MISC. CHARTS

On a variety of information relevant to counseling

See next few pages

Common Errors Related to Mental Health Diagnoses

1. Clients with the same diagnosis do not necessarily function at similar levels. Therefore, much more than the diagnosis should be documented.
2. A diagnosis, in itself, does not imply the level or type of care needed. Therefore, specific client needs must be documented.
3. If medical necessity is not documented the client may be denied services by a third-party payer. Therefore, specific problems in functional impairments must be documented.
4. Although counseling may be helpful, it does not imply medical necessity. Therefore, it is important to explain to the client that services are not necessarily covered by a third party.
5. Spending too much time counseling in the initial session can lead to lack of diagnostic information received, possibly depriving the client of future services. Therefore, it is important to stay on target.

Possible Reasons That the Same Client Could Receive Different Diagnoses From Different Clinicians Over Time

1. Multiple disorders, but not all initially detected
2. Incorrect, incomplete, or conflicting previous or current information obtained (which may be the result of any of a number of reasons, such as poor rapport or discomfort)
3. Personality disorders exacerbated by Axis I-type symptoms
4. Discrepant cyclical behaviors that are observed at different points in the cycle by different clinicians or observers
5. Effects of using (or abstaining from) alcohol or drugs
6. Medications: effects, level of compliance, changes, interactions, side effects
7. Changes in levels and types of environmental stressors lead to different reactions
8. Organic or physical factors affecting psychological condition
9. Therapist's expertise, experiences, and theoretical stance
10. Level of client insight, exaggeration, or denial
11. Malingering or secondary gain
12. Actual change in the diagnosis

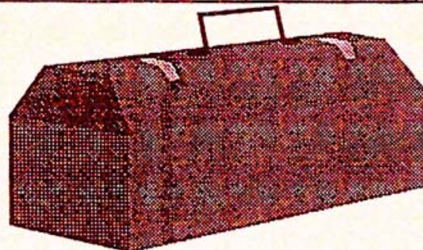
Common Specifiers to Diagnoses

1. **In Full Remission** (e.g., Panic Disorder with Agoraphobia, In Full Remission): The diagnosis was once given, but symptoms and impairments have not been prevalent for a specified amount of time.
2. **In Partial Remission** (e.g., Panic Disorder with Agoraphobia, In Partial Remission): The diagnostic criteria were previously met, but some symptoms have alleviated; thus, full criteria are not currently met. It may also mean insufficient time has passed with alleviation of symptoms.
3. **Provisional** (e.g., Panic Disorder with Agoraphobia, Provisional): The clinician is reasonably confident that the diagnosis is present, but more validation of symptoms is needed for a full confirmation of the diagnosis. There is a higher level of confidence than in a Rule-Out diagnosis. The diagnosis is generally accepted as prevalent.
4. **Rule Out (R/O)** (e.g., R/O Panic Disorder with Agoraphobia): The diagnosis is possible or probable, but either sufficient questions have not yet been asked or a moderate amount of information is needed in the future to validate the diagnosis. Without further validation, such as testing, a second opinion, or further review of records, the diagnosis is generally not accepted as prevalent.
5. **Prior History** (e.g., Panic Disorder with Agoraphobia, Prior History): Previous records indicate assignment of the diagnoses. It suggests that criteria for the diagnosis does not still exist.
6. **Med Controlled** (e.g., Panic Disorder with Agoraphobia, med controlled): Due to the client's compliance with medications, symptoms and impairments are in remission. It is likely that without medications, symptoms would recur.

The Pain Management Toolbox

These are skills which individuals who have chronic, ongoing pain have found useful in dealing with flare-ups. If you are having increased problems, see which ones work best for you. If you don't recognize one of these tools, ask your provider team to teach it to you!

Physical	**Mental**
1. Do Stretches daily. 2. Use Ice/Heat packs. 3. Do some gentle walking, outside if possible. 4. Continue activities, but do so less vigorously. 5. Make yourself stick to a routine of eating and sleeping, using sleep hygene techniques.	1. Relaxation Skills. • Diaphragmatic Breathing • Square Breathing • Progressive Muscle Relaxation 2. Think about Positives that happened today. 3. Use Positive Self-Talk about: getting through this flare-up, your tools, reframing negatives.
Work	**Pleasure**
1. Take small breaks in the day. 2. Don't overdo when you're *not* hurting. 3. Ask for help. 4. Tell other people what you can do. 5. Take responsibility to adjust your workspace.	1. Make time every day for 1 small pleasure. 2. Give yourself little rewards for good pacing and not flaring your pain. 3. Use music, nature, anything that soothes.
Communication	**Social**
1. Use I-statements in getting your wishes understood. 2. Listen to others before forming your response. 3. Take a break, you don't have to solve everything now. 4. Make Statements match your intentions.	1. Make time in your schedule for 1-2 social activities per week. 2. Try to attend even when hurting, though you don't have to do as much. 3. Use group activities so the focus doesn't have to be on you, especially when you're hurting.
Emotional	**Medication**
1. Track your moods; when are they best, when are they worst. 2. Use pleasures and positive self-talk to help increase your mood.	1. Use medication proactively, don't wait until you're really hurting to take it. 2. Take your medicine on a time basis vs. a need basis (usually).* 3. Use adjuvant medications. 4. Avoid alcohol or drugs other than prescribed. *unless told otherwise by your doctor



Questions That Help Assess Patient Strengths

- I've been hearing mostly about how bad things are for you, but I'd like to balance the view I have of you. What kinds of things do you do well?
- Now that we've discussed some things about your symptoms and stresses, I'd like to learn more about some of your satisfactions and successes. What are some good things you have enjoyed doing well?
- To get a more complete picture of your situation, I now need to know more about when the problem does *not* happen.
- What have you noticed you do that has helped in the past?
- Which of your jobs lasted the longest? What did you do to help this happen?
- Right now, some things are keeping you from doing worse than you are. What are they?
- Which of your good points do you most often forget?

Note. From Lehnhoff (1991, pp. 13–14).

Examples of Types of Information Sought in Assessing Cultural/Ethnic Considerations

- To which cultural or ethnic group, if any, do you belong?
- What do you see as most positive about your cultural or ethnic heritage?
- Are you experiencing any problems due to cultural or ethnic issues?
- Is there anything about your cultural or ethnic background you would like me to know?
- Are there any cultural or ethnic factors you would like incorporated in the counseling?
- What are some of these factors?
- How does your culture tend to feel about counseling?

Examples of Types of Information Sought in Assessing Family History and Dynamics

- Were you raised by both of your parents?
- Tell me about the family you were raised in.
- Was there anything unusual about your family?
- Is there anything you wish was different in the family you were raised in?
- What did your parents do for a living?
- How did your parents/siblings treat you as a child?
- Were you or any of your siblings ever taken away from the home?
- Do you have any history of being abused or neglected?
- Were alcohol or drugs used in the home?
- How did you parents get along?
- How do you get along with your family now?
- Does anyone in your family have a history of mental health problems?
- What changes would you like to see in how you currently relate to your family (current and family of origin)?

Suicide Risk Management Guidelines

1. Documentation should be thorough including all risk factors, confidentiality actions taken, and how issues were dealt with.
2. Information on previous psychological and medical treatment should be included in the record.
3. Involvement of the family and significant others can be crucial in creating an effective support system.
4. Consultation on present clinical circumstances should be documented to demonstrate that more than one perspective has been considered in the case.
5. Sensitivity to medical issues enables the clinician to make informed med referrals.The reason for the decision to refer or not to refer must be documented. Knowledge of organic causes of suicidality and appropriate treatment are necessary.
6. Knowledge of community resources such as available hospitals, day treatment, 24-hour emergency backup, and crisis centers should be made available to the client.
7. Consideration of the effect on oneself and others involves follow-up actions when a suicide has taken place or has been attempted.The therapist should contact his or her professional liability insurance carrier and an attorney. Also, the therapist should take care of his or her own emotional needs and the needs of the other survivors as a result of the suicide or attempted suicide.
8. Prevention preparation such as training, knowledge, and experience in dealing with high-risk clients is necessary before a therapist provides professional care to such clients.

(Bongar, 1991)