image disturbance	• Denial or minimization of binge-purge behaviors • Anxiety • Depression • Social isolation	• Erosion of dental enamel • Peripheral edema • Salivary gland enlargement • Abrasions on fingers or back of hand from self-induced vomiting • Fatigue • Headaches • Constipation • Abdominal bloating • Irregular menses	• Emaciation • Absence of bingeing and purging
Bulimia nervosa, nonpurging type	• Normal to 10% below or above normal weight • Frequent binge eating • Fasting or excessive exercise as compensatory behavior • Body image disturbance	• Shame regarding binge eating • Concern about weight • Anxiety • Depression	• Peripheral edema • Fatigue • Dry skin • Dehydration • Headaches • Constipation • Abdominal bloating • Irregular menses	• Use of vomiting, diuretics, or enemas as a method of purging
Binge eating disorder	• Frequent binge eating • Normal weight, overweight, or obese	• Shame regarding binge eating • Concern about weight • Anxiety • Depression • Social isolation	• Complications of obesity	• Compensatory behavior • Low to emaciated weight

eating, food mixing). Caloric intake may be calculated as well. Furthermore, with the use of a hierarchy of feared foods, this activity is useful as exposure with response prevention for the consumption of feared or "forbidden" foods and the act of consuming food in general (Stewart & Williamson, 2004c).

Selection of Treatment Targets and Referral

The following are treatment targets as suggested by Stewart and Williamson (2004c). These targets are listed in the order in which they would logically be addressed in the treatment process.

1. The patient and family members must be educated with regard to eating disorders, body image, and the patient's conceptualization and process of treatment. This objective serves the function of putting to rest misconceptions and misinformation about eating disorders and treatment and provides accurate information to facilitate treatment and the patient and family roles in that process.

2. Medical complications that have developed as a result of starvation, binge eating, or purging must be corrected. In conjunction with this focus, the establishment of a healthy weight is key to reducing medical risk. The objective is that as the body weight stabilizes to a healthy level, patients will become more cognizant of and responsive to other treatment modalities.

3. Establishment and stabilization of healthy eating patterns are essential for maintaining healthy weight, including a healthy schedule of eating, nutritionally sound eating (recommended content and quantity of food), and adherence to recommended meal plans.

4. Physical activity habits must be modified to promote healthy weight gain or loss, followed by healthy weight maintenance. A prescribed exercise plan to facilitate the patient's recovery, eliminating compulsive exercise or sedentary behavior, is recommended. For example, anorexic patients who need to gain weight may need no exercise for a length of time, whereas overweight patients may need exercise in order to reach treatment goals.

5. Resolution of the psychological problems that contributed to the development and maintenance of the eating disorder is important in achieving remission or recovery. These psychological goals include enhanced awareness and processing of biased information and obsessive and rigid behaviors related to eating and weight.

6. Modification of body image disturbance is a core target to be addressed in treatment but often cannot be addressed until more critical elements are stabilized (e.g., refeeding). This involves many components that aim to promote the evolution of distorted and dissatisfied thoughts related to the body into a more neutral and accepting stance (Stewart, 2004).

7. Functioning in the social and family relationships must be enhanced, marked by greater overall comfort in relationships and enhanced cooperative and effective communication.

8. Strategies must be developed for relapse prevention, marked by sustained awareness of and adherence to health behaviors and establishment of and adherence to specific plans for the management of high-risk situations that may lead to recurrence of eating disorder perceptions, thoughts, beliefs, and behaviors.

SOURCE: Adapted from Stewart & Williamson (2004a).

With these targets in mind, different levels of care are needed for different levels of severity of eating disorders. Typically, people with greater medical risk (e.g., extremely low body weight) or severe behavioral patterns (e.g., severe purging) will need inpatient care. However, some people are well suited for care at lower levels (e.g., partial hospitalization or outpatient levels) and move toward a remission of symptoms with success. A summary of requirements for the different levels of treatment is provided in Table 18.3. For further information on multidisciplinary treatment of eating disorders and levels of care, see Stewart and Williamson (2004b).

Summary

The assessment of eating disorders is complex. Psychological, behavioral, medical, and social factors coalesce to form the syndromes described by the *DSM-IV* diagnostic criteria. Eating disorders

Table 18.3 Eating Disorder Treatment Referral: Levels of Care

Level of Care	*Criteria*
Inpatient	**Criteria for Admission to Inpatient Level of Care** • The patient is medically unstable. • The patient is weighs less than 85% of his or her ideal body weight. • The patient is suicidal or homicidal. **Criteria for Step Down to Lower Level of Care** • The patient is medically stable but may have binge-purge cycles and is participating in less restrictive eating. • The patient is 85–92% of his or her ideal body weight. • The patient is not homicidal or suicidal.
Partial hospitalization	**Criteria for Admission to Partial Hospitalization Level of Care** • The patient is medically stable but may have binge-purge cycles or restrictive eating. • Patient is not suicidal or homicidal. • Patient is motivated for treatment. • Patient has body weight that is between 85% and 92% of his or her ideal body weight. **Criteria for Step Down to Lower Level of Care** • The patient has had a significant decrease in binge eating and purging behaviors. • The patient is not suicidal or homicidal. • The patient is willing to participate in treatment and motivated. • The patient achieves a stable body weight greater than 92% of his or her ideal body weight.
Intensive outpatient	**Criteria for Admission to Intensive Outpatient Level of Care** • The patient is medically stable. • The patient is not suicidal or homicidal. • The patient exhibits a significant decrease in restrictive eating or binge-purge behaviors. • The patient exhibits improved nutrition. • The patient actively participated in the treatment process and discharge planning. • The patient continues to need structure. • The patient exhibits self-motivation to achieve recovery from eating disorder symptoms. **Criteria for Step Down to Lower Level of Care** • The patient is medically stable. • The patient is not suicidal or homicidal. • The patient's levels of bingeing and purging are not severe. • The patient's nutritional status is not severe. • The patient is willing to participate in the treatment planning and discharge planning process but continues to need structure in care. • The patient's body weight is greater than 92% of his or her ideal body weight.
Aftercare or traditional outpatient	• Individual outpatient treatment with a therapist or psychiatrist. • Weekly support group. • Family therapy. • Family support group.

are multifaceted disorders. In this regard, interview questions must span psychological, behavioral, medical, and social factors to help the interviewer gain a clear idea of the person's needs. Furthermore, although eating disorders share common patterns, eating disorders from individual to individual are rarely the same, particularly with regard to historical factors and variables that maintain the eating disorder symptoms. It is particularly important in the interview to cover these bases when gathering the details of each person's story. A key feature of some interviewees is a reluctance to come forward with information that they feel ashamed of, so an empathetic, understanding, and guiding approach is necessary in the interview process in order to reach a clinically relevant outcome. Finally, the interview process is key to the identification of all treatment targets, prioritization of those targets, and referral to appropriate treatment based on the urgency of the patient's needs and the assessment of treatment progress over time. The interview often acts as the core of the assessment, with behavioral assessment, self-report measures, and self-monitoring tools supplementing the information collected in the interview. Though often time consuming, the interview can be a remarkable tool for rapport building, diagnosis, case conceptualization, development of treatment targets and planning, and treatment outcome.

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19

BORDERLINE PERSONALITY DISORDER

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DESCRIPTION OF THE DISORDER

Borderline personality disorder (BPD) is characterized by severe dysregulation across cognitive, behavioral, emotional, and interpersonal and intrapersonal spectrums. Emotional responses are intense and highly reactive. Episodes of depression, anxiety, and irritability are common, as re difficulties with anger and anger expression (both inhibited and explosive). Relationships may be intense and tumultuous; sensitivity to criticism and fear of rejection may result in concentrated efforts to avoid relationship rupture and preserve connections to significant people. In times of acute stress, cognitive processes may be affected, resulting in brief episodes of paranoia, delusional thinking, and a spectrum of dissociative experiences (e.g., depersonalization, derealization, amnesia). Additionally, identity disturbance, in the form of chronic feelings of emptiness and shifting values, preferences, and life goals, is common.

Suicidal behavior is common among people with BPD. In fact, BPD is one of only two *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) disorders for which suicidal behavior is a criterion (American Psychiatric Association [APA], 2000). It is estimated that approximately 80% of people with BPD will engage in some form of nonfatal suicidal behavior (i.e., intentional self-injurious act with or without intent to die) (Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983; Cowdry, Pickar, & Davies, 1985; Frances, Fyer, & Clarkin, 1986; Grove & Tellegen, 1991; Gunderson, 1984; Stone, 1993), and approximately 10% will die by suicide (Black, Blum, Pfohl, & Hale, 2004; Paris & Zweig-Frank, 2001). Suicide rates double among people with a history of previous suicidal behavior and triple for those meeting all nine *DSM-IV* BPD criteria (Stone, 1993; Stone, Hurt, & Stone, 1987).

The prevalence of BPD in the general population is approximately 1% to 2% (Samuels et al., 2002; Torgerson, Kringlen, & Cramer, 2001). Although it is disproportionately diagnosed in women (APA, 2000), the true prevalence by gender is unknown. Prevalence estimates for psychiatric samples range from 9% to 20% (Zimmerman, Rothschild, & Chelminski, 2005; Fossati et al., 2000), making BPD one of the most common personality disorders encountered in clinical settings.

Central to the definition of BPD are the qualities of pervasiveness and the longstanding nature of the disorder. However, recent research from two large-scale longitudinal studies is challenging this view of BPD. Data suggest that most patients exhibit substantial improvement over time, with many demonstrating complete remission from BPD diagnostic criteria (Paris & Zweig-Frank, 2001; Zanarini, Vujanovic, et al., 2003). However, people with BPD often have marked decrements

in multiple areas of psychosocial functioning, resulting in a diminished quality of life for many. Such life dissatisfaction, combined with suicidal and other life-threatening behaviors, often results in extensive use of treatment resources.

Interviewing Strategies

Scope of Diagnostic Assessment

A range of assessment procedures are available for diagnosing BPD. The first task is to decide the scope of the assessment and determine which diagnostic tools are best suited to the task. The most comprehensive level of assessment is to assess for the presence of all Axis I and Axis II disorders. Given the evidence that most people meeting criteria for one personality disorder meet criteria for additional personality disorders (Zimmerman et al., 2005) and the impact of such co-occurrence and of Axis I disorders on treatment response (Akiskal, 2004; Paris, 2005;[[**AUTHOR; 2005a or 2005b?**]] Skodol et al., 2002; Smith, Muir, & Blackwood, 2004; Tyrer, 2004; Zimmerman & Mattia, 1999), this level of assessment may be warranted. However, consideration must be given to time and monetary constraints. When both are limited, a self-report questionnaire might be the only practical choice. However, it is critical to note that such an approach is not free of limitations and would limit the scope of the diagnostic assessment.

The diagnostic battery adopted by the University of Washington Behavioral Research and Therapy Clinics ("the Linehan research lab") uses standard tools from the clinical and research field for diagnosing Axis I and Axis II disorders. The battery consists of a combination of the Structured Clinical Interview for *DSM-IV* Axis I Disorders Patient Edition (SCID-I/P; First, Spitzer, Gibbon, & Williams, 1995) to assess for all Axis I disorders, the International Personality Disorder Examination (IPDE; Loranger, 1995) to assess for all Axis II personality disorders, and the BPD section of the Structured Clinical Interview for *DSM-IV* Axis II Personality Disorders (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin, 1996) to confirm the BPD diagnosis.

All three instruments possess sound psychometric properties, are easy to administer, and are routinely used in research. The IPDE is the most widely established measure of personality disorders currently available, being compatible with both the *DSM-IV* and the *International Classification of Diseases* (*ICD-10;* World Health Organization, 1992) classification symptoms, and is used by the World Health Organization. The IPDE is of particular value in a research setting because of its conservative guidelines that require a minimum of a 5-year history of current symptoms. This decreases the number of false-positive BPD diagnoses. The IPDE has the additional benefit of being scored categorically as well as dimensionally. We confirm the diagnosis with the SCID-II because most research clinicians use the SCID-II. The combination of the two measures constitutes a robust battery for BPD diagnosis that allows meaningful comparisons across various research studies locally and internationally.

The time estimated for collecting the aforementioned diagnostic information is as follows: 30 minutes for the SCID-I social history interview (precursor to the diagnostic interview), 90 minutes for the SCID-I, 45 minutes for the IPDE BPD section, 15 minutes for the SCID-II BPD section, and 2 hours to complete the remainder of the IPDE. Individual administration times may vary depending on complexity of symptoms and whether additional information (e.g., review of medical records, interviewing treating clinicians or significant family members) is required to make definitive diagnoses.

Outside the research context, the typical provider may feel overwhelmed at the prospect of dedicating the necessary financial and time resources to this type of comprehensive assessment. In a study comparing structured diagnostic measures with standard clinical assessment, Egan, Nathan, and Lumley (2003) advise clinicians to maximize efficiency by investing resources in comprehensive diagnostic assessment "rather than spending time forcing possibly misleading selections between diagnoses in patients who present a very complex diagnostic picture" (p. 449). They go on to state, "Without accurate diagnosis and consequent treatment planning for all disorders . . . treatment may be less effective" (p. 450). Thus, the frequent overlap of Axis I and Axis II diagnoses among those with BPD and the clinical complexity thereby introduced indicates that even beyond the research context, one could save time and money by getting a more complete clinical picture at the beginning.

Selection of Diagnostic Instruments

Beyond the unstructured clinical interview, there are three approaches to assessment and diagnosis of personality disorders: structured or semistructured interviews, self-report questionnaires, and clinician report inventories or checklists. In this section we discuss semistructured and self-report questionnaires because they are the most frequently used in clinical practice. (For a comprehensive review of the most commonly used instruments for assessment of personality symptoms, see Widiger, 2002.)

Semistructured Interviews

Five semistructured interviews are in use for personality disorder diagnosis based on the *DSM-IV* criteria: the IPDE (Loranger, 1995), the SCID-II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997), the Structured Interview for *DSM-IV* Personality Disorders (Pfohl, Blum, & Zimmerman, 1997), the Personality Disorder Interview–IV (Widiger et al., 1995), and the Diagnostic Interview for Personality Disorders (DIPD-IV; Zanarini, Frankenburg, Sickel, & Yong, 1996).

To date, no empirical advantage has been identified for using one interview over another (Farmer & Chapman, 2002; Skodol et al., 2002; Zanarini, 2003). This is not to say that there are not pros and cons to the various approaches depending on the setting and context. For example, if time constraints are an issue, then there is much benefit to using the SICD-II, which takes the least amount of time to administer at 36 minutes (Beck, Freeman, Davis, & Associates, 1990), compared with the IPDE, which takes the most amount of time to administer (Widiger, 2002) at 2 hours and 20 minutes (Loranger et al., 1994). Additionally, both the SCID-II and IPDE have self-report questionnaires available that can be used as screening instruments in order to eliminate portions of the general personality disorder interview, thereby significantly decreasing assessment time (Widiger, 2002).

Self-Report Questionnaires

The following self-report questionnaires are the most commonly used self-report measures for the assessment of the *DSM-IV* personality disorders (Widiger, 2002): the Millon Clinical Multiaxial Inventory–III Axis II (Millon, Millon, & Davis, 1994), the Personality Diagnostic Questionnaire–4 + (Hyler, 1994a), the Wisconsin Personality Disorders Inventory–IV (Klein & Benjamin, 1996), and the SCID-II PQ (First et al., 1997), for use with the SCID-II as a screening device. Additionally, according to a fairly new study, the Assessment of *DSM-IV* Personality Disorders Questionnaire (Schotte & De Doncker, 1996) appears to be a promising addition to this list (Schotte et al., 2004).

Although other measures, such as the Minnesota Multiphasic Personality Inventory (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; Hathaway & McKinley, 1943), the Coolidge Axis II Inventory (Coolidge & Merwin, 1992), and the Personality Assessment Inventory (PAI; Morey, 1996) may provide valuable clinical information about personality traits and style, they are not included in the list provided here because they are not specifically tied to the *DSM-IV* personality disorder scales (Widiger, 2002).

Self-report measures for personality disorders have many advantages over interviewer-administered measures, such as shorter administration time, no interviewer bias, and less resource use in terms of staff training and time. Their primary disadvantage is that they are not recommended for diagnostic purposes because of their low diagnostic concordance with semistructured interviews and their tendency to overdiagnose co-occurring personality disorders (Beck et al., 1990; Farmer & Chapman, 2002; Hunt & Andrews, 1992; Modestin, Erni, & Oberson, 1998; Perry, 1992; Widiger, 2002). One possible exception to this is the Assessment of *DSM-IV* Personality Disorders Questionnaire (Schotte & De Doncker, 1996), which in a recent study showed good differential validity (ability to differentiate between symptomatic and nonsymptomatic clients), had decent convergent validity with the SCID-II, and did not over diagnose co-occurring personality disorders (Schotte et al., 2004).

Because of the problems noted earlier, self-report questionnaires are recommended primarily as tools to collect trait-specific information to supplement *DSM-IV* diagnoses (Beck et al., 1990; Skodol et al., 2002; Smith, Klein, & Benjamin, 2003) or as screening tools to be given before a semistructured interview. The McLean

Screening Instrument for Borderline Personality Disorder (MSI-BPD; Zanarini, Vujanovic, et al., 2003) is one such device. Adapted from the BPD module of the DIPD-IV for use as a screening device, the MSI-BPD is a BPD-specific instrument designed to inform additional assessment and not as a standalone diagnostic measure (Zanarini, Vujanovic, et al., 2003).

Successful screening reduces patient burden and maximizes assessment efficiency. Screening information directs the assessor to thoroughly evaluate only the personality disorders for which minimal endorsement has been made, the net effect of which is a reduction in assessor time and a corresponding reduction in assessment costs.

Dimensional Versus Categorical Approach to Diagnosis

The instruments described earlier are based on the *DSM-IV* diagnostic criteria. Recently, though, there has been controversy over the validity of the *DSM-IV* diagnosis of personality disorders. Peter Tyrer (2004) comments, "No one doing research on personality disorders is satisfied with the current diagnostic systems" (p. 371). In fact, the literature is full of articles questioning the *DSM-IV* criteria for Axis II disorders (Farmer & Chapman, 2002; Gabbard, 1997; Tyrer, 2004; Verheul, 2005; Widiger, Simonsen, Krueger, Livesley, & Verheul, 2005).

The most often cited deficiencies include extensive overlap between categories (Skodol et al., 1999), lack of distinction between discrete personality disorder categories and the lack of empirical support for the arbitrary cutoff points (Egan et al., 2003; Skodol et al., 2002; Widiger et al., 2005), the absence of a theoretical basis for each personality disorder (Farmer & Chapman, 2002), the heterogeneity within categories (Skodol et al., 1999), the lack of clinical utility (Skodol et al., 2002; Widiger et al., 2005), the lack of clear distinction between normal and abnormal personality (Farmer & Chapman, 2002; Skodol et al., 2002; Tyrer, 2004), and the inability to cover the breadth of personality psychopathology seen in clinical practice (Skodol et al., 2002; Widiger et al., 2005).

Because of these deficiencies, many researchers and clinicians are calling for a change in the way personality disorders are diagnosed. Rather than using the categorical model of classification, many are calling for dimensional models of classification either to replace the categorical approach or to supplement the current *DSM-IV* model (Beck et al., 1990; Clarkin, Hull, Canoter & Sanderson, 1993; Egan et al., 2003; Modestin et al., 1998; Skodol et al., 2002; Smith, Muir, & Blackwood, 2004; Tyrer, 2004; Widiger et al., 2005).

In light of this heterogeneity, both within and between categories, it can be beneficial to gather additional trait-specific information from clients diagnosed with BPD. Any two people given the *DSM-IV* BPD diagnosis are required to share only one criterion of the nine (Skodol et al., 1999) thus making generic treatment planning problematic. Distinguishing between underlying traits of the disorder can facilitate development of trait-specific treatments that target each client's most problematic areas. Several instruments have been developed specifically for measuring BPD traits and trait versus state aspects of BPD. These are described here to further aid clinicians in determining what to include in their assessment battery.

Instruments for BPD

A number of instruments have been developed specifically for BPD assessment. Two interviews, the PAI (Morey, 1996) and the Revised Diagnostic Interview for Borderlines (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989) give the treatment provider more dimensional or trait-specific information related to BPD. Skodol et al. (2002) describe four subscales within the PAI—affective instability, identity problems, negative relationships, and self-harm—and note that the DIB-R differentiates between five components of the disorder: social maladaptation, impulsivity, affectivity, psychosis, and interpersonal relationships.

Another trait-specific questionnaire that has recently been developed is the Borderline Symptom List (Bohus et al., 2001). It is a 95-item self-rating scale developed from the *DSM-IV* criteria for BPD, the DIB-R, BPD experts, and feedback from patients with BPD. It was evaluated on 308 psychiatric patients in Germany who were diagnosed with BPD. Factor analysis of the results showed seven factors: self-image, affect regulation, auto-aggression, dysthymia, social isolation, intrusions, and hostility (Bohus et al., 2001).

The Questionnaire of Thoughts & Feelings (Renneberg, Schmidt-Rathjens, Hippin, Backenstrass, & Fydrich, 2005) is a new instrument that was constructed "to measure not only behavioral aspects of BPD but to focus on underlying cognitive assumptions and motivational aspects leading to behaviors typical for BPD." It is a 34-item questionnaire that takes 5–10 minutes to complete and is meant to measure the degree and content of cognition, which can then be used for treatment planning and evaluation. It is recommended primarily for the assessment of treatment outcome of cognitive-behavioral interventions for BPD (Renneberg et al., 2005).

The Zanarini Rating Scale for Borderline Personality Disorder (Zanarini, 2003), adapted from the BPD module of the DIPD-IV, is the first clinician-administered scale for the assessment of change in *DSM-IV* borderline behaviors. There are nine questions, each based on one of the nine BPD criteria of the *DSM-IV*. Each question is answered with respect to the preceding week and ranked according to a five-point severity rating scale. Ratings range from 0 to 4, with lower scores reflecting no or mild symptoms and higher scores reflecting more severe symptoms. Total scores range from 0 to 36. The scale was developed as an outcome measure intended to help the researcher or clinician better understand the changes in psychopathology that occur in treatment (Zanarini, 2003).

Another outcome measure with a 1-week timeframe is the Borderline Evaluation of Severity Over Time (Blum, Bartells, St. John, & Pfohl, 2002). This 15-item self-report measure, based on *DSM-IV* criteria, assesses three domains: negative thoughts and feelings, positive behaviors, and negative behaviors. Each item is rated on a five-point scale, with 1 = *none or slight* and 5 = *extreme*. The composite score yielded is between 12 and 72 (Blum, Pfohl, St. John, Monahan, & Black, 2002).

The PAI and the DIB-R are both measures in widespread use that are listed frequently in PsycINFO (PAI 250 times, DIB-R and DIB 107 times). The Borderline Symptom List, Borderline Evaluation of Severity Over Time, Zanarini Rating Scale for Borderline Personality Disorder, and Questionnaire of Thoughts & Feelings (and the MSI-BPD, described earlier) are relative newcomers that probably will be seen more frequently in future literature as time goes on. Which instruments to choose depends largely on the context (research or clinical), scope (single diagnosis or multiaxial assessment), frequency of administration, and available resources of the clinician.

The Diagnostic Interview

The context of the assessment probably will dictate who conducts the diagnostic interview. In many private practice settings a single provider conducts both the diagnostic assessment and treatment. On the other hand, group practices, hospital environments, and community mental health agencies are likely to have specialized personnel conducting assessment or treatment functions. Because of the requirements for blinded assessment methods, clinical research centers require that treatment and assessment functions be separated.

There are pros and cons to separated and integrated models of assessment. In integrated models, the assessment process lays the foundation for the therapeutic relationship and helps motivate clients to change. When assessment is separated from treatment, the diagnostic assessment is purely about the interview process and about collecting information to establish diagnoses. Much like a stenographer who keeps the court record or a journalist who collects facts, the assessor records the details of the clients' lives.

The relationship between the assessor and the client is important. Valid diagnosis depends on the accuracy of the information the client provides. Establishing rapport and creating an environment where the client feels safe to freely and honestly talk about the specifics of his or her life without fear of criticism or judgment is essential. Although the concept of the therapeutic alliance has received little empirical investigation in the context of psychiatric interviewing, it is no less important in assessment than in psychotherapy (Carlat, 2005).

There are many books about effective interviewing and what skills one needs to be an effective interviewer. They generally begin with setting the tone or establishing rapport and go on to discuss the different strategies used to motivate clients to change. Although the latter is important for those who conduct both assessment and treatment, it is establishing rapport that is singularly critical for assessment. Many consider Carl Roger's core conditions, a set of skills and an attitude on the part of the clinician (Cormier & Nurius, 2003; Sommers-Flanagan &

Sommers-Flanagan, 1999), essential to creating rapport during the interview.

For those conducting diagnostic assessments for BPD, creating an early therapeutic alliance is especially important. That said, it is also somewhat daunting because the disorder's hallmarks of intense emotionality, chaotic relationships, and recurrent suicidal behaviors make an assessment interview particularly difficult because the emotional reactions that can lead to these behaviors often are elicited in the context of interviewing.

However, it has been our experience that although clients often exhibit intense mood lability during the assessment interview, they rarely show pronounced increases in urges to self-harm or suicide. One possible explanation for this is that these behaviors, which often occur in the context of therapy, simply do not show up in assessment because of the distinctive, short-term, nontreatment quality of the assessment relationship. However, because emotional reactions can be more severe with BPD, Roger's core conditions are especially important points to consider when assessing clients with BPD.

These core conditions require that the interviewer show empathy, be genuine, and have positive regard for the client. In their book *Clinical Interviewing,* Sommers-Flanagan and Sommers-Flanagan (1999) state that "empathy elicits information. . . . When clients feel understood, they also tend to feel more open and willing to talk about their concerns in greater detail" (p. 135), which is exactly what is needed in assessments of clients with BPD.

With this in mind, be genuine, noncritical, nonjudgmental, accepting, and affirming. Use self-disclosure sporadically, but not inappropriately, and use humor to lighten things up. Stay professional but not detached, and show warmth. Show interest in the client's life and the people in the client's life. Show concern for the hardships in the client's life, but don't show pity or become overly emotional about the events that plague them.

Acknowledge the difficulty of the questions asked and the length of time needed to spend at the office or clinic. If a client does not understand a question, say that you did not explain it very well and then rephrase the question. Stop the interview if clients are too upset to continue. Offer to take a walk with them or talk to them about trivial things such as movies, books, or TV shows until they are able to continue. Treat them with compassion and sensitivity and help them to move through the difficult assessment process as easily and with as much dignity as possible. In return, you will have the privilege of setting down the details of their lives.

Interviewing Obstacles and Solutions

It has been our experience in working with clients with BPD that various obstacles in the assessment process tend to occur, some more often than others. Those of note are described in this section, with solutions that we have found to be helpful.

Assessment Versus Therapy

The clinical assessment process is difficult, and assessors need to be aware that many of the questions they pose are extremely painful for the client and can elicit intense emotional reactions. Moreover, when this occurs, clients may expect the assessor to act like a therapist and help them solve their emotional problems. In the context of the integrated model, seamless shifting between the two roles is possible. In the separated model, the challenge is to offer solace, compassion, and distraction rather than therapy. For this method to be successful, it is important to explain to the client, before the assessment begins, that treatment is a separate and distinct component from the assessment. For some clients this is a relief. For others, the prospect of telling the assessor the intricate details of their lives and then moving on to build a relationship with a provider constitutes a fresh wave of emotional pain. The intense emotionality of clients with BPD can make these transitions particularly painful.

Self-Harm During Interview

Although it is not common for clients with BPD to engage in self-harming behavior such as banging their head against the wall or scratching themselves with pins or paperclips during an assessment, it does occur. The practical approach is to tell them to stop the behavior immediately. Most patients will stop because you have acknowledged that their behavior is unacceptable. If they are unable to stop the behavior, then the interview must stop. Have patients take a break, go for a walk, have a cigarette break, or get something to

eat until they are able to continue with the interview without harming themselves. Directed intervention may be uncomfortable for some assessors working from less directive models of assessment or treatment. However, clear instruction that the behavior must stop is essential with this population.

Another strategy is to have clients tell the assessor exactly when they are having the urge to harm themselves. When this happens, stop the interview and have clients stand up and move around the office for a few minutes. If they continue to have strong urges, or for those who use their hands for harming themselves, have them place their hands under their legs or give them something to hold, such as a stress ball, to keep their hands occupied.

Suicidal Patients During an Interview

Interviewing patients when they are feeling suicidal can be very stressful. The first step when you think someone is at risk for engaging in suicidal behaviors is to assess his or her level of risk. Once you have a clear picture of method, availability, lethality, and timeframe, your next step is to work to decrease the client's level of suicidal intent or bring additional caregivers in to increase postassessment monitoring and enhance safety. If possible, offer to take a walk with the client. The change of environment alone can help relax the client, as can the shift that takes place in the relationship between the assessor and client when they leave the office environment behind. Instead of a structured question and answer session, a conversation can now take place on a more intimate and less formal, though still professional, basis.

The goal is to continue to assess the client by asking questions that might pertain to the breadth, quality, and availability of the client's support system, any changes that have recently taken place in the client's life, his or her repertoires of positive self-soothing and distracting strategies, and his or her ability to use these strategies successfully in the past. Making reference to the positive things in the client's life and validating the client's feelings also help to reduce his or her overall level of distress.

If the client's suicidal intent decreases over the course of the walk, then the assessor can help the client make a detailed behavioral plan for the remainder of the day before leaving the clinic. If suicidality has not decreased and the assessment of lethality of the client's plan is high, friends or family members should be contacted to stay with the client, or the client should be taken to a nearby emergency room. It may be reassuring to know that in conducting research with clients with BPD who are acutely and chronically suicidal, we have found that detailed assessments rarely increase suicidality levels and, when they do, not significantly (Reynolds, Lindenboim, Comtois, Murray, & Linehan, 2006).

Mute Patients

It is challenging when clients come in and refuse to speak. In these instances information can be gathered in several different ways. It might be helpful to notice things about the clients, such as how they are dressed and what they are reading, and talk with the client about those things as a warm-up before interviewing him or her about intense interpersonal problems. As the interview begins, the assessor emphasizes that clients cue experts about themselves and explains that by answering specific questions they will ultimately ensure that they get the best possible treatment because they know their problems, strengths, and situation better than anyone else. If the client is still unwilling to speak, then the last step would be to obtain copies of his or her records or interview family members for the assessment information.

Chronic Lateness or No-Shows

One of the most common and frustrating aspects of working with clients with personality disorders is the frequency with which they miss, reschedule, or arrive late for appointments. In clients with BPD, whose lives are in chronic chaos, this may be even more common. In order to reduce this problem, a reminder call the day before and the morning of the appointment may be necessary. This is standard protocol in our research clinic and has greatly reduced the problem.

Another strategy to draw clients to assessment appointments is to make the assessment environment an inviting place. Having coffee or tea available for when the patient arrives shows that you care about his or her well-being. Providing accurate directions and good parking or bus

routes makes getting to appointments easier for the client. Beginning the assessment on time reduces apprehension and conveys to the client the message that he or she is important. Having snacks and hand lotion available during the assessment, taking frequent breaks, and conducting the assessment in a nicely furnished office will also help to bring clients back to the clinic knowing that they will be treated with respect and will be in pleasant surroundings.

Case Illustration With Dialogue

The following is a transcript from a screening interview for BPD using the IPDE (Loranger, 1995). This transcript was chosen to illustrate assessment strategies in diagnosing BPD using the IPDE. Questions are asked based on the nine criteria for a *DSM-IV* diagnosis of BPD.

Patient Description

Bobby is a 29-year-old married woman who lives with her husband and two cats. Bobby earned her college degree 4 years ago. Her major in college was liberal arts. She has been working for the past 9 months in finance. Her work history has been irregular, with her current position being the longest job she held since graduating from college. She has been married for the past 2 years, during which time she and her husband have separated twice. She currently has a restraining order against a former boyfriend for harassment and stalking. Before getting married she was in a clean and sober house for 6 months. She was recently released from the hospital where she had been admitted after a suicide attempt by overdose on prescribed medications. Bobby ingested a nearly lethal amount of medication and spent 3 days in intensive care, followed by 2 days on a medical floor and then 7 days in a psychiatric unit. Bobby stated she that had planned the suicide attempt but then called 911 when she started to vomit.

Before the following transcript segment, the assessor spent several minutes casually chatting with the client and orienting her to the agenda for the assessment. The italicized sections of the transcript list symptoms of BPD from the IPDE. The questions that are in bold text are questions that appear in the interview and are to be asked by the assessor. Supplement questions are at the discretion of the interviewer.

Identity Disturbance (There are five questions in this section; a positive score on two of the questions meets identity disturbance criteria.)

Assessor: **Let me ask some questions about the kind of person you are.**

Client: I don't know. I am nice, I guess, I am sad a lot, I really don't know.

A: **How would you describe your personality?**

C: Nice, I don't really know, I'm not sure who I am, I want to be whoever my husband and family want me to be. My mother thinks I am a good person, but my dad thinks I am crazy because I can't make up my mind about things. My husband just wants me to get help and get better.

A: **Have you always been like that?** Nice, a good person, not sure who you are and want to be whoever your family thinks you should be?

C: No.

[If the client responds that this is a longstanding pattern, this portion of the interview stops. If not, the assessor continues with questions to determine what precipitated the change. This is a critical element of making the diagnosis because situational variables such as trauma, cross-country moves, or significant illness may prompt such change and influence coding of this criterion.]

A: **When did you change?**

C: Oh, probably in high school things got all messed up.

A: **What were you like before?**

C: When I was in junior high and the beginning of high school I felt like I could do anything. I wanted to be a veterinarian. I love animals. I didn't think about who I was; I felt confident, I guess.

Identity Disturbance 1

A: **Do you think that one of your problems is that you're not sure what kind of person you are?**

C: I don't know who I am or what I should be doing.

A: How does that affect your life?

C: I am miserable. One day I listen to what my mother has to say about who I am supposed to be, and the next day I listen to what my husband has to say, and then I listen to the talk shows, and I get even more confused.

A: **Do you behave as though you don't know what to expect of yourself?**

C: I think so. I'm not sure what you mean.

A: Do you act like yourself when you are around people?

C: Sometimes.

A: **Are you so different with different people or in different situations that you don't behave like the same person?**

C: Yes, many times I do this.

A: Can you give me some examples?

C: Well, when I am at work, I act very professional and appear very competent because they act all professional and stuff; no one does anything wrong. When I am with my friends from my drinking and drugging days I act crazy because that is what they do. When I am with my husband I act nice and a lot of times helpless. He likes to take care of me; he would just die if he saw how I act at work and with my crazy friends because he doesn't see me that way. I am like a chameleon. I get nervous in new situations, so I watch how other people act, and I act like they do.

A: Have you always been like this?

C: Since I was in high school. People were mean to the kids who did not fit in. I haven't felt like I fit in since then, so I just act like those around me.

Identity Disturbance 2

A: **What would you like to accomplish during your life?**

C: To be happy, have a happy marriage.

A: What about a career?

C: Right now I want to be in finance.

A: **Do your ideas about this change often?**

C: Yes

A: Tell me about it.

C: I used to work in a restaurant, and I wanted to own a restaurant, and I wanted to be a veterinarian when I was in high school. I also started school to be a cosmetologist but quit. I watch a lot of TV, and I thought I should become a nurse or doctor or something like that, because a lot of shows looked fun. A couple of months ago I thought I should be a writer because I have a lot of ideas.

Identity Disturbance 3

A: **Do you have trouble deciding what's important in life?**

C: Yes, I don't know what is important.

A: How does that affect you or the way you live your life?

C: It causes me to make a lot of poor decisions and holds me back.

A: **Do you have trouble deciding what is morally right and wrong?**

C: Yes, I know stealing is wrong, but I do it anyway, and I know speeding is wrong, but I still speed, and I also am against drugs, but when I am with my friends and they offer me some pot I can't help myself. It really disgusts me. I always go against my principles.

Identity Disturbance 4

A: Do you have a lot of trouble deciding what type of friends you should have?

C: Yes, I never know who I should become friends with. If someone is nice to me I think that they should be my friend, and then I find out later that they steal. I don't know if I should stay friends with them. I get really confused about who I should have as a friend.

A: **Do the kind of people you have as friends keep changing?**

C: Yes. I have had people who are rockers, studious people, intellects, drug and alcohol addicts. I am always changing who I have as friends. I don't have any real long-term friends. I really would like to have the same friends. It makes it hard for me to have relationships because I am always changing.

Identity Disturbance 5

A: **Have you ever been uncertain whether you prefer a sexual relationship with a man or a woman?**

C: I don't know what I want sexually. I am attracted to men, but I also feel attracted to women. This has been bothering me a lot. I never wondered, but when I started college I felt very attracted to one of the other female students. We never did anything, but I have experimented with some women. I have a lot of shame talking about this because I was raised a Christian, and it is morally wrong, and I am married. I can't even talk to my husband about this.

Unstable, Intense Interpersonal Relationships

A: **Do you get into intense and stormy relationships with other people with lots of ups and downs? I mean, do your feelings about them run hot and cold or change from one extreme to the other?**

C: Oh yeah!

A: **In those relationships do you often find yourself alternating between admiring and despising the same person?**

C: That is so true of me. I love my husband so much. He is the best thing that has ever happened to me, but sometimes, like the other night when he told me that I should get a haircut, I just hated him. I even went upstairs to leave him because I just could not stand the thought of being near him for one more minute. This has happened with every boyfriend that I have had. I do this with my parents also. I think that they are the most caring and generous people that I have met, but sometimes I will go for weeks without talking to them because I think they are so awful.

Chronic Feelings of Emptiness

A: **Do you often feel empty inside?**

C: Yes.

A: **Does that upset you or cause any problems for you?**

C: It causes me to be depressed; I will cut a lot of times when I am empty just to fill up that void. I used to drink a lot when I felt empty. When I was in college I used to have sex with people I didn't know very well.

Frantic Efforts to Avoid Abandonment

A: **Do you ever find yourself frantically trying to stop someone close to you from leaving you?**

C: I do this all the time with my husband. Just the other day he had to go back to work, and I felt abandoned and begged him to stay home. Whenever we have a fight I beg him not to leave, and I even have run after him when he has driven away. I used to do this with my friends in high school. I would call them all the time because I was afraid they would leave me and I would be all alone. I have lost friendships over this because they think I am too needy.

Affective Instability

A: **Do you often change from your usual mood to feeling very irritable, very depressed, or very nervous?**

C: Yes, all the time. I have always been very moody. Just coming in here I was really nervous about this until I got to the parking garage, and the guy took forever to give me change. I became furious with him, and then I came in here and saw a homeless guy out in front of the building. I felt really depressed and sorry for him. I feel fine now, but when I get that intensity of my moods I feel out of control.

Intense Anger

A: **Do you sometimes get angrier than you should or feel very angry without a good reason?**

C: At the time it happens it feels like a good reason. When I was in the parking garage, I was so mad that when I got out of the car I slammed my car door and started kicking my car. I throw things sometimes when I get mad. I try not to throw things that are sentimental, but if I am in a rage then I can't help myself. Sometimes in stores I have embarrassed myself because the cashiers are stupid and slow, and I yell at them sometimes to hurry up. I've had the managers of several stores tell me to leave.

Paranoid Ideation or Dissociative Symptoms (five parts to this section)

A: **Sometimes when people are very upset or under a lot of stress, they have very unusual experiences. At times like this, have you ever experienced any of these? (1) Felt like you were in a dream and either you or the world around you wasn't real? (2) Felt like you were a detached spectator watching the world go on without being part of it? (3) Felt like you were outside of your own body, or some part of your body didn't belong to you? (4) Thought people could read your mind or already knew what**

your were thinking before your told them? (5) Thought your mind, body, or behavior was under the control or influence of some force or person? Thought people had it in for you or were out to harm you?

C: Some of those things have happened to me. When I get really upset I get this surreal feeling, and I just sit there and watch things happen, and I don't even feel that I am there; it's like I am watching a movie. Sometimes this can last a couple of hours, and I don't even realize that time has gone by. I feel paralyzed when that happens, and my husband has had to shake me to get me out of it.

Recurrent Suicidal Behavior, Threats, and Gestures

A: **Have you ever threatened to commit suicide, actually made a suicide attempt or gesture, or deliberately cut yourself, smashed your fist through a window, burned yourself, or hurt yourself in some other way?**

C: Two weeks ago I overdosed on my medication because I wanted to kill myself. When I was a teenager I used to cut my arms when I got upset. I also tried to kill myself a couple of years ago by driving my car into a tree.

Impulsivity (There are a multitude of questions requiring two positive scores in the past 5 years in order to meet criteria.)

A: **Have you ever had a problem with gambling or spending too much money?**

C: I don't know. I am in credit card debt for $10,000, but isn't that what most people have?

A: **Have your ever had a problem with drugs or alcohol?**

C: I used to have a problem with alcohol and cocaine, but I have been clean and sober for the past two and one half years.

A: **Have you ever gone on eating binges, so that it was a problem for you or others were concerned about you?**

C: For about 6 months after I got married I used to secretly binge when my husband went to bed. I would eat large amounts of sweets several times a week. I gained 30 pounds during that time.

A: **Have you ever shoplifted?**

C: Not since I was in high school. My friends and I would go to the makeup counters and steal makeup all the time.

A: **Do you get into sexual relationships quickly or without thinking of the consequences?**

C: When I was in college I did. It was really bad. . . . I even ended up pregnant.

A: **Have you ever taken unnecessary chances and risked harm or injury to yourself or others?**

C: I don't think so.

A: **Have you ever driven a car while intoxicated with alcohol or drugs?**

C: I used to all the time, but not since I have been clean and sober.

A: **Have you ever been stopped for the police for speeding or reckless driving?**

C: I have gotten three speeding tickets in the last year.

This assessment vignette is typical of many of the subjects who participate in our research studies but may not be typical for those seeking BPD assessment in private practice or community-based organizations. Note that this case illustration reflected a person who met nine out of nine *DSM-IV* BPD criteria but that a positive diagnosis requires only five out of the nine to be met.

Multicultural and Diversity Issues

Minimal research has been done in the area of multiculturalism and personality disorders. Therefore, cross-culture community prevalence rates of personality disorders are mostly unknown (Akhtar, 1995; Paris, 1996, 1998). BPD has been reported most often in North America, Europe, and the United Kingdom, with infrequent reports of BPD in developing countries (Pinto, Dhavale, Nair, Patil, & Dewan, 2000). Cross-cultural research aside, attention to racial, ethnic, and cultural diversity as it pertains to personality disorders is rare even within a single cultural, geographic, or sociopolitical entity. Despite the increased focus on such issues in the past few years in the United States, very few studies have examined the prevalence of personality disorders across different groups, and where a study has been undertaken, findings are largely inconsistent (Chavira et al., 2003).

In a 1990 U.S. Epidemiologic Catchment Area study, demographic characteristics of those meeting criteria for BPD included being female, widowed, single, young, non-White, an urban

resident, and of lower socioeconomic status (Swartz, Blazer, George, & Winfield, 1990). Another study that looked at the demographic profile of BPD in 23 studies found that patients meeting criteria for the disorder were similarly mostly young and female, but in contrast to the 1990 study it found that most people with BPD were White (Akhtar, Byrne, & Doghramji, 1986). Countering both these findings, one study of 1,583 psychiatric inpatients found no significant difference in the prevalence of BPD between Whites, Blacks, and Hispanics (Castaneda & Franco, 1985). Interestingly, the same study showed higher rates of BPD in women among Whites and Blacks but showed equal rates of BPD between Hispanic men and women. Another study of 554 patients taken from the recent Collaborative Longitudinal Personality Disorders Study showed higher rates of BPD in Hispanics than in Caucasian and African American participants and no significant gender by ethnicity interactions (Chavira et al., 2003).

In discussing the possible reasons for a higher rate of BPD in Hispanics, Chavira et al. (2003) note more frequent endorsements of intense anger, affective instability, and unstable relationships by Hispanics than by Caucasians. They speculate that the acculturation process for some ethnic minorities, which can include feelings of anxiety, emptiness, alienation, abandonment, loss of control, identity confusion (Hovey & Magana, 2002;[[**AUTHOR: There's no Hovey & Magana in References; please add.**]] Williams & Berry, 1991, as cited in Chavira et al., 2003), disruption of the family system, and intergenerational conflicts (Negy & Snyder, 2000, as cited in Chavira et al., 2003) might be one explanation for the higher rate of BPD found in the Hispanic group. Another explanation is that characteristics deemed acceptable in one culture, such as novelty seeking, quick temper, and extravagance, may be seen as pathological from a Western psychiatric standpoint and diagnosed as such by Western clinicians (Chavira et al., 2003). Both explanations point to the importance of taking cultural factors into consideration when looking at the prevalence of BPD across ethnic groups.

Culture is clearly important in a discussion of personality and its disorders. Because disorder is defined as a departure from the norm, it is critical to assess what defines the norm, and there is no better vehicle for that than culture. Even the concept of *personality* has a culturally defined base, and the one to which the label *disorder* is attached is an extension of the Western cultural ideal of individualism. How well this fits the various people of the world or the cultural subsets represented in modern, Western, industrial societies is in question. We must look at how different cultures shape specific behavior and personality norms, how pathology is defined and expressed differently between cultures, and how the prevalence of personality disorders might change as the culture of an individual or population changes (Miller, 1996; Paris, 1996, 1998). For example, antisocial personality disorder was rarely seen in women when their behavior was strongly controlled by societal norms. As these norms shifted and women became free to express themselves, the prevalence of antisocial personality disorder among women increased (Bjorklund, 2006). In a similar fashion, in more traditional cultures or societies where compliance, indirect expression of emotions, and conformity are rewarded in order to keep the family or group intact, the symptoms of BPD such as impulsive action and excessive emotionality, traits associated with an individualistic, Western culture, tend to be discouraged (Paris, 1996, 1998).

Although traditional societies may play a role in discouraging and extinguishing expression of BPD behaviors, the disorder may be expressed in other ways. For example, in traditional societies people tend to show less psychological distress and disordered behavior (Murphy, 1982, as cited in Paris, 1996) and more physical or somatic distress (Leff, 1988, as cited in Paris, 1996). In her article on BPD in a social context, Miller (1996) discusses the different cultural expressions of distress, comparing BPD to certain "ethnic disorders" such as spirit possession, *nervios, susto,* and *latah,* and notes how all of these disorders tend to develop from problematic social histories, which leave people with a sense of social failure, inadequacy, marginality, and powerlessness.

As traditional societies modernize or as people from these societies immigrate to developed countries, roles and ties that were clear and guaranteed become unclear or perhaps nonexistent. The accompanying decrease in structure and clarity of individual, family, and community roles that traditional societies provide may lead some people in these communities to experience higher levels of discord and discomfiture consistent with criteria defining borderline personality disorder. Moreover, personality characteristics,

such as dependency, that were adaptive in one culture become maladaptive in another and those that were previously seen as deviant, such as self-focus and individualism, become expected (Paris, 1996, 1998).

Thus, it is possible that the prevalence of BPD may increase with modernization and immigration because of the decrease in protective factors that traditional societies provide. It is also possible that BPD prevalence may increase in these circumstances because the change in culture allows a higher degree of acceptance of emotionally expressive and impulsive behaviors. Both are likely to play a role in the emergence of BPD within a culture and are important when one is considering how culture can affect the prevalence of BPD in different cultures. Moreover, because the definition of *disorder* and the diagnostic instruments reviewed in this chapter were developed from the Western cultural vantage point, care must be taken in the assessment process. That said, a standard for cultural competence in the assessment of something so culturally informed, shaped, and determined as personality, let alone its disorders, has not been identified. In the absence of such, the prospective assessor is encouraged to be as informed as possible about cultural norms and deviations for the various groups (e.g., racial, ethnic, religious) they encounter so that culturally normative behavior is not pathologized or disordered behavior normalized.

Differential Diagnosis and Behavioral Assessment

BPD co-occurs with several Axis I disorders, most notably mood, substance use, anxiety, and eating disorders. It is important to note that the diagnostic criteria defining BPD are not an exclusive set; co-occurrence may reflect the overlap in diagnostic criteria of BPD with other disorders. Conversely, the observed co-occurrence may reflect the complexity and pervasiveness of BPD, the impact of multiple disorders, or common etiological factors. Prevalence estimates of co-occurrence of BPD with Axis I disorders vary widely. Such variation may be attributable to a variety of factors: the assessment approach (chart review, self-report screening, clinical interview, standardized interviews) and diagnostic criteria (*DSM-III, DSM-III-R,* or *DSM-IV*); (2) experience, training, and reliability of diagnosticians; sample composition (e.g., community, clinical, inpatient, outpatient); and time focus (current or lifetime diagnosis).

Using structured interview methods and rigorous diagnostic specificity, co-occurrence of Axis I disorders in BPD samples have been estimated to range from 39% to 96% for mood disorders, 13% to 86% for substance use disorders, 7% to 99% for anxiety disorders, and 15% to 53% for eating disorders (Skodal et al., 1999; Trull, Sher, Minks-Brown, Durbin, & Burr, 2000; Zanarini et al., 1998a; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2004; Zimmerman & Mattia, 1999). Among people with BPD selected for current suicidality (i.e., either a recent suicide attempt or a recent intentional self-injury with or without intent to die), 72% met criteria for current diagnosis of major depressive disorder, 78% met criteria for current diagnosis for any anxiety disorder, 40% met criteria for current substance use disorder, and 24% met criteria for current diagnosis of an eating disorder (Linehan et al., 2006).

BPD also co-occurs with other Axis II personality disorders (McGlashan et al., 2000; Zanarini et al., 1998b; Zimmerman et al., 2005). Each of the Axis II personality disorder groups (the so-called odd, anxious, and dramatic cluster disorders) has been observed in patients with BPD. In a general clinical sample of adults McGlashan et al. (2000) found that BPD significantly co-occurred with antisocial and dependent personality disorders. Zanarini et al. (1998b) examined comorbidity in a sample of 504 inpatients diagnoses with personality disorders and found that those with BPD had significantly higher rates of paranoid, avoidant, and dependent personality disorders than those without BPD and that although rates of avoidant and dependent personality disorders were similar across genders, men who met criteria for BPD were significantly more likely than women to meet criteria for paranoid, antisocial, narcissistic, and passive-aggressive personality disorders. In a sample of 101 women with BPD and recent suicidal and self-injurious behaviors, Linehan et al. (2006) found that 3% met criteria for a cluster A personality disorder, 10.9% met criteria for an additional cluster B personality disorder, and 25.7% met criteria for a cluster C personality disorder.

Borderline Personality Disorder Versus Bipolar Disorder

Since the advent of the *DSM-IV,* a tremendous amount of controversy has surrounded the Axis II personality disorders, not the least of which is the validity of the BPD diagnosis. The main argument is whether clients meeting BPD criteria should be considered part of the "bipolar spectrum" instead. Discussions of differential diagnosis have centered on distinguishing BPD from bipolar disorder (BD). Determining the presence or absence of BD has been one of the most difficult differential diagnosis issues in our research. The difficulty concerns the overlapping features of the two disorders, specifically affective instability and impulsivity (Benazzi, 2006; Paris, 2005;[[**AUTHOR: 2005a or 2005b?**]] Skodol et al., 1999) and, on a behavioral level, high novelty seeking, harm avoidance, low self-directedness, and low cooperativeness on a trait level (Akiskal, 2004).

According to Hutto (2001) the *DSM-IV* distinguishes between BD and personality disorders based on episodes. BD has discrete episodes in which features that are similar to those of BPD are present, but when the episode ends, patients are not symptomatic. Patients with BPD, on the other hand, continue to experience features that are present in BD regardless of episodes.

Many patients with BPD experience intense mood swings that usually last a few hours and sometimes can last for a couple of days (APA, 2000). By contrast, a manic episode is defined by a distinct period of abnormally elevated, expansive, or irritable mood that lasts 4 or more days (APA, 2000).

Another difference is in the impulsivity criterion. A patient in a manic episode can exhibit impulsive behavior. This impulsive behavior is out of the ordinary for the person and can cause painful consequences (i.e., buying sprees, sexual indiscretions, reckless driving). Borderline patients also may engage in impulsive behavior. This is a pattern of behavior over a long period of time that can include excessive spending, sexual activity, drug and alcohol problems, binge eating, shoplifting, and reckless endangerment. In contrast to BD, these are problems that occur on an ongoing basis, not just discrete episodes.

Magill (2004) found that obtaining an illness history is key to determining whether a patient has one or both disorders. Most people with a BPD diagnosis experience intense mood lability. This is short lived and usually is in response to external stimuli. People with BD also have this experience, but the duration of mood lability is experienced over several days or more and is not short lived. In screening people for possible inclusion in our BPD treatment studies, we have discovered that many of those referred to us with preexisting diagnoses of rapid cycling BD or cyclothymia do not meet criteria for those disorders. Detailed and careful assessment indicates that their symptoms are better accounted for by BPD, the essential feature being that the subjects may never have had a hypomanic episode, and their mood swings are mislabeled as a mood disorder instead of the mood lability of BPD.

According the *DSM-IV-TR,* BPD often cooccurs with mood disorders. The *DSM-IV* specification of episodes of distinct periods is paramount in determining the presence or absence of a bipolar diagnosis. A detailed interview with the client and significant others and a review of records may be necessary to distinguish the scope and specifics of behavioral episodes. If full criteria are met for both disorders, then a diagnosis of both disorders may be given. This is also true for BPD and other personality disorders that have overlapping features.

Other Axis II Disorders

Histrionic personality disorder (HPD) and BPD share similar features of rapid shifting of emotions and attention seeking. BPD differs in that its features are more self-destructive and intense (APA, 2000). The shifting emotions associated with HPD are associated with shallow expressions of emotions and are not internally intense. This is not to say that a person with BPD doesn't also have HPD or traits of HPD. It is our experience that most of our research subjects do not meet this particular criterion of rapid shifting of emotions because their emotions, although they may appear overly dramatic and superficial to the external observer, are not experienced as such by the subject.

Many people with BPD experience quasi-psychotic features. In our research these features rarely meet criteria for an independent psychotic disorder. They are better explained by either

psychotic depression or the dissociative and paranoid symptom of BPD. People with BPD and paranoid personality disorder (PPD) have overlapping symptoms of thinking people are out to harm them. The BPD paranoid symptoms are transient and in response to external stimuli (Loranger, 1995). This is different from PPD because PPD symptoms are not necessarily in response to external stimuli. People with the paranoid symptoms of BPD are more likely to trust others after gaining familiarity with them, whereas people with PPD remain reticent.

Behavioral Assessment

The best way to assess BPD is to use semistructured clinical interviews like those mentioned earlier in this chapter. Using a semistructured clinical interview can help in discerning differences in diagnosis and co-occurrence of diagnosis. Self-report assessments are helpful but may give an inaccurate presentation of the person. With patients who are poor historians or who lack insight into their own behavior, a review of past records and clinical interviews with previous clinicians and family members might be needed for a diagnosis. Direct behavioral observation can also help in determining the presence or absence of BPD symptoms. Furthermore, information obtained in the context of therapy can help solidify provisional diagnosis.

Selection of Treatment Targets and Referral

Psychotherapy is the recommended treatment for BPD, with symptom-targeted pharmacotherapy serving in an adjunctive role (APA Work Group on Borderline Personality Disorder, 2001). Two psychotherapy approaches have been demonstrated as more effective than treatment as usual[[**AUTHOR: What exactly do you mean by "treatment as usual"?**]] in randomized controlled studies: dialectical behavior therapy (DBT; Linehan, 1993a, 1993b) and mentalization-based treatment (Bateman & Fonagy, 1999, 2001). Of the two, DBT has the most empirical support (Linehan et al., 1999, 2002, 2006; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan & Heard, 1993, Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994; Verheul et al., 2003).

DBT is based on a conceptualization of BPD as a disorder of pervasive emotion dysregulation. Maladaptive behaviors are conceptualized as reducing (or, in the case of suicide, terminating) painful emotional states or are themselves a consequence of dysregulated emotion. Selection of treatment targets is based on a behavioral management and capability deficit model of BPD (Linehan, 1993a). There are two parts to the model: People with BPD are theorized to lack critical problem-solving, interpersonal, and self-regulation skills (including emotion-based skills such as distress tolerance and general self-management skills), and effective behaviors in the person's repertoire are inhibited by intense emotions, faulty beliefs and assumptions, or environmental contingencies that punish (or ignore) effective behavior and reward "borderline" behavior. Thus, principal treatment strategies include skill training, behavioral rehearsal, exposure techniques, cognitive modification, and contingency management procedures. Balancing this focus on change is the acceptance of the patient, the therapeutic relationship, and the world as it is.

People with BPD often are referred to treatment because of out-of-control behavior that poses immediate and serious risk of substantial harm or death. Treatment targets in the first stage of DBT are reducing life-threatening and suicide crisis behavior, reducing treatment-interfering behaviors that could lead to premature therapy termination, decreasing factors contributing to a diminished quality of life (e.g., Axis I disorders, homelessness) and increasing behavioral skills to manage behavior and emotions and build a life worth living. Once behavioral stability is achieved, treatment turns to increasing nontraumatic experiencing of emotions, resolving trauma-related issues of childhood, resolving the sense of incompleteness, and enhancing self-respect and freedom.

Standard DBT consists of weekly individual therapy, group skill training, a consultation team for the therapist, and telephone consultation to the patient as needed. Skill training focuses on the acquisition and strengthening of behavioral skills. Individual psychotherapy addresses motivational factors related to behavioral targets and strengthening and generalization of skills. The consultation team functions as therapy for the therapists; motivational factors and capability deficits of the treatment provider are addressed in a group therapy format by the other members

of the consultation team. Telephone consultation is the purview of the individual therapist and is used to manage suicide crises and coach application of new skills to the real-world environment.

Summary

People with BPD are common in clinical settings. Accurate assessment and diagnosis are critical for treatment. In this chapter we have reviewed several of the most commonly used instruments for personality disorder assessment in general and BPD in particular. The very qualities of the disorder often make assessment and diagnosis challenging. Strategies to maximize diagnostic efficiency and accuracy have been reviewed. Finally, empirically based treatment recommendations have been outlined.

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20

Alcohol and Other Drug Disorders

Jon Morgenstern and Thomas Irwin

Description of the Disorders

For the purposes of this chapter we will define alcohol and other drug use disorders consistent with the approach of the *Diagnostic Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV;* American Psychiatric Association, 1994). *DSM-IV* groups substances into 11 pharmacological classes including alcohol, amphetamines, cannabis, cocaine, nicotine, and opiates. This chapter will not address nicotine because treatment of nicotine dependence differs substantially from that of other substance use disorders. In addition, *DSM-IV* divides substance use disorders into two major classifications—abuse and dependence—and provides a set of operational criteria to determine categorically whether these disorders are present or absent. *Abuse* is broadly defined as a maladaptive pattern of use leading to recurrent negative consequences such as legal problems. Dependence, a more severe disorder, is defined by presence of a cluster of symptoms indicating psychological and in many cases physiological dependence. *DSM-IV* also defines more minor disorder classifications such as substance intoxication, but these will not be discussed in this chapter.

Although *DSM-IV* provides an accepted and simplifying clinical heuristic for classification purposes, it is important for clinicians treating alcohol and other drug use disorders to understand a broader set of conceptual, empirical, and clinical knowledge that underlies the *DSM-IV* and other classification schemes. First, alcohol and other drug use problems are best understood as existing along a continuum of three interrelated dimensions: patterns of consumption, negative consequences, and dependence or addiction. In order to adequately characterize substance use issues for any client, clinicians should assess each of these domains within a continuous framework. Second, although the broad concepts of patterns of consumption, negative consequences, abuse, and dependence apply across different substance classes, their manifestations can be specific to each drug class. For example, dependence may manifest itself in different sets of symptom clusters in alcohol and in cannabis. Therefore, clinicians need general and substance class–specific knowledge to adequately assess and treat substance use problems.

Contemporary schemes for understanding substance use problems are strongly influenced by Edwards and Gross's (1976) work on the

dependence syndrome and by an emerging public health framework (Saitz, 2005). The essential postulates of the dependence syndrome include clustering of cognitive, behavioral, and physiological elements that are related to a common process; distribution of these elements along a continuum of severity; and independence of dependence from negative consequences of use. These postulates set the stage for defining dependence and negative consequences as separate but related dimensions. Dependence is characterized by salience, impaired control, and manifestations of physiological dependence. Salience is defined by cognitive and behavioral preoccupation with the substance use to the exclusion of other valued activities. Impaired control is manifested by an inability to stop or control use despite knowledge of recurrent negative consequences. Physiological dependence is defined by the presence of tolerance, withdrawal, and use of substances to avoid withdrawal. Although *DSM-IV* provides an operational demarcation of presence or absence of dependence based on a threshold of three symptoms, studies have shown that dependence exists along a continuum of severity (Meyer, 2001), and measures are available that provide reliable and valid dimensional ratings (Cooney, Kadden, & Steinberg, 2005).

Negative consequences are problems that occur as a result of substance use. Negative consequences typically are grouped based on life domains such as social, health related, legal, and psychological. A wide variety of clinically informative measures provide dimensional ratings of negative consequences (Miller, Tonigan, & Longabaugh, 1995). People who are dependent invariably experience negative consequences. As substance dependence grows more severe, the experience of negative consequences increases across life domains. However, people can experience negative consequences without being dependent. *DSM-IV* defines abuse as the recurrent experience of negative consequences in the absence of dependence.

Patterns of consumption consist of the frequency, quantity, type, and route of administration of a substance. Patterns of consumption do not in themselves define substance use disorders. Therefore, knowing someone is a daily drinker doesn't indicate that he or she has a drinking problem. However, each feature of a pattern of use can have important assessment implications. For example, the oral ingestion of amphetamines has much less addictive potential than smoking or injection (Hanson, 2002). Contemporary public health frameworks have attempted to place people into a unified classification framework based on consumption, consequences, and dependence (Institute of Medicine, 1990). Such classification helps to guide public policy and may be useful in communicating effectively with patients. For example, Richard Saitz (2005) defines a continuum of unhealthy alcohol use. People are classified as risky drinkers if they consume excessive amounts of alcohol that put them at future risk of disease, even if they currently not experiencing drinking problems. People are classified as problem drinkers if they drink excessively and experience occasional, mild problems, even if they do not meet *DSM-IV* criteria for alcohol abuse or dependence.

In summary, *DSM-IV* divides the major categories of substance use disorders into abuse and dependence. Although *DSM-IV* provides a useful heuristic, it is critical for clinicians to understand substance use problems along three interrelated dimensions of consumption, negative consequences, and dependence and to know how to assess the unique manifestations of these constructs across different substance classes. Readers interested in a more comprehensive explication of these issues can find it in recent books devoted to the topic of addiction (Donovan & Marlatt, 2005; Frances, Miller, & Mack, 2005).

Interviewing Strategies

There are many functions that interviewing serves when working with those who have substance use disorders. Strategies used for interviewing purposes depend heavily on the amount of time available to conduct the interview and its function, such as a brief assessment, structured intake interview, or an initial session that leads to ongoing treatment. For didactic purposes we will focus on the latter context, although the principles described here can apply to any context. The conduct of a good interview with any client requires knowledge, skill, and experience. This is especially true for clients with substance use disorders. The particular challenges in interviewing clients with substance use disorders stem from the client's ambivalence about change, the difficulty in accurately assessing this complex disorder, and, at times, the interviewer's beliefs or

reactions to clients that can interfere with establishing rapport. The past 20 years have witnessed a sea change in approaches to interviewing substance-abusing clients and a revolution in the knowledge about the disorder. This sea change is represented in two conceptual and clinician approaches: motivational interviewing (Miller & Rollnick, 2002) and behavioral assessment. Each approach outlines a clear set of principles and techniques that can function on their own. However, most experts agree that the approaches complement each other. In this section, we describe motivational interviewing and its contribution to addressing obstacles typically encountered in developing a working relationship with substance use–disordered clients. We will also outline the principles of behavioral assessment, but we provide a description of behavioral assessment techniques in a later section.

Establishing Rapport and Facilitating Change

Motivational interviewing is a brief intervention strategy designed to mobilize a client's internal resources for change by increasing intrinsic motivation. Motivational interviewing is not just a set of techniques, but a style of being with people that shares many of the qualities of Rogerian therapy, such as therapist communication of empathy and genuineness. Perhaps the most innovative aspect of motivational interviewing is the assumption that even a brief encounter with a professional can facilitate change if that encounter is appropriately structured. This approach argues that any encounter with a patient should never be relegated solely to information collection but rather should be viewed in the context of a dynamic change process. Similarly, approaches that take a confrontational or even neutral information-gathering stance are likely to elicit client resistance and lead to inaccurate or incomplete information.

Clearly, the first challenge in interviewing any client is establishing rapport. Motivational interviewing posits that in order to establish rapport, therapists must understand client behavior within the conceptual frameworks of stages of change (Prochaska, DiClemente, & Norcross, 1992) and cognitive conflict theory (Orford, 1985). Both theories view client's attitudes toward change as dynamic, fluctuating based on interpersonal context, and multilayered. Stages of change theory views clients' attitudes about changing any behavior as arrayed along a continuum of five distinct stages: (1) precontemplation, in which the client does not believe he or she has a problem; contemplation, in which the client is concerned about the issue but not considering change just yet; preparation, in which the client acknowledges having a problem and is ready for change; taking action to change; and maintenance, in which the client has made changes and is working to maintain these changes. Identifying what stage of change a client is in is critical to the interviewing process and the establishment of good rapport. Cognitive conflict theory posits that ambivalence is the central feature of the struggle to overcome addictive problems, that ambivalence is present even when not apparent, and that ambivalence must be identified and engaged rather than overridden. A key aspect of motivational interviewing is identifying the occurrence of ambivalence via various manifestations of patient resistance and responding in a manner that engages rather than confronts the patient.

Motivational interviewing identifies four specific interviewing strategies as critical to establishing initial rapport: expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy. Expressing empathy involves the use of classic nondirective interviewing strategies, especially open-ended questions and reflective listening. If a client with a substance use problem feels that he or she is being listened to and understood in a nonjudgmental fashion, it dramatically increases the chances he or she will discuss sensitive topics that the therapist might not have had access to using a more neutral or confrontational stance. In addition, motivational interviewing has identified 12 typical types of therapist communications that can interfere with the self-disclosure process and are labeled roadblocks to communication. Use of nondirective counseling techniques, especially reflective listening and avoidance of communication roadblocks, provide a basis for the establishment of initial rapport, although motivational interviewing recommends several more advanced strategies.

Content Domains

Although motivational interviewing provides the strategies for facilitating rapport and mobilizing the change process, a complementary component of any interview is the collection of

information needed for appropriate assessment and treatment planning. The literature on behavioral assessment of substance use disorders provides a comprehensive framework on what information should be collected and specific assessment techniques needed to ensure accurate reporting. Behavioral assessment entails a concrete and highly structured approach to gathering information. The behavioral assessment approach is clearly different from the one used in motivational interviewing. Experienced interviewers typically develop a feel for how to blend these approaches. Beginning interviewers are advised to start with motivational strategies and transition to more a directive and structured approach after rapport has been established.

In this section, we describe the primary domains of behavioral assessment. This will provide readers with a context for understanding the case illustration. Then we will elaborate on each domain. A reasonably complete behavioral assessment should cover four content domains: descriptive features of the problem, learning factors that maintain the problem, the patient's views on change, and other information including environmental and social factors needed to determine the recommended setting, intensity, and foci of treatment, if treatment is warranted. Assessment of the descriptive features of the problem includes patterns of consumption, negative consequences, substance dependence and the assessment of co-occurring mental health, cognitive, and medical problems.

Empirical evidence provides strong support for the role of learning factors including classical and operant conditioning and cognitive mediation as key elements that maintain addictive behaviors (Rotgers, 2003). These factors are assessed via a functional analysis of substance use behaviors. A functional analysis begins with identification of the antecedents of substance use. These are either situational cues, such as the presence of the substances or surroundings associated with substance use such as a bar or club, or internal cues, such as negative mood states. These cues, or conditioned stimuli, trigger a highly automatized set of physiological, cognitive, and behavioral processes that often occur outside awareness. Cues trigger strong positive cognitive expectancies about the rewarding aspects of substance use, often accompanied by strong cravings to indulge. If they remain unchecked, these appetitive processes lead to substance use. However, cues also set off higher-order cognitive control processes. These involve future judgments of the positive and negative consequences of use, coping actions that can be taken to restrain behavior, and the person's beliefs about whether he or she is capable of exercising self-control. A well-conducted functional analysis will yield a portrait of the factors that maintain addictive behaviors, including the set of situational factors that trigger use, positive and negative expectancies about use, the positive and negative consequences of use, coping behaviors available to the patient to exercise control, and situational self-efficacy judgments indicative of how well the patient feels he or she can control his or her behavior in tempting situations. These constructs will be elaborated on and illustrated in later sections.

A third content domain is the client's views about change. Although it may seem self-evident to the therapist that the client is engaged in self-destructive behavior, it is important to remember that any client change entails decision making and selection of alternative choices. Therefore, understanding the client's perspective on these issues is critical. Clients' views of change can be characterized by four domains: readiness to change; decisional balance; self-efficacy, or the belief that positive change can occur; and goal setting. Readiness to change has already been discussed. Decisional balance consists of cognitive appraisals about the likely positive or negative impacts of change, specifically the likely benefits of continuing to use substances and its costs as opposed to the likely benefits of reducing or stopping the use of substances and its costs. Novice therapists often fail to appreciate that substance abusers experience strong positive rewards from using despite the consequences and may see stopping use, at least initially, as a less attractive alternative. In addition to self-efficacy judgments about individual situations that trigger use (e.g., attending a party where liquor is served), clients also have generalized beliefs about their ability to change. These beliefs are intimately connected with judgments about self-worth, shame, and hopelessness and the desire to prevail over self-destructive behavior. Finally, clients have views about their goals for change. These include choices about moderating or reducing use versus quitting, choices about whether to attempt to change on one's own, and

if one is seeking help, choices about whether to attend self-help groups or formal treatment.

A fourth and final content domain is environmental and other factors that influence the selection of setting, intensity, and foci of treatment. Clients with chronic and severe substance use disorders experience an array of medical and social problems that complicate treatment decisions. For example, if a client lives in a shelter surrounded by drug abusers, the appropriate recommendation for treatment will look quite different from that of the same client who lives with a supportive family. The American Society of Addiction Medicine Patient Placement Criteria (Mee-Lee & Shulman, 2003) provides an assessment framework for considering these issues and will be discussed in a later section.

Interviewing Obstacles and Solutions

Clients with substance use disorders often present special challenges. These problems entail minimization or even denial of factual aspects of the problem, a displacement of responsibility onto others, and a seeming indifference to even dire consequences of substance abuse. In the face of such behavior, it is not uncommon for professionals to conclude that most substance abusers are inherently dishonest and untrustworthy, that standard interview strategies are useless, and that more confrontational or coercive methods of information gathering are needed. An important first step in taking a more productive stance is to understand the factors that underlie surface manifestations of resistance and denial.

Cognitive conflict theory (Orford, 1985) views ambivalence about change as the core feature of addictive problems. Although people may present as either blithely uninterested in their problems or, conversely, unequivocally motivated to change the problem, a deep sense of ambivalence is invariably present. Equally important is the notion that at times of high conflict ambivalence usually is represented by "hot cognitions," which are not organized in coherent or rational systems. Thus, clients can present as indifferent or denying the problem in an interview and yet later experience intense panic and fear. Such defensive cognitive distortions are well described in the psychodynamic literature under the label of primitive defense mechanisms such as splitting (Kernberg, 1983). However, cognitive conflict theory posits these as temporary manifestations of a struggle with addiction rather than stable, enduring cognitive styles rooted in character pathology. Once it is viewed from this perspective, recognizing and addressing ambivalence is critical to effectively dealing with denial.

In addition, social stigma about substance abuse plays a profound role in the interview process. Self-disclosure of many private behaviors is problematic because they are viewed as socially undesirable. However, substance abuse typically is more stigmatizing because it is often viewed by society as morally reprehensible. By the time they seek help most clients have been told by others that their behavior is shameful and corrupt. Thus, clients enter the interview situation with at least the implicit expectation, often a reflection of their own internal perceptions, that therapists will judge them harshly as well. Failure to manage these expectations interferes with the process of self-disclosure.

Another more subtle but potentially powerful obstacle concerns a client's belief or self-efficacy about the ability to change. Almost without exception clients have experienced repeated failures to change their behavior on their own, and many have failed to resolve their problems even after treatment. Client resistance may reflect profound doubt about the ability to change and unwillingness to wholeheartedly engage in a process that will once again lead to deep disappointment. In addition, clients often have negative views of treatment and see placement in treatment as a stigmatizing and potentially punitive experience.

In addition to these psychological factors, other aspects of the setting and cognitive functioning of clients can present obstacles. Many clients with substance use disorders are referred for assessment by others, including family members, employers, and the criminal justice system. The extent to which information from the interview will be shared with others obviously is a complicating factor. Finally, clients with substance use disorders can experience cognitive problems as the result of either acute intoxication or the chronic effects of substances. These problems impair a client's ability to remember events. Cognitive impairment often goes undetected and is confused with resistance.

The natural tendency of most caring professionals when interacting with a client in denial,

especially one facing imminent risks, is to confront, direct, advise, and warn clients. Unfortunately, these actions exacerbate the underlying causes of resistance, leading to surface compliance on the part of clients or outright argument and conflict. Instead, motivational interviewing recommends that therapists adopt a quite different stance, one that is client centered and attempts to engage rather than override ambivalence. This approach begins with use of nondirective counseling skills and attention to establishing good rapport. In addition, therapists help clients to develop discrepancies between their current behaviors and wished-for goals. For example, a therapist might use a value clarification task to initiate a discussion of goals or dreams a client has that have been thwarted by substance use. Developing discrepancies help clients become aware of their ambivalence and to turn "hot cognitions" into more organized constructs that are accessible to reasoning.

Another useful strategy to engage ambivalence is rolling with resistance. Clients can be expected to express resistance in overt or subtle ways during the interview. If the therapist takes on resistance directly by confronting it, the effect is often that the therapist ends up advocating the argument for change, while the patient argues against change. Instead, therapists are counseled to note resistance but deal with it in a way that facilitates the client's recognition of both sides of the issue. For example, rather than beginning by asking the client about the negative effects of substance use, the therapist might start by asking what the client enjoys about substance use. A final advanced interviewing strategy is supporting self-efficacy, or the client's belief in the possibility of change. Here again the focus is on a client-centered rather than prescriptive or didactic approach. Overall, motivational interviewing strategies are designed to manage the obstacles that underlie denial and resistance. Although motivational interviewing strategies facilitates greater client openness, it is important to recognize that for some clients coming to grips with the full extent of substance abuse can be a long and painful process. In these cases having additional sources of information about the client's behavior from family members, employers, and biological assessment of substance use can be extremely useful. (Interested readers can learn more about motivational interviewing in Miller & Rollnick, 2002, and Moyers & Waldorf, 2003.)

Case Illustration With Dialogue

A.R. is a client who has been seen in outpatient therapy for several months. He is a man in his mid-50s who has been drinking since his early college days. He has a successful life on almost any domain that could be measured. He is a husband to the woman he fell in love with in college. They have two sons who are young adults and have begun to be quite successful in their own careers. A.R. has been a successful lawyer for a large law firm in an urban area, in spite of, as he says, having a personality that might be suited to a more passive profession.

He acknowledges that he has very high levels of anxiety related to his profession and is uncomfortable when he is in litigation. He describes himself as passive and nonconfrontational and has used alcohol to help him cope with stress and anxiety associated with his career. To his credit, he used his own resources and professional help through psychotherapy to battle what was probably a very high level of social anxiety and kept it from interfering with his professional goals as a lawyer.

He sees that the culture and society around him and his profession have changed dramatically in the three decades since he first started working. Twenty-five years ago it was common to see professionals drink heavily even at lunch and go back to work afterward obviously impaired. Although he participated in this to some extent, he was always very cautious about his drinking and how it might affect his career. Mostly, drinking has been a way to relax after hard days and continues to serve this function even to this day. He states that weekends, particularly Sundays, are very stressful for him, and he rarely is able to enjoy his time because he is constantly thinking about the week ahead and the challenges he will have to face.

By his self-report, he states that he usually drinks two to three drinks on weekday evenings after getting home from work but that there are frequent occasions when he has more. He indicates that rarely will he have more than five or six in any given weekday evening. Weekends are different, though, and his drinking starts earlier in the day and lasts longer. One of his favorite things to do is to cook for the family on Sundays, and he enjoys drinking during the early afternoon and into the time when he starts his meal preparation. By the end of the meal, he has found himself going to sleep long before others

are ready to retire because of his alcohol intake. This and other situations like it make him feel that he isn't connected to his family and friends as much as he would like.

He feels that drinking has caused some tension in his relationship with his wife, but his wife has been very supportive and patient with him over the years. The negative consequences of his drinking have not been extensive but have included some incidents when he has been embarrassed after getting too intoxicated at a dinner out with his wife and friends when he was slurring his words. His wife has been upset by this and similar incidents, and A.R. feels that he wants them to end.

Overall, A.R.'s profile fits that of a problem drinker with mild alcohol dependence. He is drinking more than 20 standard drinks per week. On weeks when he drinks heavily, he can consume more than 50 standard drinks. He experiences current negative consequences. Although these negatively affect his life, they are not severe. In addition, he experiences loss of control over drinking and salience in the sense that he has given up other valued activities in order to drink. However, he does not manifest *DSM-IV* symptoms of withdrawal or drinking to avoid withdrawal and therefore does not meet criteria for more severe dependence associated with physiological dependence.

A.R. has attempted to moderate his drinking for many, many years. He has tried disulfiram, naltrexone, and acamprosate as methods to reduce his cravings and alcohol intake. These have not been effective for him, he says. He has participated in many years of psychotherapy, mostly to cope with anxiety directly but also to help him discuss his drinking and try to keep it from getting out of control. Over the years, A.R. has had times when his drinking was successfully controlled, and he often wonders whether he can return to those drinking patterns. He was able to not drink during the week and limit weekend drinking to two or three drinks an evening.

One of the criteria A.R. used for choosing a professional was to find someone who would be willing to work with him on his drinking from a behavioral or cognitive-behavioral perspective. Early discussions about the philosophy of how people change were important to him, including a desire not to have to rely on religiosity or spirituality as a treatment component, which was something that had turned him off from Alcoholics Anonymous (AA). He also found the label *alcoholic* uncomfortable, but he did recognize that he was not always able to control his drinking. Powerlessness, the concept in AA that an alcoholic is completely unable to control his drinking, was something that puzzled him. He believed this to be inconsistent with his setting and trying to achieve goals related to drinking. He felt it might be possible to cope with alcohol problems in a similar way as he had with his problems with anxiety, via self-mastery. A.R.'s views and experience about change are similar to those of many problem drinkers. He is unsure whether he can successfully moderate his drinking. He has attended AA meetings, been treated with medications, and received psychotherapy. None of these approaches has worked especially well.

Probably because of his experiences in therapy, a positive therapeutic working alliance appeared to be achieved quickly. He seemed comfortable disclosing negative consequences related to drinking. Throughout the early sessions, motivational interviewing techniques were used, such as open-ended questions and reflective listening, to explore factors related to his drinking. Drinking had long been an important part of A.R.'s life, and he was not easily able to envision himself as a nondrinker (or ex-drinker). Throughout these sessions he was always highly ambivalent about change, and he recognized this ambivalence. He found it helpful to understand that ambivalence is a normal experience for people in his situation.

One of the difficulties A.R. faced as he weighed the positive and negative consequences of drinking is that he never experienced consequences so grave that he was in immediate danger. Instead, A.R. believed that the most powerful negative consequences were that drinking limited his ability to participate in activities that were meaningful to him and to fully enjoy time with his family. The positive side of drinking for him was that it was a fast and effective means of managing the anxiety he experienced from work, and it was helpful in getting him to relax after a long day of work. His father drank to excess and stopped only when a doctor told him that if he didn't stop drinking he would die. His father once commented to A.R. that quitting drinking is easy if you know that you will suffer grave physical effects quickly. This comment made an impression with A.R. because he knew that his situation wasn't as dire.

At the same time, however, he was very much aware that his drinking conflicted with things he valued dearly, such as his role as a father and husband. These realizations achieved via the use of motivational interviewing strategies helped A.R. become aware of this ambivalence while solidifying the therapeutic alliance.

Over the course of several sessions, it became apparent that his motivation for change fluctuated and to some degree depended on the successes and failures he had experienced in the prior week. In the first few sessions he was not interested in setting goals; rather, he wanted to discuss his options. Rather than pushing for change, the therapist reflected A.R.'s desire to make his own decisions. Eventually, A.R. asked for advice about setting drinking goals, and he and the therapist discussed what would be considered safe levels of drinking. Additionally, they compared what he might experience by trying to abstain altogether with the challenges of moderated drinking. From early in these discussions it was apparent that he wanted to choose moderation as an option to at least try and to perhaps shift to abstinence if these attempts were not successful. After about a month, A.R. decided that he wanted to try to moderate his drinking by not having any nights where he drank heavily, which was defined as more than three drinks. Also, he did not want to drink during the week, but only Friday through Sunday. A.R.'s selection of a goal was the end point in a process of struggling with his ambivalence, becoming aware of the positive and negative consequences of his drinking, and weighing various change options. His setting a clear goal for drinking was an important accomplishment that helped frame subsequent sessions.

It was always a pleasure to work with A.R., in large part because of his consistent attendance and his ability to discuss his successes and failures frankly without a great deal of defensiveness. It was not like him to hide what he saw as his failures or hide his shame or guilt when he had not been able to stop drinking during the week. At times, his emotions were quite evident in session, particularly when he felt that he had let his wife or children down during these episodes. Despite his nondefensive nature, A.R. did have some barriers that interfered with his ability to change. A.R. felt that having to quit drinking altogether was a sign of weakness. The idea of not drinking in a social setting was challenging not because he didn't have think he could accomplish this but because he didn't want to be perceived as a person who "couldn't drink," which he felt was a sign of weakness or inferiority. Additionally, he probably underestimated the quantity of drinking he was doing. He did not measure or count, and after getting started with a few beers or a few glasses of wine, he lost track of how much he had actually consumed. When asked to review his drinking experiences, he would often fail to include these heavy drinking episodes. Although this might be chalked up to "denial," a more clinically useful way to conceptualize this phenomenon is to attribute it to cognitive distortion that serves to protect a more functional view of oneself when reality is too threatening to consider closely.

Other that A.R. experienced included a view of self-help programs that were somewhat unrealistic. Although he understood that social support was an important component, in previous attempts to attend AA meetings he had found it difficult to relate to others with similar circumstances. During the course of treatment, it was clear that he wanted to set his own agenda and that directive efforts to guide him would be met with resistance. He wanted collaboration rather than someone dictating what he should do and when.

Through a functional analysis with A.R., it became apparent that several key times posed a particular problem for his plan. First, weekdays were difficult because he commuted out of the city where he lived via commuter rail. Before getting on the train, he usually passed several beer vendors and often picked up a beer or two for the trip home on weekend nights. He believed that this trigger was the biggest barrier for him on weekdays and that if he could cope with the urge at this stage he would have a good chance of making it through the rest of the evening. However, weekday evenings were also difficult when he got home from work. He often got home from work before his wife did and would start dinner for the two of them. This usually included a glass of wine, which he would continue to consume throughout the evening. Uncorking a wine bottle had become strongly associated with his official end of the business day and a time when he could start to unwind from his job. Also, being alone, he did not have the support and or pressure from his wife to not have the wine.

Weekends were a little more difficult because these were days when A.R. wanted to limit his

drinking instead of not drinking altogether. Information from the functional analysis suggested that drinking earlier, say with lunch, was not easy to manage for A.R. For him, it was easy to disregard his goal after one or two drinks, and if this occurred too early he would often think to himself, "I'm not going to be able to meet my goal for the day, so I might as well drink as much as I want." One or two beers during lunch would turn into many before the afternoon was over. Sundays were particularly difficult for him. He often cooked Sunday dinner for the family, and this process almost always included drinking wine throughout the meal preparation time, which could last much of the afternoon. He came to enjoy this activity very much because it gave him an opportunity to spend time with his family.

Probably the most powerful trigger A.R. faced each week was coping with the anxiety he experienced as Sunday morning turned into Sunday afternoon and A.R. started to contemplate the week ahead. His anxiety rose in a very predictable way, and by late Sunday afternoon A.R. would be ruminating about the challenges he didn't want to have to deal with at the office. Drinking wine afforded him the ability to not think about the difficulties until Monday morning. Further behavioral analyses indicated that it was likely that his drinking severely exacerbated the anxiety he experienced on Monday mornings, once the anxiolytic effects of the alcohol had worn off. Two examples from a functional analysis worksheet completed during treatment appear in Table 20.1.

Table 20.1 Examples from A.R.'s Functional Analysis Worksheet

Trigger: Getting off work			
Thoughts and Feelings	*Response*	*Positive Consequences*	*Negative Consequences*
Wanting to relax after working, feeling tired and tense	Having a beer for the train ride home	Was able to forget about the day	Kept drinking and wasn't able to enjoy the evening with his wife
Trigger: Sunday afternoon			
Thoughts and Feelings	*Response*	*Positive Consequences*	*Negative Consequences*
Feeling anxiety about work on Monday	Drinking wine during the day while cooking	Was able to avoid thinking about the day	Feeling even more anxious on Monday morning Not enjoying the evening with his wife and kids

During his treatment A.R. fluctuated in his motivation for change, which was reflected in his ambivalence in his goal choice. Once he had set goals for not drinking during the week and drinking in moderation on weekends, complete success occurred only occasionally. Most weeks he was not totally successful and would describe situations that had come up for which he made exceptions to his drinking goal. These exceptions would be explored in session to evaluate whether the goals he had set were appropriate and whether they should be reevaluated. This would usually end up with him reaffirming his goals and stating that he was comfortable with them as they were. After several months of therapy, he came in one day and described an event that had a very large impact on how he felt about his drinking, related to an acquaintance he had known for many years.

A.R.: I'd like to start with something this week that had a big impact on me. And it has really changed the way I am thinking about my own life and what I should do. I've had a friend, not a great friend, but someone who has lived in my neighborhood for many years and who has kids about the same age as mine. He is a doctor who has been working for a hospital in the area. I'm not really sure what he does, but he's been at it for a long time and has done real well for himself and his family. He

worked very long hours and didn't really have a lot of time for his family. Anyway, I heard over the weekend that he overdosed on some kind of painkiller, which just surprised me. No one knew that he had a problem with it, but apparently he has been using drugs from the place he works for a long time.

Therapist: It sounds like that was difficult to hear.

A.R.: The thing that got me was that you would never know that this was going on. He never seemed like the type to get involved with that kind of thing, and I never saw that he was affected in any way. I don't think other people saw it either.

T: So how did this change your thinking about your situation?

A.R.: The thing that made me take notice is that it reminds me of myself and that I've had the ability to go through my life without my drinking being too noticed by others. I get by okay. The realization is that like him, I haven't been very good at balancing my life the way I'd like to. I work too much, and while I have a good relationship with my kids, I feel like I missed a big part of their growing up. The real issue is that I feel like the drinking takes me away from the most important things in life, much like the drugs probably did for him. It's like he had this whole separate life that existed without anyone else. It just seems sad to me. I don't want to end up sick or, even worse, wishing that I would have stopped drinking a long time ago.

T: So does this change how you want to proceed with things?

A.R.: I think so. It certainly changes the way I've been thinking about my drinking and makes me think this is maybe more serious than I have wanted to believe. I've been wondering if it might be better to not drink altogether. I'm not sure how to go about doing that, but I'm starting to think in that direction.

Although this event did not have an immediate effect on his goals and behaviors, it certainly changed the way he thought about his drinking, and soon after this event he had another occurrence of drinking heavily and causing an awkward situation for his wife. One morning session after a holiday weekend, A.R. came to the office, and the only way to describe his look was defeated. He went on to discuss the event.

Therapist: How was your holiday?

A.R.: I've not had a good week. My wife and I had friends over for the holiday, and things just kind of slipped away from me. I had a great time putting things together for the meal and preparing for company. I did start drinking pretty early in the day, which was a big mistake I guess. I thought I was doing well. The meal went well, and everyone seemed to be enjoying themselves, including me. I'm not sure what happened really. I got really tired during the meal and afterwards was talking to the guests. I kind of had the impression at some point that our guests were slowly heading out to go home, so I went upstairs to take a nap. I kept sleeping through the rest of the afternoon and evening, and it was only the next day that I knew something was wrong. My wife was very upset with me and told me that she was disappointed that I just abandoned the party. Apparently people were not leaving, as I had thought, and my wife was in the position of having to tell people that I wasn't feeling well.

T: How are you feeling about that at this point?

A.R.: Well, I feel bad that I let her down. That's what feels the worst right now. I'm not really sure what to do. I don't think I can do this anymore. I feel like I get it right a lot of the times but that sometimes it just kind of gets away from me.

T: So experiences like this make you wonder if it's worth it?

A.R.: Very much. I just am tired of disappointing her and myself. I don't really know how to proceed here, though. I would like to walk away from drinking, but I don't really know how to. How do you just stop and not drink anymore?

T: It's hard to imagine what your life would look like if alcohol weren't a part of it.

A.R.: I've been talking to my sister—the one that is in AA—about this stuff. She hasn't had a drink in many years and has really

> enjoyed it. She likes AA a lot but doesn't really go to meetings anymore. I don't think that it's right for me, but I am thinking that I might need to stop.

These events illustrate the expected unfolding process of change. A.R. has embarked on a plan to reduce drinking, is struggling to achieve his goals, and in the process obtains a deeper realization of the true cost of his drinking in terms of what he is giving up and the disappointment his drinking is causing to his wife. The therapist's role is help A.R. experience his disappointments and the consequences of his goal choice and use them to increase his motivation and efforts toward change. After these events, A.R. decided to try to go to some AA meetings in his area. Most often, he found it difficult to relate to others, and the concept of being powerless over alcohol was difficult to incorporate into his concept of change. Several ensuing discussions involved his ambivalence about abstinence and attendance at AA meetings. A.R. continued to struggle with whether to stop drinking altogether and eventually decided to continue to try to moderate.

A behavioral intervention strategy continued to be tailored for his goal choice, and a treatment plan was put together based on the functional analysis. The treatment plan for A.R. included a focus on several general tasks that would help him cope with the desire to drink. The first was to develop a plan to reduce the anxiety and tension related to his job. In analyzing some tools he had used in the past, A.R. reported that he had meditated and indicated that it had been helpful at one point, but he had gotten out of the habit. A daily meditation plan was developed, and he thought it would be a good idea to try to meditate three times a day, each for about 10 to 15 minutes.

The second task was to develop a support network. This proved to be somewhat difficult for A.R. It did not seem to be his nature to reach out to others in difficult times, which may have been one reason that self-help meetings were difficult. However, he did have a friend that he considered close enough to talk to, who also tended to drink a lot and who was also interested in limiting his alcohol intake. He thought that this might be a good place to start and was able to have several lunch meetings with this friend in order to discuss these issues.

The third task was to make attempts to use his time away from work in ways that were more rewarding. During a discussion of things that would serve this purpose, he mentioned that he had thought for many years that volunteering would be a very good thing to do. He had several ideas, which included the possibility of mentoring people who were interested in pursuing a career in law through a local college. A second idea was to involve himself in a local nonprofit that served the needs of underprivileged boys and girls. These discussions of volunteering were very exciting to A.R., and volunteering seemed to serve several functions. It provided a way to feel more connected to the community and also to help him feel that his time could be used in valuable ways because he often felt that the time he spent drinking was time being wasted. A fourth task was related to his overall health, which he recognized as being compromised by his drinking, at least in part because he didn't exercise as often as he thought he should.

Specific temporal tasks were also included in his treatment plan, which again were based on information from his functional analysis. The two primary scenarios that posed the most difficulty for him were related to when he got off work during the work week and weekend days, particularly Sundays, when he would be at home with nothing planned. For weekdays when he was getting off work and going home, he decided that going to the gym on his way home would be a way to feel more relaxed without having to drink. This also was helpful for him in another way. He felt it was easy to not pick up the beer at the train station if he knew that he was going for a workout. For the trip home, he would try to avoid the beer vendor areas as much as possible when walking through the train station.

The plan for times when he was at home in the evenings during the week and on weekends was to try to avoid going to the refrigerator and opening a bottle of wine or picking up a beer when he was by himself. The tools to help with this included making a phone call to his friend when he felt tempted to drink and trying not to spend as much time at home during downtimes. Of all the coping strategies available to him, A.R. particularly relied on cognitive strategies and decision-making tools as a way to cope with thoughts about drinking. For example, when necessary, he would attempt to think through what picking up a beer could lead to, challenging thoughts that it would be relaxing without also thinking about the potential negative consequences if he continued to drink.

A.R. was not always successful with these strategies, but was able to reduce his drinking through these techniques. A.R. remained committed to a moderation goal that included not having heavy drinking days and not drinking during weekday evenings, although at times he considered abstinence. He was able to develop a more positive lifestyle that included working out more frequently, and he continued to pursue activities that involved volunteering. Reaching out to others continued to be difficult for him. The friend that he had connected with ultimately was not that helpful in providing support for him. Although A.R. made many positive changes during treatment, he continued to be frustrated by his ambivalence about his drinking goals and the combination of his successes and failures in accomplishing the goals he set.

Differential Diagnosis and Behavioral Assessment

Having introduced the basic concepts of motivational interviewing and behavioral assessment and illustrated their application in a case example, we now turn a more detailed explication of the types of information needed to assess substance use disorders and how this information is used to create an initial treatment plan. Assessment interviews must answer four broad questions. First, what is the nature of the substance use disorder, if present? Second, does the client have other problems, including other psychiatric disorders? If so, what is the relationship between these other problems and substance abuse, and how do these factors affect treatment? Third, what does the functional analysis indicate about the types of situations that trigger episodes of use, and what coping skill deficits and coping strengths does the client possess that can become potential targets of treatment? Fourth, what is the client's view of his or her problem and openness for change?

Substance Use

Substance use is a complex behavior, and accurate assessment entails use of several well-developed techniques. These techniques have been incorporated into existing measures. Familiarity with these measures, whether or not they are used as part of the interview process, will greatly improve interviewers' skills. To illustrate this point, let's consider how a client might respond to the question, "How much do you drink?" Clients might respond, "Well, not much," "I have a couple of drinks on the weekend," and so on. Such responses do not yield much information. The Timeline Followback Interview (Sobell & Sobell, 2000) is an excellent measure designed to assess patterns of substance use that incorporates several well-validated techniques needed to yield accurate assessment. These techniques include defining the content of alcohol in drinks based on a standard drink concept. A 12-ounce bottle of beer, a 5-ounce glass of wine, and a 1.5-ounce glass of hard liquor all contain one standard drink, or 9 grams of ethanol. In addition, the Timeline Followback Interview uses a calendar format as a memory aid and asks clients to review on a daily basis for a period of several weeks their patterns of substance use. Although such detailed techniques may seem like overkill to the novice interviewer, they typically yield invaluable data that help clarify not only the quantity and frequency of substance use but also a consumption pattern that may be linked to specific risk situations, such as heavy drinking on weekends. Use of this calendar method was invaluable in characterizing A.R.'s pattern of drinking.

It is helpful to classify negative consequences of substance use into life domains and characterize them on a continuum from mild to severe. Life domains include physical health, psychological problems, spouse or partner, family, friends, work, and legal. Gaining a clear understanding of the current (within the last several months) and past negative consequences is among the most useful ways to characterize the severity of substance use problems. Those with mild problems typically are functioning reasonably well in most domains but may have one domain that is especially problematic (e.g., a person who has several recent drunk driving arrests but whose other life domains appear intact). By contrast, people with multiple severe current and past consequences such as loss of several jobs, ruptured family relationships, and serious chronic medical and psychological problems that are the result of substance use clearly present a severe picture of the disorder. The Drinker Inventory of Consequences (Miller et al., 1995) is a well-validated measure of negative consequences of alcohol use that illustrates the concepts of different life domains and a continuum of severity.

Clinical diagnosis and severity of dependence complement assessment of patterns of consumption and negative consequences. Most assessment interviews require generation of a *DSM-IV* classification of abuse or dependence. Several semistructured diagnostic interviews exist that can provide useful didactic guides. Among the best for didactic purposes is the Substance Use Modules of the Structured Clinical Interview for *DSM-IV* (First, Spitzer, Gibbon, & Williams, 1996), which is a measure designed for use by clinicians. Assessment of the severity of dependence goes beyond assignment of a diagnosis to consider the extent of loss of control, salience, and neuroadaptation. For example, A.R. met criteria for alcohol dependence but experienced mild to moderate loss of control and salience, as evidenced by his ability to function well and set appropriate limits on his drinking in most situations. Assessment of physiological dependence, specifically withdrawal or use to avoid withdrawal, is important in assessing severity, especially with substances such as alcohol or opiates, where there are direct implications for selection of detoxification protocols.

Other Problems

Substance use disorders often co-occur with other Axis I and Axis II mental health disorders. At a minimum, it is important to determine whether a client meets criteria for other Axis I disorders and how the presence of these symptoms will affect treatment planning. Differential diagnosis of other mental health disorders among clients with active substance use disorders is complex, in part because chronic use of substances or acute intoxication can induce psychiatric symptoms or exacerbate symptoms in those who are vulnerable. For example, amphetamine use can cause hallucinations in someone without a history of psychosis or trigger these symptoms temporarily in someone vulnerable to psychosis. In neither case would separate treatment for psychosis be needed beyond perhaps a very brief stabilization period. As a general rule, it is important to determine whether an Axis I disorder is primary, defined as occurring before the substance use disorder or when the client was not using substances. If so, then it is likely that additional primary treatment for a mental health disorder will be needed. Axis II disorders also co-occur at high rates among clients with substance use disorders (Verheul, Ball, & van der Brink, 1998). Although the reliability and validity of these diagnoses in the context of substance use disorders is uncertain, enduring character traits manifest in a wide array of contexts, such as impulsivity, affective instability, and sociopathy, have important implications for treatment planning.

It is also important to assess other areas of life functioning to determine whether they present problems that might interfere with initial treatment goals or might be positive supports. In clients who have a chronic history of substance use disorder, many areas of functioning are likely to be negatively affected. Several multidimensional assessment measures exist that provide comprehensive but brief coverage of relevant life domains. The Addiction Severity Index (ASI; McLellan & Kushner, 1992) is among the most widely used of these measures. The ASI uses semistructured interview strategies to obtain information about seven possible problem areas: alcohol use, drug use, psychiatric status, medical problems, family and social relationships, employment, and legal status. Interviewers who expect to be assessing clients with chronic substance use problems are strongly recommended to learn more about the ASI. Finally, interviewers should consider assessing cognitive impairment when clients present with clear memory or attentional problems because such problems can affect the ability to benefit from treatment.

Functional Analysis

Gaining a clear understanding of the nature of the substance use disorder, other psychiatric problems, and functioning in other life domains provides a framework for moving forward to analyze the antecedents that give rise to episodes of uncontrolled use. For clients with mild to moderate dependence, there are likely to be a few specific situations that trigger use. For example, antecedents for A.R. included leaving work and being home on Sunday. By contrast, clients with moderate to severe dependence are likely to experience loss of control in most situations. Similarly, knowing a client has a primary Axis I disorder can be helpful in forming hypotheses about the functional relationship between use and reduction of negative affect. In the case of A.R., drinking reduced intense experiences of anxiety. At times interviewers may assess a client who has recently relapsed after a period of

extended abstinence. Assessment of relapse requires specialized knowledge and is beyond the scope of this chapter; a recent chapter by Dennis Donovan (2005) contains a comprehensive overview of the topic.

Although there is no set technique for conducting a functional analysis, interviewers may find it useful to introduce a functional analysis worksheet similar to that presented in Table 20.1. The worksheet provides an opportunity to educate the client about behavior analysis and specifically that substance use episodes involve triggering events, thoughts and feelings, actions, and the positive and negative consequences of those actions. For clinical and heuristic purposes antecedents can be categorized into proximal or immediate triggers and distal or broader problems that underlie vulnerability to use. Proximal antecedents typically are situations that become strongly associated with substance use, such as being in a bar, being in the company of others who use drugs, or particular times of the week. Distal antecedent are a broader set of general coping skill deficits. In A.R.'s case, high levels of anxiety related to work and his inability to manage that anxiety was a distal antecedent that exerted a broad influence over his excessive drinking.

In addition to identifying proximal and distal antecedents, interviewers should note coping capacities and deficits described throughout the interview because they will be important in determining treatment targets. Coping capacities can be usefully organized into proximal ones, related to handling immediate triggers to use such as strong urges, and distal or general coping skills, such as social, assertiveness, and communication skills, affect tolerance, and affect regulation. Also, it is useful to consider broad coping style. Does the client engage in approach coping such as active problem solving when confronting problems, or is coping characterized by avoidance, passivity, and escape? In addition to assessing internal coping capacities, it is important to assess environmental resources. The environment plays a critical role in maintenance and change of addictive problems (Moos, 2006).

Three characteristics of the environment are important to consider: restraint or structure, support, and provision of alternative rewards. Environments can provide strong restraint factors via social structure. For example, if the client is working full time, that activity presents an important restraint factor. Environment can also be supportive or interfering in efforts to change. For example, if a client's social network consists mainly of other heavy drinkers, then the social environment is likely to exert pressure to continue drinking. Finally, to what extent do the client's life circumstances provide alternative rewards via work, family, leisure, or community activities? Clients such as A.R., whose environment provides restraint in the form of social structures such as a job and family; a supportive social environment, and a meaningful investment in family, job, and community, are much more likely to change their behavior than clients who have fewer or none of these environmental features.

Client's Views on Change

The client's views on change include an assessment of readiness to change, decisional balance, situational and general self-efficacy, and selection of goals. These have been reviewed extensively in prior sections. A more complete explication of these concepts can be found in Miller and Rollnick (2002) and DiClemente (2003).

Selection of Treatment Targets and Referral

Even a cursory familiarity with substance abuse treatment indicates the wide array of treatment options that vary from brief interventions of less than 10 minutes to 18- to 24-month residential treatment programs. The purpose of this section is to provide an introductory framework for treatment planning and refer interested readers to more specialized texts for additional information. One of the most comprehensive approaches to treatment selection is the American Society of Addiction Medicine Patient Placement Criteria (Mee-Lee & Shulman, 2003). The perspective presented here is consistent with that framework. Treatment for substance use disorder can be conceived as involving three phases, each with different targets: detoxification and stabilization, primary phase treatment, and continuing care. In addition, decisions about how to structure each phase, especially with regard to setting (inpatient vs. outpatient) and intensity are related to questions about the need for ancillary services, the

existence of a supportive environment, and the involvement of other health care or system-level services such as criminal justice, child welfare, or social welfare.

A first question for assessment is whether clients need detoxification or a period of initial stabilization. Clients who use substances with classic withdrawal potential such as alcohol, sedatives, and opiates should undergo careful assessment of the need for detoxification. However, even other substances such as cocaine, which do not require specific medical care for withdrawal, have strong withdrawal potential that may necessitate high levels of structure and monitoring. Readers interested in detoxification issues are referred to Graham, Schultz, Mayo-Smith, Ries, and Wilford (2003) for a detailed discussion of each substance class. Even clients who are not experiencing withdrawal may need an initial period of stabilization before beginning treatment because of the exacerbation of acute psychiatric symptoms, intense mood fluctuations caused by high levels of recent use, inability to abstain from substance use without some external structure, temporary cognitive impairment or disorientation secondary to high levels of use, or medical problems that complicate or prevent a primary focus on reducing substance use. Detoxification and stabilization typically are conducted in inpatient settings. However, detoxification from alcohol, sedatives, and even opiates can be accomplished on an outpatient basis in cases uncomplicated by medical or psychiatric problems and with a client who is highly motivated and has a supportive social environment.

The target of primary treatment is reduction of substance use to an appropriately safe level, either abstinence or nonproblem use. A critical assessment question in planning primary treatment is whether the client has ancillary problems that necessitate concurrent treatment and whether the client's environment is sufficient supportive and structured to allow outpatient care. An important and historically controversial issue has been whether primary treatment should always take place in residential or 28-day inpatient settings or can be accomplished in outpatient settings. The consensus, at least currently, is that primary treatment is recommended to occur in residential settings if clients have significant medical or psychiatric problems or live social environments (e.g., homeless shelters, drug-saturated neighborhoods) that would not support recovery efforts (Finney & Moos, 2003). Clients who have psychiatric disorders need treatment that is integrated with primary addiction treatment. Similarly, if clients have basic needs, such as housing, transportation, or child care, these ancillary services should be provided as part of any treatment package.

Summary

Whatever the particular setting and package of services that make up primary treatment, the achievement of a sustained period of abstinence or nonproblem use requires a focus on a set of factors. These factors, or intermediate targets, include enhancing motivation, reducing cravings, increasing substance-specific and general coping skills, strengthening affect regulation, developing a social environment supportive of recovery, and developing alternative rewards and goals that are inconsistent with prior patterns of substance use. A variety of effective psychosocial interventions exist that, in general, target these factors (cf. Rotgers, Morgenstern, & Walters, 2003). For example, each of these factors was addressed in the cognitive-behavioral treatment of A.R. In addition, a variety of medications are available that, when delivered in the context of effective psychosocial interventions, can enhance outcomes. Interested readers are referred to Frances, Miller, and Mack (2005) for further discussion of the appropriate use of medication and counseling approaches.

Continuing care is the final phase of treatment. It is widely acknowledged that most clients should continue with some form of ongoing treatment even after achieving a stable period of abstinence or nonproblem use. This recognition is rooted in the emerging understanding that for many, substance dependence is a chronic illness that may recur repeatedly (McLellan, Lewis, O'Brien, & Kleber, 2000). The goals of continuing care are to help clients maintain behavior change, deal with slips or lapses without letting these events turn into full-blown relapses or a return to initial levels of problem use. In addition, continuing care can provide a forum for clients to begin to address broader rehabilitation goals such as job training and education.

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21

Sexual Dysfunction and Deviation

Tamara Penix and Dahamsara Suraweera

That the sexual dysfunctions and deviations are grouped together may seem appropriate at a cursory glance and inappropriate with a slightly more detailed look. Both categories have to do with sexuality, a decidedly unique set of behaviors that garner a great deal of attention. Furthermore, they are nonnormative forms of sexuality. However, a sharp divergence in the presentation of these problems quickly emerges. The former disorder entails a person being unable to move through the human sexual response cycle at will, thereby producing psychological distress or interfering with normal social functioning for the individual or dyad. For the latter, it is the sexual stimulus itself that is nonnormative, often resulting in distress or social dysfunction in the individual or in the inappropriate object of his or her sexuality. These categories are nearly opposites: One set of problems involves being unable to function sexually when that function is desired in some fashion, and the other involves functioning sexually when some aspect of the sexuality is deemed inappropriate.

Interviewing for these two kinds of problems entails appreciably different strategies. As a result, they will be handled separately in this chapter. One unifying theme is their most common obstacle: the difficulty of discussing sexuality forthrightly and accurately. Despite the ubiquity of sexual commentary, full disclosure about one's sexuality, even in clinical settings, challenges the cultural prohibitions against it. Direct observation of human sexual problems is not done. There is consequently a problem of access to information requisite to solving sexual problems. All of the following recommendations refer to the goal of fully accessing relevant and accurate information about sexual behavior.

No structured clinical interviews specific to sexual dysfunctions or sexual deviance disorders were found for clinical use. The chapter aims to aid in structuring a sexual dysfunction or deviance interview.

Description of Sexual Dysfunction Problems

There are 11 categories of sexual dysfunction in the *Diagnostic and Statistical Manual of Mental Disorders Text Revision* (*DSM-IV-TR;* American Psychiatric Association [APA], 2000), very similar to those of the International Classification of Diseases (*ICD-10;* World Health Organization, 1992), 8 of them shared by women and men. They are further divided into four major categories, two additional context attentive categories, and the not otherwise specified (NOS) category. The four

primary areas of diagnosis are the sexual desire disorders, sexual arousal disorders, orgasmic disorders, and sexual pain disorders. Also taken into account are sexual dysfunction caused by a general medical condition and substance-induced sexual dysfunction. Specifiers for each diagnostic category include whether the problem is lifelong or acquired, generalized or situational, and caused by psychological factors or combined factors (both psychological and physiological). The sexual desire disorders affecting both genders include hypoactive sexual desire disorder and sexual aversion disorder. The sexual arousal disorders include female sexual arousal disorder and male erectile disorder. Orgasmic problems include male and female orgasmic disorder and premature ejaculation in males. The final subcategory is the sexual pain disorders, which include dyspareunia in men and women and vaginismus in women.

Prevalence of the sexual dysfunctions in the population is unknown. It is essential to note that little is known about normative sexual practices and regular fluctuations in sexual desires and practices, thus rendering the diagnosis of a sexual dysfunction very subjective and dependent on clinician perceptions of marked distress or interpersonal difficulty. The most comprehensive study of the sexual dysfunctions to date (Laumann, Paik, & Rosen, 1999) found sexual desire disorders in the 30% range for women and 15% for men, 20% for female sexual arousal disorder and 10% for males, 25% for female orgasmic problems in the past year and 10% for males, 27% for premature ejaculation, 15% for female dyspareunia, and 3% for male dyspareunia. Vaginismus separate from a primary diagnosis of dyspareunia is rare according to a recent literature review by Reissing, Binik, Khalife, Cohen, and Amsel (2004).

The following are the essential features of each sexual dysfunction, taken from the *DSM-IV-TR* (APA, 2000). The second criterion for each problem is the presence of marked distress or interpersonal difficulty. The sexual dysfunction may not be better accounted for by another Axis I disorder (except another sexual dysfunction) and is not caused exclusively by the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (criterion C; APA, 2000).

Hypoactive Sexual Desire Disorder. Persistent or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life.

Sexual Aversion Disorder. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.

Female Sexual Arousal Disorder. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.

Male Erectile Disorder. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.

Female Orgasmic Disorder. Persistent or recurrent delay in, or absence of, orgasm after a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of female orgasmic disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, her sexual experience, and the adequacy of sexual stimulation she receives.

Male Orgasmic Disorder. Persistent or recurrent delay in, or absence of, orgasm after a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judged to be adequate in focus, intensity, and duration.

Premature Ejaculation. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.

Dyspareunia. Persistent or recurrent genital pain associated with sexual intercourse in either a male or female.

Vaginismus. Persistent or recurrent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.

Sexual Dysfunction (specify) Due to a General Medical Condition (specify). Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates in the clinical picture (Criterion A). There is evidence from the history, physical examination, or laboratory findings that the sexual dysfunction is fully explained by the direct physiological effects of a general medical condition (Criterion B). The disturbance is not better accounted for by another mental disorder (Criterion C).

Substance-Induced Sexual Dysfunction. Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates in the clinical picture (Criterion A). There is evidence from the history, physical examination, or laboratory findings that the sexual dysfunction is fully explained by substance use because the symptoms in Criterion A developed during, or within a month of, substance intoxication or medication use is etiologically related to the disturbance (Criterion B). The disturbance is not better accounted for by a sexual dysfunction that is not substance induced. Evidence that the symptoms are better accounted for by a sexual dysfunction that is not substance induced might include the following: The symptoms precede the onset of the substance use or dependence (or medication use), the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of intoxication or are substantially greater than what would be expected given the type or amount of the substance used or the duration of use, or other evidence of an independent non-substance-induced sexual dysfunction (e.g., a history of recurrent non-substance-related episodes).

For the sexual dysfunctions due to general medical conditions or substance use, it is specified whether the problem includes impaired desire, impaired arousal, impaired orgasm, or sexual pain. For the latter category, the diagnostician also specifies whether the onset is during intoxication.

Interviewing Strategies

The key to successful interviewing for the sexual dysfunctions is to build strong rapport rapidly. It is essential that clients acclimate to the interview situation, developing comfort, trust, confidence, and expectations that the dialogue is worthwhile and will lead to favorable outcomes. No data have been gathered thus far on the necessary and sufficient conditions for establishing rapport around sexual issues. The following recommendations are based on more general successful interviewing strategies and prevalent clinical practices.

A professional atmosphere and demeanor on the part of the clinician should be established. The environment should convey cleanliness and a sense of formality while remaining inviting. The interviewer should be on time and address the client formally. Clinic policies, informed consent, the limits of confidentiality, and release of information policies should be reviewed at the start of the interview and all questions answered before the clinician advances to the next step. It is important for the clinician to convey experience and comfort discussing sexual matters. Clients will take their cues in this regard from the interviewer. It may be useful to note the number of sexual dysfunction cases seen, years assessing and treating these problems, or any specialized training in the assessment and treatment of sexual dysfunctions.

Sexual issues should be discussed as openly as other topics, with full, soft eye contact and an unwavering demeanor. The interviewer should set a serious tone, one that may be loosened if the client demonstrates receptivity to humor by using it first. Humor may be used to increase the client's comfort; however, the humor should address the interviewing situation or the problem itself, not the client. Next, the interviewer may offer reassurances that sexual dysfunctions are common and that most are treatable. Interviewers should be aware of prevalence rates, in order to be able to produce them readily if asked, and the variety of available treatments. It is important to acknowledge how difficult it is to talk about a sexual problem and the relationship difficulties that may result (LoPiccolo, 2004). The client should be asked about any concerns about assessment or treatment in order to give the clinician the opportunity to alleviate any unrealistic fears or misconceptions about these endeavors.

One founded fear many clients have is discussing their sexual behavior in detail with a stranger. It is essential to lay the foundation for full disclosure of relevant information by elucidating the access problem. Behavioral assessments are not routinely conducted for problems of sexual dysfunction for privacy reasons. Clients must understand that the only way the clinician can access the problem is through the client's

accurate description of its features and that greater accuracy leads to better assessment and treatment of the problem. It is critical that the clinician convey unflappability, genuine interest in the client, and concern for his or her welfare and sexual functioning. Finally, any cultural factors that may affect rapport should be acknowledged and addressed. Cultural dimensions on which the clinician and client may not be matched include age, gender, socioeconomic status, ethnicity, disability status, sexual orientation, spiritual beliefs, language, marital status, and ideological differences. It is important in the rapport-building phase to ascertain whether differences on any of these dimensions are important or of concern to the client. If a client identifies one or more category of concern, the interviewer may explore the origin of the concern and whether the difference could affect the assessment. Differences that the client perceives as affecting the interview and that cannot be resolved to his or her satisfaction are grounds for referral to another provider. See Hays (2003) for additional information on culturally sensitive assessment and intervention practices.

Once adequate rapport has been established, the interview takes on an investigative quality. The broad goals of the interview are to learn the parameters of the problem, to delineate its causal and maintaining factors, to understand the function of the symptom for the individual and the dyad, to identify potential targets for treatment, and to understand the palatability of and expectations for treatment as efficiently as possible. Toward these ends we have culled from the literature 20 general categories of questions that may be useful in gathering information, arranged from those that assess the most common features of these disorders to those that are rarer. A number of experts in the field of sexual dysfunction recommend this type of multidimensional approach to interviewing and assessment (Beck, 1995; Heiman, 2002; Kaplan, 1979; LoPiccolo & Friedman, 1988; Rosen & Leiblum, 1995; Trudel et al., 2001).

Demographic Information. It is important to know the client's age, ethnicity, marital status and presence of a regular sexual partner, sexual orientation, religious affiliation, income, level of education, and age and number of children because these variables may affect sexual functioning directly or indirectly. If the problem occurs in the presence of a regular sexual partner, the client should be encouraged to include the partner in the interview. Ideally partners are interviewed separately and then jointly.

Problem Description. A detailed description of the problem is critical. This description should include the level and frequency of desire, arousal, orgasm, and genital pain, the degree of sexual satisfaction, subjective distress regarding the problem, and whether it is global or situational and lifelong or acquired (Heiman, 2002). In the case of a desire problem, it is important to note whether desire emerges once sexual activity is initiated (Letourneau & O'Donohue, 1993). If the problem is situational, follow-up questions must distinguish the features of contexts in which the problem arises from those in which it does not occur. Heiman encourages the interviewer to be aware of the affect and nonverbal behaviors surrounding the initial description. The features of actual sexual behavior must be voiced. These include the frequency, course, and sexual activities, evaluation of self and other, and satisfaction. Additional variables are participation in sexual activity when it is undesired, sexual activity outside the primary relationship, solo sexual activities, and use of the sex industry, ranging from using pornography to visiting strip clubs and prostitutes. Clients should address the presence of lubrication, swelling, or erection to sexual thoughts, to self-stimulation, and to stimulation by others. Finally, if the dysfunction occurred in the presence of another person, what was the reaction?

Medical History and Medications, Including Sexual Health. The first bit of essential medical information is the date of the last checkup and whether the sexual problem was addressed. Many sexual dysfunctions are partly or entirely physiological (Basson et al., 2001). The medical history should take into account all developmental abnormalities and insult, injury, and disease. Of particular interest are the client's medications because there are many with undesirable sexual side effects, including commonly used antidepressants and antihypertensives. Supplements and herbal remedies should be noted also because they may produce unpredictable side effects and are governmentally unregulated. Any sexual health problems should be identified, including any history of sexually transmitted disease and any problems necessitating a medical procedure involving the sexual organs.

Mental Health History and Current Psychological Functioning and Well-Being. The client's history of psychological functioning may be important. Clients should be asked whether they have ever been diagnosed with a major mental illness or received psychological or psychiatric treatment. The client's view of his or her current psychological functioning and sense of well-being warrant consideration. A number of psychological disorders and more transient emotional states may interfere with sexuality (Beck, 1995).

Substance Use. Like prescribed medications, illicit drugs and alcohol may interfere with sexual functioning and merit examination (APA, 2000).

Sexual History. A complete sexual history should be taken. This narrative should include the diagnostic elements of desire, arousal, orgasm, pain, and satisfaction for each type of sexual experience and partner. The features of partners and intimate relationships that included sex may be important as well. The clinician should distinguish the features of instances in which the sexual response cycle progressed uninterrupted from those that were cut short by dysfunction. Questions may focus on who was involved, which sexual thoughts or behaviors occurred, contextual factors that added to or detracted from the experience, and how the event ended. Common themes across sexual experiences and distinctions in those that were different may be noticed. Clients should be asked about their perception of their sexual skill. Use of contraceptives, pregnancy concerns, postpartum states, menopause, and surgeries such as hysterectomy are relevant. Experiences of sexual abuse and any related physical or psychological effects should be discussed at this time. LoPiccolo and Heiman (1978) suggest asking about the treatment of sexuality and affection in the family of origin, both overt and covert. They also propose exploring the affect associated with sex and the degree of enjoyment of other sensual experiences. Rates of lifetime sexual activity and the range of activities should be tracked (Hall, Andersen, Aarestad, & Barongan, 2000). Accounts should include extramarital sex, past or present.

Contextual Factors Including Stressors, the Environment, and Time. Queries must cover all elements that set the stage for sexuality. These include whether the environment supports sexual activity. The client may rate her or his stress with respect to how much of it there is and whether there is a perception of personal control over it. Does the client make time for sexual encounters? Is that time realistic or adequate to fulfill his or her sexual desires? What is the client's typical sexual environment like? Does the client have a space appropriate for uninterrupted sexual activity? Is it inviting? Do the client and his or her sexual partner maintain their attractiveness? Have the attractive features of a sexual partner changed in some discernible way? Is any novelty introduced into sexual relationships by the client or a partner? Does the client or partner have children who may be a concern during sexual activity? Is the couple trying to conceive a child? Is a woman in the dyad pregnant? Are the client and partner taking care of their physical and emotional needs?

Dyadic Adjustment. If the sexual dysfunction occurs in the context of an intimate relationship, the quality of that relationship should be explored. Questions should address relationship satisfaction, conflict and tension and its duration, roles in the couple, and power in the relationship. Unresolved conflicts have a way of affecting sexual intimacy. Relationship problems make participation in sex therapy less likely (Hawton & Catalan, 1986). Is there romantic love or compassion for the partner? This is the place to ask about sexual communication. Is communication about sex direct? Are the partners able to express their sexual preferences and desires? Who initiates sex, how, and how often? Desire discrepancy is an issue that must be addressed (Letourneau & O'Donohue, 1993). How often does each partner desire sexual contact, and how often does it materialize? The sexual drives of men and women peak at different ages (Letourneau & O'Donohue, 1993), potentially affecting a couple's sexual synchrony.

Sexual Attitudes and Beliefs and Perceived Sexual Norms. This category attempts to draw out the client's strongly held sexual ideas. Questions that may be useful here include the following. "From your perspective, who is permitted to have sex (e.g., ages, genders, orientations)?" "Who should not be having sex?" "What kinds of sexual activities are allowable?" "Which activities are unwise or not permissible?" "How do you think most people view sexual relationships?" "Are there any differences between how you approach sex and

how other people do? If so, do those discrepancies concern you at all?"

Sexual Interests and Preferences. The focus of this category is the client's ideal interests and preferences and those of a partner if the sexual dysfunction involves the couple. What types of sexual partners and activities are of interest? Of these possible partners and activities, which ones are more and less preferred? Does the client think about sex at all? Are there common sexual activities or those preferred by a sexual partner that are aversive to the client? Does the client masturbate and, if so, how often, and is it a preferred sexual activity? Is there conflict in the sexual or gender orientation? Are there paraphilic interests? Letourneau and O'Donohue (1993, p. 94) describe the possibility of a "narrow sexual comfort zone" for people trying to balance an unnerving dependent attachment with a fear of real love and commitment. This is an issue that warrants exploration when a sexual dysfunction occurs within a dyad.

Sex-Related Cognitions. This is a more difficult category to describe because it can be highly individualistic. The major question that needs to be addressed is, "What kinds of associated thoughts arise when you think about sex during or outside a sexual encounter?" Important cognitions suggested by Lavie-Ajayi (2005) have to do with the meaning of the sex or orgasm, its importance, and the imperative to reach orgasm addressed by Potts (2000). Are there specific thoughts about whom or what the sex is for (Heiman, 2002)? Do thoughts about missing out or losing control arise? Is the dysfunction viewed as a sexual difficulty or a relational difficulty? Is there a perceived social stigma associated with not having orgasms? Body image concerns may emerge as well as judgments about a partner's body. Is there an acceptance of sexual differences from person to person?

Ravart, Trudel, Marchand, Turgeon, and Aubin (1996) suggest a number of different types of cognitions that may negatively affect sexual functioning. These include negative and causal attributions about events, negative self-talk, negative automatic thoughts, irrational beliefs about sex and relationships, sexual misconceptions, self-defeating attitudes, unrealistic expectations (especially hypersexual standards inducing performance anxiety; Letourneau & O'Donohue, 1993), aversive imagery, and antisexual thinking styles, which include focusing on the negative or unpleasant features of the partner, relationship, or sexuality in general. Letourneau and O'Donohue draw attention to the significance of incompatible sexual scripts, rendering it useful to discover how each partner views an ideal sexual encounter for comparison. Challenging cognitions may be accessed by asking about the incidence of nagging or worry thoughts and negative self-talk, strong ideas about the self or others including expectations, and beliefs about sex and relationships. The presence and content of aversive imagery or thoughts related to sex may also be examined.

Sex-Related Emotion. Several emotional states are implicated in sexual difficulties. These include anxiety, depression, anger, guilt, worthlessness, shame, and love. Clients may be asked whether any noticeable feelings arise in the contemplation of or participation in sexual activity and how they manage them if they do. Common anxieties include fears of losing control, pregnancy, becoming too close emotionally, and adequacy of performance (Letourneau & O'Donohue, 1993). An additional issue is whether there is subjective distress under sexual demand conditions.

Views of Cause and Solution. The client's view of what has caused the sexual dysfunction and the helpfulness of potential solutions are useful. Many clients present to their primary care physician for treatment of sexual concerns and often are surprised to be referred to a mental health professional. It is necessary to ascertain whether the client views the problem as entirely physiological in nature and whether he or she is amenable to psychological intervention. According to LoPiccolo (2004), men tend to seek a physical cause and a medical solution to sexual dysfunction.

Cultural Considerations. Sexual dysfunctions appear cross-culturally, with somewhat different prevalence rates in the few cross-cultural epidemiological studies that have been conducted (Hwang, 1999; Kadri, Mchichi Alami, & Mchakra Tahiri, 2002; Laumann, Paik, & Rosen, 1999). Cultural attributes that may influence these problems include culture-specific views of sexuality and sexual practices, prohibitions against sexual thoughts or activities, prescriptions for preferred sexual practices, views regarding men's and women's roles and how they should interact,

and perspectives on sexual pleasure and procreation. It is up to the interviewer to assess cultural norms and how they may or may not affect the client's sexual functioning.

Concerns About Sex Therapy. Many clients who are assessed for sexual dysfunction harbor concerns about the potential recommendation of sex therapy (LoPiccolo, 2004). Asking about these fears permits the interviewer to dispel myths about common sexual therapies, particularly the concern that the therapist will engage in sexual activities with the client. Is the client motivated for and willing to comply with treatment, including completing homework?

Expectations for Change or Outcome. Expectations that the sexual dysfunction will be alleviated have been linked to better outcomes (Hawton & Catalan, 1986). Therefore, it is important to ask what the client expects from the interview and any interventions that may follow. This is a good opportunity for the interviewer to detect hopelessness in the client and to instill hope for change based on the latest research findings. LoPiccolo (2004) stresses the importance of a man seeing the benefit of therapy to himself and not simply to his partner in the case of premature ejaculation.

Accuracy of Sexual Knowledge. Sexual myths abound, and clients are as susceptible to them as anyone else. Based on the problem description, it is possible to determine the accuracy of the client's sexual knowledge in relevant areas. Questions such as the following may be helpful. "Do you think your experience is a common one?" "What do you think leads to your desired outcome?" "What has interfered with your desired outcome?" "How does the sexual response cycle generally progress? Is it always the same?" "Are there any beliefs about what should be stimulating or the kinds of fantasies one should have?" A woman who has never experienced an orgasm may not be aware that most women are not able to achieve orgasm from vaginal stimulation alone (Masters & Johnson, 1970). She may believe that there is something wrong with her body or mind, when in fact she may need greater skillfulness and breadth of stimulation to orgasm.

Body Self-Knowledge. These queries have to do with the client's understanding of his or her sexual functioning. Is he or she aware of natural sexual rhythms, such as being organically more interested in sexual activity during the few days of the month a female partner may be able to conceive a child? Does the client know how his or her body works? Does he or she know the type of stimulation or sexual activity that is interesting and linked with preferred sexual outcomes? Is there awareness of how to intensify or cool the sexual activity in order to increase one's or one's partner's sexual satisfaction?

Quality of Attention and Awareness. Is the client easily distracted from the sexual thought or experience occurring in the moment? Is it possible for the client to disconnect from disengaging thoughts and reconnect with sexual experience in the moment? Is the client willing to practice calming the mind and focusing solely on sex when time is set aside for it?

Prominent Sexual Memories. Asking the client about pervasive sexual memories, both positive and negative, can be revealing. Clients may idealize past sexual experiences or partners, they may have intrusive memories about bad sexual experiences, or they may experience guilt when reminded of a former sexual partner in a new sexual encounter. It may be useful to discuss the client's most vivid sexual memories relative to his or her current sexual functioning.

Interviewing Obstacles and Solutions

A number of obstacles arise during interviews in cases of sexual dysfunction. Perhaps the most important of these is discussing sexual beliefs and practices, particularly those that are unconventional. Several ideas for paving the way for sexual candor were offered earlier. The most important qualities of the interviewer bear repeating: professionalism, caring, and the unflappability that comes with experience and good training. Exhortations in praise of the value of honesty to positive outcome are also indispensable. A related obstacle is lack of access to the sexual partner or partners. The client may not want to have the partner involved. If the partnership is long term, it may be useful to appeal to outcome once again. A more accurate assessment presumably will lead to more appropriate intervention and a better resolution. Another impediment that may arise in these interview situations is the judgment or

values of the clinician bleeding into the interview. Clinicians are members of cultural groups and the larger society, just as clients are. They have their own beliefs about sexuality and sexual values. It is crucial that these beliefs not be allowed to emerge and affect clients. For many clients the difficulty in accessing treatment for a sexual dysfunction is the fear of being evaluated. Clinicians must maintain the neutral stance in order to be effective. A useful exercise in this regard is exploring one's sexual attitudes, beliefs, and norms using the aforementioned questions. Holding those values with awareness and recognizing the effect of significant departures from those norms are good preparation for noticing when value differences arise in interviewing situations and taking care not to impose one's values on the client.

Interviewers need to keep in mind that the lack of objective behavioral criteria for many of the sexual dysfunctions is problematic and may lead to misdiagnosis, overdiagnosis, and possible stigmatization if one does not conduct a thorough and cautious interview. Nearly all of the sexual dysfunctions depend on the clinician's judgment relative to the client's self-reported private behavior. In some cases the clinician is asked to judge whether a person's "orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives" (APA, 2000, p. 549). Other than age, which may not be an adequate marker of sexual drive depending on health status, these are highly subjective phenomena that a clinician may find it difficult to assess adequately. A proposed solution to this dilemma is to use the client and several of his or her closest friends and family members who are demographically similar as a reference group for sexual experience and the judgment of adequacy of sexual stimulation.

A related issue is what appears to be a tremendous amount of variability in individual sexual desire, fantasy, arousal, orgasm, and the associated satisfaction. Sexual desire easily fluctuates from several times a year to several times a day between individuals, and may even change significantly within the same person across a life span. It is paramount that the interviewer keep in mind this diversity when working with a particular client rather than comparing him or her with some perceived standard. What really seems to matter is the disparity between the client's sexual ideal and his or her reality and how the two may be brought a bit closer together through as accurate information and behavior alteration as is available.

Last but not least, it should be acknowledged that little attention has been paid to sexual dysfunction in women (Bancroft, Loftus, & Long, 2003; Basson et al., 2001), so many of them may never have an opportunity to be assessed or treated. A reasonable solution may be to bring information about female sexual dysfunction and its treatment into the public eye, a task for which interviewers may be well suited.

Case Illustration

Marie is a married White female homemaker with two children, ages 3 and 6, who has presented for an assessment of sexual dysfunction on the recommendation of her psychologist. She received mental health treatment for approximately 1 year secondary to the reemergence of latent symptoms of posttraumatic stress disorder cued by the release of her rapist after a 10-year prison term. Marie expresses some hesitation discussing her sexual functioning with a stranger but states that she is willing to do it in order to make some positive changes in her marriage. She explains that she and her husband attempt to have intercourse approximately twice per month but only sometimes complete the act because it is too painful for Marie.

The clinician first focuses on building rapport with Marie, using the guidelines described earlier. The interviewer's aim is to help Marie feel comfortable disclosing all of the relevant information about her problem. Relevant demographic information is gathered. Marie and her husband do not have any strong cultural affiliations. Marie's husband is 2 years older than she is and works as a postal supervisor. He is unwilling to participate in the assessment because he views the problem as Marie's. The family is financially stable, and Marie is dependent on her husband economically. Marie describes the problem as excruciating vaginal pain (rated 8.5 on a scale with 10 as the most severe pain she has ever felt) that arises when she and her husband attempt sexual intercourse about twice monthly. She states that she braces herself against the pain so that her husband can experience an orgasm. The pain lasts as long as there is genital contact. No vaginal spasms were felt. She reports that she has never experienced an orgasm with her husband. She

reports desire for sexual contact with her husband about once per week, which she never pursues. That desire usually is related to positive feelings about their relationship and is never accompanied by physiological arousal. Marie's husband initiates all of their sexual activities.

Marie reports she has experienced sexual intercourse without pain and with orgasm in the past, including after her rape and recovery. She currently experiences sexual arousal and orgasm with self-stimulation that requires approximately 1 hour of very soft and slow stimulation of her clitoris and no vaginal stimulation. She feels embarrassed about masturbating and judges that she is cheating her husband by having orgasms without him.

Marie's general medical history is unremarkable. She does not take any medications and is fit and in excellent health. She had chlamydia when she was 17 years old and two pregnancies as an adult. Marie was recently seen by a gynecologist for sexual pain. She has scar tissue inside her vagina, the result of a violent rape. Marie experienced mild vaginal pain during the examination. Her doctor confirmed the presence of areas of the vagina that were highly sensitive and others that were highly desensitized.

Marie was sexually active with boys in high school. She reports she did not particularly enjoy sexual intercourse, although it was not painful. She began experimenting sexually with a girlfriend. She had her first experiences of desire, arousal, and orgasm through this experience. After a 1-year relationship, she was cut vaginally during a violent rape at a party. She became a recluse, moving away from the area and changing her name out of fear after she testified against the perpetrator. She ceased all sexual activity until she met and married her husband several years later. She reports loving and trusting him immensely and finding her relationship extremely satisfying; however, they never had a satisfactory sexual relationship for him or for her. She states that sex with her husband has always been painful. They have never engaged in the extended foreplay or exclusive clitoral stimulation that makes orgasm possible for her. She thinks he would not be interested in that kind of sexual encounter, based on his resistance to such activities in the past, and she is afraid to initiate touching because it will lead to intercourse. She has found her husband supportive of her despite his frustration with their sexual relationship. She reports that he subdues his sexual desires most of the time because he knows sex is painful for her.

Marie cheated on her husband early in their marriage because of her strong desire for and arousal to another man. She was able to have an orgasm with him during extended lovemaking sessions, and intercourse was not painful. She reports that she has been afraid to discuss other ways of having sex with her husband because he was so generous as to take her back after the affair, and she would not like to remind him of it. Marie reports equal sexual interest in men and women but states she is pleased to be in her current relationship. She is satisfied with all other aspects of her life and their relationship. Marie is not under significant stress. She and her husband like their home and bedroom environment, and they have time together alone for sex after the children go to bed. Marie has accurate sexual knowledge. However, she views herself as deficient for being unable to climax without extensive gentle stimulation and views her husband's quick move to intercourse as "the right way." She is somewhat ashamed of her same-sex partnership in the past and thinks she may have contributed to her sexual problems by participating in that kind of sexual experimentation. She sees the psychological and physiological effects of the rape as causal as well as her affair, which she views as making the subject of her sexuality taboo. She also entertains the idea that she is "just not a sexual person." She is afraid if she does not fix the problem she may pursue another affair, or her husband will leave her. She presents no ideas about potential solutions, however, she emphatically states that her husband will not participate in sex therapy. She states that she has a strong faith in psychological interventions, is hopeful for change, and is willing to participate fully in the recommended interventions. She reports an acute awareness of sexual desire, arousal, and pain. Her attention does not waver. She knows how to pleasure herself sexually. Prominent sexual memories include the negative flashbacks to the rape, which occur rarely, and positive recalls of sex with her girlfriend and male lover.

Marie was diagnosed with dyspareunia. Primary targets of treatment were altering sex-related cognitions, bringing the husband into treatment to participate in talk therapy around sexual communication, and sexual skill lessons, including sensate focus and directed masturbation exercises.

Multicultural and Diversity Issues

Culturally competent assessment practice is mandated by the 2002 APA Ethical Code. The *DSM* admonishes its users to take into account cultural backgrounds that may influence sexual desire, expectations, and attitudes about sexual performance (APA, 2000). The sexual dysfunction literature is replete with warnings that many cultures view male and female sexuality differently, typically diminishing the importance of female desire, arousal, and orgasm and sanctifying those experiences for the male. These perspectives are presumed to affect sexual functioning. Religious prohibitions against sexuality outside approved relationships that typically involve joint child rearing are also noted as affecting sexual functioning. However, no studies were found linking particular cultural views of sexuality or practices and sexual dysfunction.

Appendix I of the *DSM-TR* (APA, 2000) provides useful recommendations for making a cultural formulation to complement other diagnostic considerations. The goal is to ascertain features of the client's culture that are relevant to the problem and its treatment. A narrative summary that addresses the following points is recommended.

- *Cultural identity of the individual.* Important cultural reference groups should be identified and acknowledged along with the level of acculturation into the major culture and language abilities, use, and preference.
- *Cultural explanations of the problem.* The meaning and perceived severity of the problem in the client's primary culture should be noted.
- *Cultural factors related to psychosocial environment and levels of functioning.* This includes both protective factors and stressors.
- *Cultural elements of the relationship between the client and the clinician.* Differences in culture should be acknowledged along with potential pitfalls such as establishing rapport, developing an egalitarian trusting relationship, and understanding the cultural meaning and significance of particular thoughts, feelings, and behaviors.
- *Overall cultural assessment for diagnosis and care.* The predicted influence of cultural variables on diagnosis, treatment planning, and intervention may be offered.

Culture matching, though often desired by clients, is often impossible. There is no contraindication to culturally diverse interview dyads in which the clinician is culturally sensitive and competent. Language differences may be overcome with the use of a professional translator. Children and family members of the client are not appropriate translators.

Differential Diagnosis

Comorbidity of the sexual dysfunctions and of sexual dysfunctions with other psychiatric disorders is high (Basson et al., 2001). A diagnostic study of 900 clients by Segraves and Segraves (1991) found that of 113 men with a sexual desire disorder, 47% had a secondary diagnosis of erectile dysfunction. For the 475 women with a sexual desire disorder, 41% also endorsed either an arousal or orgasm dysfunction, and 18% acknowledged both. The diagnostic task is to identify the problem as one involving sexual fantasy or desire, aversion to genital contact, lack of physiological arousal, delay or absence of orgasm, genital pain with or without vaginal spasms, or some combination, in which case multiple diagnoses are given. It is also imperative to determine whether the sexual problem is secondary to a medical condition such as multiple sclerosis, diabetes, abdominal surgery, bladder or bowel problems, or the effects of substances including antidepressants, over-the-counter medications, and recreational alcohol and drug use (Heiman, 2002).

Selection of Treatment Targets and Referral

All of the data gathered through the methods described earlier are useful only if they inform a comprehensive treatment plan with jointly identified targets. Those targets should be the distal and proximal causal and maintaining factors for the thoughts, feelings, and behaviors of interest. These will be somewhat unique to each client and problem and are based on an analysis of the function of a particular symptom, its antecedents, and maintaining consequences. Common targets include altering the environment (e.g., making dates for sex), improving sexual and emotional

communication, increasing sexual skill, attending relationship therapy, altering cognitions, treating mood disorders, altering contraception practices, and many others. Assessments of sexual dysfunction should routinely include coordination with the client's primary physician, given that the origins of many sexual dysfunctions are partly or entirely physiological. Referral to a psychiatrist may be warranted in the case of a primary or secondary co-occurring psychiatric disorder.

Description of Sexual Deviance Problems

Paraphilia is the formal term used to indicate a problem of sexual deviance. The implication of the word is that it has to do with aberrant love; however, it really has to do with sex, a different matter altogether. The *DSM-IV-TR* section on sexual deviance delineates a broad general category of recurrent, intense sexually arousing sexual fantasies, urges, and behaviors lasting at least 6 months that involve nonhuman objects, the suffering or humiliation of oneself or one's sexual partner, or nonconsenting people (Criterion A; APA, 2000). These thoughts, feelings, and behaviors range from those that garner attention only when they cause evident distress or a loss of social functioning in the afflicted person to those that may be unwanted or harmful to the object of the sexual behavior. The presumed nonnormative object of sexual desire is necessary for sexual arousal in some cases and in others may be featured in the sexual behavior. This often occurs during times of stress. There is little research on the paraphilias other than pedophilia, so the following information is necessarily limited. These issues are rarely diagnosed in general medical settings (APA, 2000). One must keep in mind that many people, if not most (true prevalence is unknown), eschew traditional avenues of treatment for the paraphilias. These behaviors often are unaccompanied by distress, and speaking about one's actual sexual behavior with a stranger remains taboo.

Nine major or more common paraphilias receive special categorization in the *DSM-TR*. A diagnosis of frotteurism, exhibitionism, pedophilia, or voyeurism is made if the person has acted on the sexual thoughts or they have caused significant distress or interpersonal difficulty. The diagnosis of sexual sadism is made only if the person has acted on sadistic sexual urges with a *nonconsenting* person or the urges have caused significant distress or interpersonal difficulty. For fetishism, transvestic fetishism, sexual masochism, and paraphilia NOS, the diagnosis is given if the sexual thoughts or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The form of the behavior determines the exact diagnosis as follows:

Exhibitionism is exposing the genitals to an unsuspecting person.

Fetishism is using nonliving objects to achieve sexual gratification.

Frotteurism is touching and rubbing against a nonconsenting person.

Pedophilia is sexual activity with a prepubescent child or children (generally age 13 or younger). The person must be at least 16 years old and 5 years older than the child or children involved. Pedophilic subtypes have been proposed consisting of people who are attracted to males exclusively, females, both genders, and those limited to incestuous interests. They are further identified as exclusive or nonexclusive in their sexual interests.

Sexual masochism is receiving sexual pleasure from humiliation or suffering.

Sexual sadism is receiving sexual pleasure from inflicting humiliation or suffering.

Transvestic fetishism is receiving sexual pleasure from cross-dressing. One specifies whether gender dysphoria is a feature of this paraphilia.

Voyeurism is observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

Paraphilia NOS is a nonspecific diagnosis for sexual behavior that may be considered aberrant but does not fall into one of the other more common categories. Telephone scatologia, receiving sexual pleasure from making obscene telephone calls to unsuspecting strangers, is one example.

The *DSM-TR* does not devote a specific category of disorder to those who sexually assault adults. These behaviors sometimes are diagnosed with paraphilia NOS or sexual sadism depending on the details and overall pattern of behavior.

Significant distress is not a necessary condition for the paraphilia diagnosis. For some paraphiliacs, it is the reaction of others and the ensuing social difficulties that are of concern rather than the behaviors in themselves. For some, significant distress, particularly depression, guilt, or shame, is associated with paraphilic thoughts and behavior. Many paraphiliacs are unable to connect with other people sexually because of their focus on the object of arousal. They are cut out of that part of human experience. It is often the sexual inflexibility of the paraphiliac that is remarkable. Whereas it is common for people to be interested in novel sexual experiences, paraphiliacs pursue novelty within a restricted range, around the nonnormative object.

Interviewing Strategies

This section concentrates on assessment, diagnosis, and treatment planning for problems of sexual self-control. It is worth noting that clinical interviewing is also an integral part of risk assessment in forensic settings; however, a much more highly structured, semi-actuarial or fully actuarial approach is recommended to inform estimations of risk (Hanson, Morton, & Harris, 2003).

First we offer a selection of general strategies for successful interviewing with people with sexual deviance problems. Fifteen troves of pertinent information are then offered. It is possible that clinical interviewing that accesses accurate and relevant information efficiently is more difficult for issues of sexual deviance than for many other behavioral and psychological disorders. The difficulties discussed earlier in the chapter in discussing one's sexual ideas and practices are magnified by two additional sources of difficulty. First, it is not normative sexual interests that are the focus of these interviews. Clients are well aware that it is their abnormal sexual practices that are of interest. Thus, they are being asked to speak about private behaviors that are often abhorred or ridiculed by others. Moreover, many of the behaviors of interest are unlawful, and interviewers tend to be mandatory reporters of sexual crimes. People with sexually deviant behaviors who are also sexual offenders therefore present with additional motivation to maintain their silence. Once again, building rapport and establishing reasons for the interview that are useful to the client are paramount.

Several useful strategies may aid in building rapport quickly. The first is taking a down-to-earth, egalitarian stance with the client while conferring respect for the person, if not for the behaviors of interest. Interviewers should covey professionalism but not act superior to the client. People with sexual problems are accustomed to being devalued. An offer of respect and a sense of humanity can be unexpected and welcomed, opening the door for a positive interview. A related point is the importance of transmitting experience and comfort with sexually explicit discussions (Hunter & Mathews, 1997; Thornton & Mann, 1997). Many clients expect people to be uncomfortable with their sexual behavior and to judge it, and sometimes the client for it. It is important for the interviewer to overcome these preconceived ideas.

Rapport is also improved by predicting how the interview may be useful to the client. In forensic settings, it may be difficult for the client to ascertain any possible benefit to speaking candidly with an interviewer. In all cases it is useful to spark the client's motivation to respond with candor, emphasizing personally valued outcomes (Ward, McCormack, Hudson, & Polaschek, 1997). In interviews in which the benefit to the client is not an immediately obvious one, such as learning to manage a fetish, appealing to the client's need for disclosure and for relief may be effective. Clients with sexual deviance tend to feel burdened by their sexuality. Unburdening through self-disclosure often is an appealing proposition (Ward et al., 1997). Of course, this is successfully accomplished hand in hand with fully informed consent. Making clients aware that they may choose what to report and explaining the limits of confidentiality may encourage a sense that the client is in control of the boundaries of information. Wincze (2000) suggests that in order to introduce the least amount of error into the results, the assessor should begin with an assumption that the client will try to conceal important information.

Interviewers should be aware of the purpose of the interview, whether diagnostic, treatment oriented, or forensic in nature, and tell the client up front. In all cases involving sexually deviant behavior it is important to access collateral information, preferably before the interview with the client, in order to be able to address the minimization and denial of aspects of the behavior during the encounter (Ward et al., 1997).

Collateral information may include contacts with family members, arrest reports, victim statements, prior evaluations, and medical records to start (Krueger & Kaplan, 1997). The interview environment should be private and free of distractions. This may be difficult in a forensic setting but should be pursued nonetheless for better outcomes.

The following classes of information are ordered from those that would be expected to be the most useful to those that may be less relevant given the specific characteristics of the problem. They have been suggested by a number of researchers and clinicians in the field, including Abel (1989), Adshead (1997), and Ward et al. (1997), and by the available treatments for sexual deviance. Factors commonly correlated with sexual deviance and presumed to be causal include social skill deficits, deviant sexual arousal, distorted thinking, poor cognitive and emotional coping strategies, substance abuse, personality disorders, deviant sexual fantasy, a history of sexual victimization, young adulthood, sexual interest in children, a general criminal history, stranger, male or related victims if sexually abusive, sexual diversity, being single, and a history of dropping out of treatment (Hall, Andersen, et al., 2000; Hanson et al., 2003). Rapport is skillfully built with some subtlety by discussing nonsexual and noncriminal matters first and then moving into discussing criminal and sexual histories.

- *Demographics.* Sexual interests are affected by factors reflected in demographic information. Most relevant are age, gender, marital status, sexual orientation (including solely pedophilic interests), ethnicity, and income. Number of children and custody status may be useful as well.

- *Medical history, medications, and sexual health.* The first bit of essential medical information is the date of the last checkup and whether the sexual problem was addressed. The medical history should take into account all developmental abnormalities and insult, injury, and disease. Any history of head trauma should be addressed (McCormick, 2005). Also of interest are the client's medications because there are many with sexual side effects. One of our clients, an adolescent female with symptoms of a major depressive episode, was prescribed sertraline, which initiated manic symptoms including exhibitionism in the client. The behavior abated when the medication was discontinued. The frustration of impotence has been cited by clients as a reason for rape with an object, although no formal studies of this phenomenon were found. Any sexual health problems must be identified, including any history of sexually transmitted disease, sexual injuries including hypoxia, and any problems necessitating a medical procedure involving the sexual organs.

- *Mental health history.* Of interest are prior diagnoses of Axis I or II mental disorders. Cooccurring disorders include the affective disorders and personality disorders, particularly antisocial personality disorder (Ertz, 1997; Hanson et al., 2003; Serin & Mailloux, 2003) and statistically uncommon but important psychopathy (Cale & Lillienfeld, 2004), in people with criminal sexual misconduct. Questions should also address any cognitive abnormalities, affective difficulties, especially emotional numbing (Ertz, 1997), current or past suicidality (Strosahl, 2004), dangerousness, and impulse control (Hucker, 2004).

- *Developmental history.* Early exposure to nonnormative behaviors is of interest, whether they are criminal or sexual in nature (Ward, McCormack, Hudson, & Polaschek, 1997). This includes exposure to pornography and violence. School conduct may also be explored.

- *Sexual history.* Interviewing around sexual history benefits from a developmental slant. One is interested in the client's earliest sexual experiences and objects of sexual desire, fantasy, and arousal and the significant experiences that follow through the life span. Initial and subsequent masturbation practices should be discussed, including frequency and associated fantasy. Both deviant and nondeviant sexual desires, fantasies, and experiences should be discussed, as should any history of being sexually abused (Barbaree & Seto, 1997). Experiences of sexual dysfunction are also relevant. If the client's sexual activities have involved another person, determine whether the sex was impersonal (Thornton & Mann, 1997) or more meaningful to the client.

- *Sexual urges, fantasies, and arousal.* The last category explored the client's actual sexual behavior. This one is concerned with a full exploration of the client's recent sexual desires, fantasies, and sources of physiological arousal. Once again the focus is on both deviant and nondeviant material. Queries should address

descriptors of the objects of sexuality; characteristics of willing or unwilling partners, including gender, age, physical characteristics, and stranger status; and the importance of novelty to the mental or physical experience. Of special interest are preferred sexual scenarios. It is imperative to find out whether the client experiences any arousal to nondeviant interests and, if so, how it compares with arousal to his or her deviant interests.

- *Problem behavior.* In this section the deviant behavior is explored in greater depth, as recommended by Krueger and Kaplan (1997). Antecedents to the behavior and its consequences are discussed, along with its perceived impact on the client and others. The client's understanding of the problem is cued, as is whether he or she views it as problematic (Hunter & Mathews, 1997). Clients are asked how performing the behavior makes them feel during the fantasy stage, during the behavior, and afterward. The frequency of the behavior is addressed here, along with an estimate of its situational severity, if that varies. If the sexually deviant behavior is also a sexual offense, additional questions must be addressed. Ward and his colleagues (1997) and Serin and Mailloux (2003) offer suggestions for accessing relevant details about the behavior. It is important to know whether physical or psychological force was involved. How many instances of the offending behavior have there been? Was physical or psychological force used (Johnson, 1997)? Who are the victims, and what are their characteristics? Where does the offending typically occur? Does it include planning and grooming the victim to go along with the sexual misbehavior? What does the behavior achieve for the client? What is its function? Is the behavior impulsive or planned? Does the client take full responsibility for the behavior or deny, minimize, or blame the victim? If there is denial, is it of awareness, facts, impact, or responsibility (Palmer, 1997)? What is the client's relationship to his or her victim? Finally, what is the relative importance of or preference for nonconsenting sexual partners (Hanson & Harris, 1997)?

- *Sexual attitudes and beliefs.* This category attempts to draw out the client's strongly held sexual ideas. Questions that may be useful here include the following: "From your perspective, who is permitted to have sex (e.g., ages, genders, orientations)?" "Who should not be having sex?" "What kinds of sexual activities are allowable?" "Which activities are unwise or not permissible?" "How do you think most people view sexual relationships?" "Are there any differences between how you approach sex and how other people do? If so, do those discrepancies concern you at all?" It is important to access sexual offense supportive attitudes and beliefs in alleged or known offenders. Examples include viewing children as sexual beings and characterizing people who do not want to be exposed to exhibitionism as frigid. Cognitive distortions may be readily identified in this interview segment because they are often the byproducts of strongly held beliefs and are mental permission to offend. These include rationalization, minimization, justification, and all-or-none thinking. See Sbraga and O'Donohue (2004) for a more comprehensive discussion of sexuality-related cognitive distortions and their treatment.

- *Sexual knowledge accuracy.* The lack of accurate sexual knowledge has been implicated in the maintenance of deviant sexual behavior (Barbaree & Seto, 1997; Hunter & Mathews, 1997). For example, some exhibitionists view their behavior as an aphrodisiac for their victims. They imagine the victim accepting them once they have exposed themselves. They do not understand that being flashed by a stranger is unexpected and often frightening for victims. It is consequently important to assess the accuracy of the client's basic sexual knowledge and information about the paraphilia in question.

- *Criminogenic needs.* One of the best predictors of additional sexual offending behavior is a history of general criminal behavior (Hanson & Bussiere, 1998). This type of behavior has been conceptualized recently as serving the function of meeting a set of perceived needs for the offender (Andrews & Bonta, 1994). Chief among these needs are employment, relationships, emotional fulfillment, escape or avoidance, and belonging in a community (Serin & Mailloux, 2003). Indicators of criminogenic need consist of items such as criminal history, incarcerations, substance abuse, criminal attitudes, criminal associations, and a "predator/prey life view," as described by Ertz (1997, p. 14–4). It is important for the interviewer to discover not only the incidence of the aforementioned needs but also their function for the client.

- *Skill deficits.* A number of social skill deficits have been associated with paraphilic behavior (Langstrom & Grann, 2000; Nezu, Nezu, Dudek, Peacock, & Stoll, 2005; Ward, Hudson, Marshall, & Siegart, 1995). These consist of difficulties in conducting normative social relationships and include intimacy, problem solving, communication, assertiveness, and emotion regulation problems. Questions that may reveal some of these deficits include the following: "Is it hard for you to get close to other people?" "Do you find yourself in conflict with others more than you would like?" "Does it seem like other people take advantage of you?" "Is it difficult for you to handle some feelings like anger, anxiety, or depression?"

- *Treatment history and expectations.* Knowing the client's treatment history may provide pertinent information about the client's sexual functioning, how his or her problems were conceptualized, whether the treatment was at all successful and why or why not, how the client viewed that treatment and treatment in general, and ideas about new treatment recommendations. Some clients have unrealistic expectations for treatment (e.g., never having another fantasy about the deviant behavior), and this is the opportunity to preview realistic outcomes for the client and plant some seeds of hope for change if warranted.

- *Cultural concerns.* Cultural attributes theorized to influence these problems include culture-specific views of sexuality and sexual practices, prohibitions against sexual thoughts or activities, prescriptions for socially sanctioned sexual practices, views about men's and women's roles and how they should interact, and perspectives on sexual pleasure and procreation. It is up to the interviewer to assess cultural norms and how they may or may not affect the client's sexual functioning. A useful question in this regard is, "Are there any family or group beliefs that seem to affect your sexual behavior or the way you see sex or relationships between men and women?"

- *Strengths and lifestyle balance.* In preparing to make treatment recommendations, it is essential to understand the client's strengths and the healthful, positive aspects of life (whether present or ideal) that motivate her or him. Strengths may be found in many different aspects of the client's life, including cognitive or emotional abilities, physical health, good social supports, financial or career stability, commitment to children, and many others. Keeping in mind that for many people with detected sexual deviance problems sex has taken on a variety of functions edging out more prosocial activities and connections, it is important to identify vehicles for restoring balance in the lifestyle. In the most current nomenclature in the field of sexual offending, the goal is to create "good lives" (Ward & Stewart, 2003). This embraces the development of a healthy sex life, as a key aspect of a fulfilling and balanced existence.

Interviewing Obstacles and Solutions

The significance of building strong rapport quickly has been discussed several times in this chapter. There is nothing more important in interviewing about sexual behavior than overcoming the client's natural inclination to avoid the guilt, shame, and embarrassment that often accompany it. The accuracy this supports is presumed to have substantial weight in making a correct diagnosis that informs a useful and individually relevant treatment plan. That being said, the second most important obstacle is the lack of strong empirical research on the sexual deviance disorders. Most paraphilia treatment articles are either case studies or studies that included a small number of self-selected participants, leaving clinicians without a solid treatment foundation. It is difficult to inspire much confidence in a course of treatment that is essentially experimental. The only solutions to this problem are ethically explaining the experimental nature of the treatments, working from a solid theoretical foundation, ideally while collecting data on the interventions, and expanding the paraphilia research base.

Another interviewing obstacle is some clinicians' unwillingness or inability to maintain a respectful stance toward the client, separating the client as a person of worth from the behavior, which the interviewer may find distasteful or even horrifying. In this regard we recommend that clinicians practice these types of interviews repeatedly under intensive supervision during their graduate training, eliciting feedback about disrespectful nonverbal or verbal behaviors.

A helpful way of approaching these cases for some is to view the client as a product of his or her environment. Had the early environment been different, the client's behavior may have been different. Thus, it is the behavior that is deficient, not the client. If the deviant behavior is unlawful and involved victims, a related issue is maintaining that neutral stance and rapport while not colluding with the offender against the victim. It can be challenging to disagree with the client and do it agreeably. This may be achieved by withholding outright judgments of the behavior without offering any reinforcement for the client's behavior or his or her justifications for it.

The last major obstacle is managing discomfort. This regularly arises in two forms in these types of interviews: discomfort created by the clinician and that created by the client. Interviewers often feel uncomfortable when they challenge offenders' accounts of the problem behavior with collateral information and when they provide clients with feedback they do not want to hear (e.g., diagnosis of a paraphilia). Useful methods for being effective with these sensations include practicing often and exposing oneself to the unease repeatedly, being well prepared for sessions, having great familiarity with the details in the collateral information, not taking the offender's affect personally, and considering the greater good of getting the story straight—for the client and, perhaps, the community. The second category of discomfort is that produced by clients intentionally trying to test or titillate the clinician. This appears common, particularly if the clinician appears in any way inexperienced. Once again, it is the poise that comes with practice and experience that saves the day. A final, related issue is achieving privacy for confidentiality in the forensic setting while maintaining safety with clients with sexually abusive or violent pasts. Safety should always come first. Interviewers should work with security personnel in forensic settings to establish precedents for safe and private interviewing environments.

Case Illustration

Ray is a 20-year-old single White man who was referred by his probation officer for an assessment of his sexual behavior to determine his need for treatment. Ray is on probation for possession of marijuana and breaking into a vacant home to host a party there. He lives with his mother and 16-year-old sister, both of whom have reported missing undergarments. These items have been discovered in Ray's bedroom. Ray's mother has expressed concern to his probation officer that Ray may be a potential sexual offender, given his history of criminal offenses and the missing underwear. Ray is healthy and reports no history of disease or serious injury. He was prescribed alprazolam in jail to alleviate symptoms of anxiety, which he takes on an as-needed basis approximately six times per week. He also takes methylphenidate in the morning to alleviate hyperactivity. At age 5 Ray was diagnosed with attention-deficit/hyperactivity disorder, combined type. He reports that if he does not take medication he sleeps approximately 3 hours per night and cannot sit still for longer than a couple of minutes during the day. He finds it difficult to concentrate, even with the medication. He was not diagnosed with conduct disorder as a child and does not meet criteria for antisocial personality disorder. Ray drinks alcohol socially, which he describes as "about four drinks on a weekend night." He used marijuana three or four times per week before his recent arrest. He denies any subsequent use and use of any other substances. He said he was intoxicated on cannabis when he committed breaking and entering.

Ray's sexual history began with an instance of abuse. He was touched on the genitals by an adult male neighbor when he was 7. The man was arrested but never incarcerated and continued to live near the boy and to threaten him verbally throughout his childhood. His consensual sexual activities began when he was 16 with girls his age and older. He reports his enjoyment of traditional foreplay activities and sexual intercourse. He stated he has had approximately seven sexual partners, practiced safe sex with all of them, and is currently not having sex with anyone. He stated that some of his sexual relationships have been meaningful to him and that he has been in love with two of these girls but that sometimes the relationship was purely sexual. He emphasized that he was respectful of his partners and clear about his intentions. He has never had a homosexual or pedophilic encounter or any sexual dysfunction. He reports that he masturbates about once daily. He states that his interest in women's underwear began "by accident," when he was folding the family's clothes and admired them. He said he rubbed them in his

hands, which made him feel aroused and have thoughts about having sex with one of his ex-girlfriends. He decided to keep them in order to be able to bring up the arousal at will for masturbation purposes. His curiosity extended gradually over several months to additional underwear. He stated he found the arousal strengthened when he introduced a new pair to his practice. In response to the interviewer's question about wearing the garments, he stated he did not put them on but preferred to hold them in his hand while masturbating. He stated with disgust that he has never had any sexual fantasies about his mother or sister. He acknowledged regular fantasies about sexual intercourse with an ex-partner. He stated that his arousal is greater with a "real person" but that he is unable to arrange regular sexual activities while living with his mother. He reported a fantasy of spanking a partner and being spanked if his partner was interested in trying it. He stated that he would not want to inflict pain but would like to feel a different kind of sensation during sex. He has never tried this with a partner. He estimates he has taken about 15 pairs of underwear over the past 3 months, about one a week. He said he feels excited when he takes the clothing and embarrassed when his mother confronts him about it. He said he is afraid there is something wrong with him sexually. He feels angry that he would be viewed as a potential abuser because he would never harm anyone sexually. He views his behavior as unusual but not harmful to him or to anyone else. He thinks his mother and sister are overreacting, because they have many pairs of underwear. Ray is unemployed because of his recent incarceration, but he is a skilled mechanic with a promised job when he is no longer on probation. He reports a close, caring relationship with his mother and several friends who know him well. He admits that he handles anxiety poorly and that his marijuana use was to "calm my nerves." He noted his friends do not have criminal histories and that he is opposed to harming anyone. He reported his crime as impulsive and "stupid." This was his first offense.

Ray appears socially skilled in every domain. He has never been treated for a sexual issue. He states he would like to understand his sexual behavior and to know his options for dealing with it. He would like to put his family at ease. He has no cultural concerns around sex. Ray's strengths are his adequate cognitive ability, his social support network, his social skill, his trade and the financial support of his mother, his physical health, and his sensitivity to others. Ray has many diverse interests that fill his time, including working on cars, fixing and selling antiques, expanding his music collection, and spending time with friends.

Ray was diagnosed with attention-deficit/hyperactivity disorder, combined, generalized anxiety disorder, substance abuse in remission, and fetishism. Treatment plans include cognitive-behavioral treatment for improved impulse control and anxiety management, contingency management relative to criminal behavior, and management of his fetish behavior privately.

Multicultural and Diversity Issues

The sexual deviance literature is sparse with the exception of studies of sexual assault. There is an even greater need for information addressing multicultural issues in sexual deviance. Dominant theories of sexual deviance are embedded in a Western cultural context (Hall, Teten, & Sue, 2003) and primarily in the sexual behaviors of young males. It is these perspectives on normality and abnormality that are brought to bear on sexuality. An awareness that perceptions of appropriate behavior are culturally prescribed is essential because cultural group norms are important determinants of behavior. Dana (1995) identifies four issues that need to be addressed in a culturally competent assessment: cultural history and beliefs, acculturation status and cultural identity, health and illness beliefs, and appropriate language skills.

Behavior evolves through the cultural history and norms of groups of people, and each person belongs to a variety of different cultural groups by birth and often by choice. These groups may be ethnic, religious, gender, age, ideological, racial, or ability based. Although it is clear that cultural norms are influential, it is unclear precisely how they influence sexual behavior. Familiarity with cultural norms, which may entail an understanding of the history that shaped them, is necessary for full comprehension in an assessment. Although knowledge of general history and immigration may be useful in this regard, asking the client is the only way of understanding the specific elements of culture that may be relevant to the problem of interest.

For example, more than 500 American Indian tribal groups and more than 30 groups make up the "Hispanic" designator. Thus, knowing something about American Indians and Hispanics is *not* knowing something about an individual with membership in one of those groups.

Sexual behavior may be guided by the attitudes and beliefs of groups. Misogynistic and patriarchal beliefs have been implicated in sexually deviant behavior (Malamuth, Linz, Heavey, Barnes, & Acker, 1995). It also appears that collectivity versus individualism in groups differentially affects behavior, including sexual behavior (Hall, Sue, et al., 2000). Interpersonal concerns and social reputation are seen as a driving force in collectivist cultures, whereas intrapersonal interests may drive behavior in a more individualistic society. Depending on the sexual values of the culture, a greater concern for others in the group over the individual may be either protective or harmful (Hall & Barongan, 1997). The disapproval of others may be a powerful deterrent to sexually deviant behavior, or it may impede reporting of sexually deviant behaviors in order to maintain order in the group. Asian females my not report sexual assault, for example, because it is seen as less important than the need to maintain group cohesiveness (Dussich, 2001). Ethnic identity, the extent to which one subscribes to membership in a particular ethnic group, is also associated with adherence to particular cultural beliefs. The degree of acculturation to majority group norms is important to understand in determining whether beliefs about sexuality may be more like those of the majority group or may be more unique to a minority group. The stronger the ethnic identity and less assimilation into broader society, the greater the variability in socially acceptable beliefs from the majority. As Dana (1995) suggests, the view and production of sexually deviant behavior as healthy or unhealthy may be seen through different lenses, and as a result, culturally based interpretations of sexual behavior may clash. For example, some cultures view married women as the property of their husbands and view sexual behavior as an obligation of the woman to that relationship. If the wife did not consent to a sexual request by her husband and he had sexual intercourse with her anyway, some cultures would view this as rape, a sexually deviant behavior, whereas others would not see this as problematic. The same behavior may be viewed differently by different cultures. Conversely, there may be culturally distinct expressions of and moderators of psychopathology as well (Mahaffey, 2004). Carrasco and Garza-Louis (1997) provide the example of machismo and macho nonegalitarianism in some Hispanic cultures. Although there is often a value of different but respected roles for men and women in Hispanic cultures, machismo is the abuse of the power differential that accompanies those differences. The beliefs and behaviors of machismo are associated with sexually abusive behavior (Garza-Louis & Peralta, 1993).

Attention to language is essential in culturally competent interviewing. Ideally the client is able to listen and respond in his or her primary language in order to ensure that meaning and accuracy are not lost in translation. That being said, a clinical interview should not be conducted by a clinician who does not share the client's primary language without an interpreter. Family members and friends of the client (especially children) are not appropriate translators. Awareness of nonverbal communication is also important in the interview (Ertz, 1997).

It must be acknowledged that there is no evidence that ethnicity itself creates a risk for sexually coercive behavior, and there are similar rates of sexual abuse cross-culturally (Hall et al., 2003).

Finally, normative sexual differences across ages, genders, sexual orientations, and other cultural divides are not well understood, rendering issues of nonnormative sexuality across these domains even less well comprehended. The probability of paraphilic behavior is greater in young heterosexual males. The reasons for these differences are unknown.

Differential Diagnosis and Behavioral Assessment

There are many healthy varieties in sexual fantasy and expression that should not be confused with paraphilic behavior. Sexual thoughts, feelings, behaviors, and objects are diagnosed only when they produce "clinically significant distress or impairment (e.g., are obligatory, result in sexual dysfunction, require participation of nonconsenting individuals, lead to legal complications, interfere with social relationships" (APA, 2000).

Unexpected sexual behaviors may also accompany disorders including schizophrenia,

bipolar disorder, substance intoxication, mental retardation, dementia, and a personality change caused by a general medical condition (APA, 2000). According to the *DSM,* these secondary sexual deviance problems are distinct from a primary diagnosis in that the symptoms are present only during the course of the other mental disorder, the behaviors do not represent the client's preferred sexual activities, performance of the behaviors is isolated, and the behaviors have a later onset.

Each sexual deviance problem is uniquely focused and distinguished from others on that basis. However, the paraphilias are highly comorbid (Kafka & Prentky, 1994), and it is common for more than one paraphilia to be diagnosed for a single person. Clinicians may be curious about how to distinguish between fetishism, transvestic fetishism, and sexual masochism. In fetishism sexual arousal is associated with the object, and in transvestic fetishism it is wearing the clothing that is arousing. One form of sexual masochism is being forced to wear other-sex clothing. The arousal in this case is associated with that humiliation, not with the wearing or the clothing itself.

Behavioral observation is not conducted in assessment of the paraphilias for privacy reasons. A solid interview that rests on a functional analysis of the client's behavior including its antecedents, behavioral presentation and accompaniments, and consequences is very useful in creating a viable and individualized treatment plan (Sbraga, 2004; Serin & Mailloux, 2003).

Selection of Treatment Targets and Referral

All data gathered through the methods described in this chapter are useful only if they inform a comprehensive treatment plan with jointly identified targets. Those targets should be the distal and proximal causal and maintaining factors for the thoughts, feelings, and behaviors of interest. These will be somewhat unique to each client and problem and are based on an analysis of the function of a particular symptom, its antecedents, and its maintaining consequences. Common targets include managing the environment through the acquisition of new coping skills, such as not going places that cue the behavior. Improving cognitive and emotional skills may be useful, such as altering cognitive distortions, accepting aberrant sexual thoughts, acting in a value-based way, and learning to regulate intense emotion. Sexual arousal to deviant objects may be altered and managed through techniques such as masturbatory and verbal satiation, aversion therapy, and covert sensitization. However, no technique has been reliable in changing arousal from deviant objects to nondeviant objects. Consequently, if a client has an entirely paraphilic arousal, the problem may be exceptionally difficult to treat because of the prospect of having no satisfying sexual outlet. Assessments of sexually deviant behavior should routinely include coordination with the client's primary physician. Referral to a psychiatrist may be warranted in the case of a primary or secondary co-occurring psychiatric disorder or a severe sexual self-control disorder. Chemical and surgical castration significantly reduce sexual drive in males and reportedly produce a great deal of relief for many (Bradford, 1997). However, they are not a panacea. Reducing sexual urges and fantasies may not be sufficient to eliminate sexual behavior with alternative roots such as hostility toward women or belonging to a group such as a sadomasochism club. For these treatment needs, cognitive and behavioral interventions may be more conducive to creating meaningful change.

Summary

The void of objective assessment tools for the sexual dysfunctions and deviations renders effective clinical interviewing crucial to positive intervention in these cases. Whereas clinical interviewing may be a useful supplement to the assessment enterprise in other clinical matters, it is paramount here. Unfortunately, interviewing around human sexuality is also hampered by sparse empirical investigation. Therefore, this chapter offers the most logical approach stemming from the available data, one that will need revision as this literature evolves.

For both sets of disorders the goal of professionally accessing relevant and accurate information about a person's most private behavior is, ironically, impeded by a lack of intimacy. It is the clinician's ability to convey and maintain professionalism while confidently, skillfully, and carefully engaging the client in a frank discussion of his or her most personal behavior that preserves the dignity of the client while permitting access

to information essential to the change process. Complementing this fundamental task, the apparently broad variability in normative and healthy human sexual functioning should be emphasized throughout the interview and in any reports or recommendations it informs. Clinical interviewers who are accepting of their clients (if not their behavior), discreet, anchored by normative sexual knowledge, well informed about relevant and irrelevant content areas, and skilled in communication will be most effective in assessing and treating human sexual problems.

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